Legislative Assembly of Alberta

The 29th Legislature
Fourth Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Wednesday, April 11, 2018
9 a.m.

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Fourth Session

Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
- Hon. Sarah Hoffman, Minister
- Hon. Brandy Payne, Associate Minister
- Milton Sussman, Deputy Minister
- Kim Wieringa, Assistant Deputy Minister, Health Information Systems

9 a.m. Wednesday, April 11, 2018

[Ms Goehring in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: I'd like to call this meeting to order and welcome everyone. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2019.

I'd ask that we go around the table and have all MLAs introduce themselves for the record. Minister, please introduce the officials that are joining you at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and chair of this committee. We'll start to my right.

Mr. Smith: Mark Smith, Drayton Valley-Devon.

Mr. Yao: Tany Yao, Fort McMurray-Wood Buffalo.

Mr. Ellis: Mike Ellis, Calgary-West.

Mr. Gill: Good morning. Prab Gill, Calgary-Greenway.

Mr. Orr: Ron Orr, Lacombe-Ponoka.

Mr. Clark: Good morning. Greg Clark, MLA, Calgary-Elbow.

Dr. Starke: Good morning. Richard Starke, MLA for the consistently above-average constituency of Vermilion-Lloydminster.

Ms Payne: Good morning. Brandy Payne, Calgary-Acadia, also Associate Minister of Health.

Ms Hoffman: I'm Sarah Hoffman, Minister of Health as well as MLA for Edmonton-Glenora. With me I have Deputy Minister Milton Sussman, Associate Deputy Minister Andre Tremblay, and Mary Persson, ADM of finance and corporate services.

Ms Luff: I'm Robyn Luff, MLA for Calgary-East.

Ms Renaud: Marie Renaud, MLA for St. Albert.

Drever: Good morning. Deborah Drever, MLA for Calgary-Bow.

Mr. Hinkley: Good morning. Bruce Hinkley, MLA, Wetaskiwin-Camrose.

Mr. Shepherd: Good morning. David Shepherd, MLA for the constituency with the highest concentration of MLAs, Edmonton-Centre.

Ms McKitrick: Good morning. Annie McKitrick, Sherwood Park.

The Chair: Please note that the microphones are being operated by *Hansard* and that the committee proceedings are being live streamed on the Internet and broadcast on Alberta Assembly TV. Please set your cellphones and other devices to silent for the duration of this meeting.

Hon. members, the standing orders set out the process for consideration of the main estimates, including the speaking rotation. As provided for in Standing Order 59.01(6), the rotation is as follows. The minister or the member of Executive Council acting on the minister's behalf may make opening remarks not to exceed 10 minutes. For the hour that follows, members of the Official Opposition and the minister may speak. For the next 20 minutes members of the third party, if any, and the minister may speak. For the next 20 minutes members of any other party represented in the Assembly or any independent members and the minister may speak. For the next 20 minutes private members of the government caucus and the minister may speak. For the time remaining, we will follow the same rotation just outlined to the extent possible; however, the speaking times are reduced to five minutes, as set out in Standing Order 59.02(1)(c).

I would ask that members refrain from talking so loudly, please. Thank you.

Members who are wishing to participate must be present during the appropriate portion of the meeting. Members may speak more than once; however, speaking times for the first rotation are limited to 10 minutes at any one time. A minister and a member may combine their time for a total of 20 minutes. For the rotations that follow, with speaking times of up to five minutes, a minister and a member may combine their speaking time for a total of 10 minutes.

Discussion should flow through the chair at all times regardless of whether or not the speaking time is combined. Members are asked to advise the chair at the beginning of their rotation if they wish to combine their time with the minister's time. If members have any questions regarding the speaking times or the rotation, please feel free to send a note or speak directly with either the chair of the committee or the committee clerk about this process.

A total of three hours has been scheduled to consider the estimates of the Ministry of Health. With the concurrence of the committee I will call a five-minute break near the midpoint of the meeting; however, the three-hour clock will continue to run. Does anyone oppose having this break? Thank you.

Committee members, ministers, and other members who are not committee members may participate; however, only a committee member or an official substitute may introduce an amendment during a committee's review of the estimates.

Ministry officials may be present and at the direction of the minister may address the committee. Ministry officials seated in the gallery, if called upon, have access to a microphone in the gallery area. Ministry officials are reminded to introduce themselves prior to responding to a question or questions. Pages are available to deliver notes or other materials between the gallery and the table. Attendees in the gallery should not approach the table. Members' staff may be present and seated along the committee room wall. Space permitting, opposition caucus staff may sit at the table to assist their members; however, members have priority to sit at the table at all times.

If debate is exhausted prior to three hours, the ministry's estimates are deemed to have been considered for the time allotted in the schedule, and the committee will adjourn. The scheduled end time of today's meeting is 12 o'clock p.m.

Points of order will be dealt with as they arise, and the clock will continue to run.

Any written material provided in response to questions raised during the main estimates should be tabled by the minister in the Assembly for the benefit of all members.

The vote on estimates and any amendments is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on April 19, 2018.

Amendments must be in writing and approved by Parliamentary Counsel prior to the meeting in which they are to be moved. The original amendment is to be deposited with the committee clerk, and 20 copies of the amendment must be provided at the meeting for committee members and staff.

I would now invite the Minister of Health to begin with her opening remarks. You have 10 minutes.

Ms Hoffman: Thank you very much, and good morning, Madam Chair, and good morning to all members who are here in attendance

today. It's certainly my pleasure to present the estimates for the 2018-19 fiscal year for the Ministry of Health, and Associate Minister Payne is here and can answer any of the questions that you raise with regard to mental health and addiction services as she is lead on the strategy as well as on tackling the opioid crisis in Alberta. I expect we'll hopefully have some questions in that regard as well.

With us today are several officials who I'd like to introduce before we get started. Again, just to reiterate, Deputy Minister Milton Sussman, Associate Deputy Minister Andre Tremblay, and Mary Persson, ADM of finance and corporate services, have joined us here at the table. We have some additional department staff here in the gallery to support our conversations as well, and I'd like to thank them for their ongoing dedication and service to the people of Alberta. It's nice to have so many of you here in one meeting at one time. I don't think we do this other than at estimates. I thank you all for your attendance.

The 2018 Health budget protects vital public services for working people by providing stable and predictable funding to make sure that Albertans can get the care that they need. Our consolidated Ministry of Health budget is $22.1 billion, an increase of $634 million, or 3 per cent. This year's budget is a reflection of our government's careful management of health spending, and it also reflects our commitment to slow health care spending to a rate that is more sustainable for future generations. From 2008 to 2015 health spending grew an average of about 6 per cent per year. Since then our government has slowed health spending growth. In this year's budget we are holding that spending to only 3 per cent, as I've mentioned, so a significant reduction in the rate of growth, but of course we know that there are increased needs in our province and that growth is a necessity.

We're doing this while improving the services Albertans count on, including home care, community care, and ambulance services. Our efforts to reduce health spending and address system sustainability will continue this year. We're working collaboratively with our health partners to develop solutions that will improve health services for patients over the long term while slowing the growth in health spending.

One of our priorities continues to be supporting more community-based care closer to home. Health care is structured around people and their communities, not patients who are in hospitals but people who sometimes happen to be patients. That's why we're working with our partners and stakeholders to shift from a focus on hospitals and facilities to providing more services and care in neighbourhoods and communities. It means more Albertans will stay independent in their homes and places where they feel most comfortable, and demands and wait times for acute-care services will be reduced while at the same time delivering efficient, effective care that meets Albertans' health care needs.

Let's turn to AHS, the largest portion of the 2018-19 voted expense estimates. The Alberta Health Services budget will receive $12.5 billion based on operating funding, an increase of $328 million, or 2.7 per cent, from forecast. The additional funding will expand services in areas of continuing care, community care, home care, and ambulance services.

Continuing care will receive a $30 million, or 2.8 per cent, operational funding increase from forecast, bringing operational spending to $1.1 billion. This increase will be used largely to increase capacity in long-term care and enhanced care in the community.

The ministry will spend $1.2 billion on operational funding for community care this year, which is a $90 million, or 8.1 per cent, increase from forecast. This increase will go towards initiatives that include investing in designated supportive living beds and mental health spaces, midwifery, courses of care, opioid treatment, and new services.

9:10

Home care will receive a $112 million, or 19.5 per cent, increase from forecast. This increase will be used largely for new investment and enhancing care in the community.

Ambulance services will receive a $32 million, or 5.3 per cent, increase from forecast. The increase will go towards new front-line resources, including EMS stations, ambulances, and paramedics. Emergency medical services are a critical part of the health care system, so we're ensuring funding is in place to support the important work of Alberta's paramedics on the front line.

As part of the increase for acute care, we are addressing wait times. The increase will be used for initiatives including more surgeries, cancer treatments, and increasing continuing care capacity, which includes mental health and palliative care beds that are based in acute-care sites.

Our work to address health spending includes $100 million saved over the last three years on generic drugs, $49 million saved at AHS within the department last year through administrative constraint, $163 million saved over two years through AHS's non workforce benchmarking initiatives. We've reached a practical agreement with no raises and better job stability with many labour partners, including nurses, with our allied health professionals such as paramedics, lab technologists, and X-ray technologists. More details on specific AHS programs within each line item of the investments will be released when AHS announces its budget later in the spring.

The second-largest area of health spending goes towards physician compensation and development. There is a $4.9 billion budget here allocated for physician compensation and development. The increase is due largely to expected volume growth as a result of anticipated population increase and growth trends to physician services. We have saved approximately $300 million over the last two years through the amending agreement with physicians, and we are currently still negotiating with the AMA on a new agreement for physicians.

In the area of addiction and mental health our estimates anticipate a $14.2 million, or 19.6 per cent, increase from forecast. This budget will largely be used to respond to the opioid crisis and implement recommendations from the Valuing Mental Health report. A significant component is to support community-based organizations to deliver services and building capacity across our province. I want to emphasize that this section of our estimates is not the total amount that the Ministry of Health spends on addictions and mental health services. Alberta Health Services provides extensive addiction and mental health services, that are reflected within the AHS budget.

Overall, to address Alberta's opioid crisis, there is $63 million through the budget. This includes money in the addictions and mental health budget, as I mentioned. The $63 million is an increase of $7 million, or 13 per cent, from the $56 million that was available to respond to the crisis last year. We've made significant progress in the opioid response, including distribution of over 49,000 naloxone kits throughout the province, which has resulted in at least 3,300 reversals that we are aware of. We've also expanded the ability of front-line health care professionals to administer naloxone and opened supervised consumption services at key locations to help save lives. But more needs to be done, and we are putting the resources in place to do just that.

Turning to our capital plan, our budget allocates $4.6 billion over five years for health facilities and equipment. This includes $221 million for existing and new continuing care capital grant

commitments in addition to over $500 million for public continuing care facilities in Edmonton, Calgary, and Fort McMurray and $150 million to replace and upgrade medical equipment. This new investment includes $59 million over five years for medical device reprocessing and $1 million for health capital planning in Red Deer. In addition to the $4.6 billion, the capital plan also includes $700 million to maintain or renew existing health infrastructure. Our budget provides sustainable, predictable funding to protect the public health care services that Alberta families count on.

The Humboldt tragedy has shaken our country to the very core, and it has had a profound effect on me personally. It solidifies my resolve for Albertans to get the care they need most, especially in the face of tragedy. As I joined grieving family members at the vigil in Humboldt on Sunday night, I was moved by the gravity of their loss and also by the strength of the heroism of the young men whose lives were cut short.

Logan, an incredible young man from Lethbridge, had just signed his organ donation card and made his wishes known to his family. He and his family's decision to donate organs has saved lives. His story is becoming known as the Logan Boulet effect. Across the country Canadians are signing their organ donation cards. From Sunday to Tuesday morning 4,785 Albertans had registered their intent to become organ donors through the provincial program. Typically there would be an average of about 500 registrants during the same period. As Logan's family has said, "even in his eventual passing, he was a selfless hero," and I have to say that I couldn't agree more.

I want to thank those first responders on the scene and the medical personnel who were there to help and also our pilots and medical personnel from Alberta who flew to assist with patient transfers from Nipawin to Saskatoon.

To the families of lost loved ones, we wish you strength. To the boys still in hospital, we wish you a swift recovery although we know that many physical and emotional wounds will last a lifetime.

The Chair: Thank you, Minister.

Before we go into the rotation, I would like to invite Mr. Horne to introduce himself.

Mr. Horne: Thank you. Trevor Horne, MLA for Spruce Grove-St. Albert.

The Chair: Thank you.

For the hour that follows, members of the Official Opposition and the minister may speak. Mr. Yao, would you like the timer set for 20-minute intervals so that you are aware of the time, or would you prefer to let the full hour flow without interruption?

Mr. Yao: Twenty-minute intervals would be great.

The Chair: Thank you.

Members are asked to advise the chair at the beginning of the rotation if they wish to combine their time with the minister's time, and discussion should flow through the chair at all times regardless of whether or not speaking time is combined.

Mr. Yao, are you wanting to combine your time with the minister?

Mr. Yao: Split time?

The Chair: You would like to do 10 minutes-10 minutes?

Mr. Yao: Combined. Sorry.

The Chair: Combined.

Minister?

Ms Hoffman: Yeah. Let's try it for the first round and see how it goes.

The Chair: Go ahead.

Mr. Yao: First off, thanks to you and your team for being here today and for serving Albertans. It's greatly appreciated.

All right. Let's get this one out of the way: AHS. For budget item 2 you have AHS, 2.1 through to 2.11. It's set by you as the Health minister, and these are concrete numbers that'll be used as the budget for each of the categories such as continuing care, community care, et cetera. How do you allocate that money? Do you write each area a cheque, or does it all flow through the Alberta Health Services umbrella?

Ms Hoffman: Thank you very much for the question. Certainly, this isn't our first time having this opportunity together, and I think it's given us an opportunity to sort of flesh out some of the processes. As you may have noted from last year's budget, even though the EMS allocation that was outlined in the budget was one number, AHS actually moved some of their funds around within the budget parcels to increase EMS allocation, so their forecast is higher than what was in the budget documents that we had approved. We supported them in making that amendment.

They bring us their business plan, so we essentially do a larger transfer, and then they create their own budget and their own business plan. Then it comes back to our office, to me, for approval. We say that these are the areas that we would like to see the increased investment in. They develop their plans through their budget process, and then it comes back to me for approval. We do have many different bundles that we do transfers for, but I believe in this regard it's one larger transfer and these are the areas that inform their business plan.

Mr. Yao: Is AHS accountable to you?

Ms Hoffman: Yes. They're accountable to all Albertans, to their board, and to myself as Minister of Health.

Mr. Yao: So the buck does stop at you?

Ms Hoffman: I've said that before.

Mr. Yao: Right on. If taxpayers are funding health services, are they entitled to know precisely where their tax dollars are going?

Ms Hoffman: AHS does produce a budget, and they are embarking on that process as soon as we finalize our budget through the Legislative Assembly and pass it on to Alberta Health Services. Their budget is brought forward to their board, which is approved through a public process, and it will be on their website. The meetings you can attend publicly or they are broadcast publicly, so it's certainly a public process. They do send their business plan to us for sign-off as well.

Mr. Yao: But are you prepared today to answer any questions specific to AHS?

Ms Hoffman: Any that relate to the budget of the province of Alberta, yes. The budget for AHS itself – so these are allocations that we're giving to AHS, just like if you were in the Education estimates, they would have bundles for how much they'll be transferring, but you don't ask specific questions about class mix or those types of things because those are worked out through the school boards. A similar process applies to Alberta Health Services.

Mr. Yao: Yeah. I understand you like to use a lot of educational analogies, but it's hard for me to conceive of a scenario where the school boards, principals, superintendents are not accountable to their superiors.

Ms Hoffman: They are.

9:20

Mr. Yao: On the first page of your business plan it states that the Ministry of Health "consists of the Department of Health, Alberta Health Services and the Health Quality Council of Alberta." So, to clarify, these all fall under your ministry. We are here to debate the ministry's budget. AHS takes up about a third of the budget. The buck does stop at you, and you have stated that you are accountable for AHS. Will you answer questions specific to AHS?

Ms Hoffman: Yeah. Just to clarify, it's actually more than half the budget, and we do have AHS line items that are broken down. As I've said in the analogy that I gave – and I think it's a fair analogy – asking questions about transfers, about priorities, about the areas of consistency with Education, for example, or with Transportation, asking specific questions about class sizes or about specific hirings in specific communities, that's a level of detail that others are accountable for, school boards or the AHS board, for example. If you have questions about AHS, I'd be happy for you to ask them, and if they're within the scope of the provincial budget, I will certainly answer them. If not, they would be best directed at a later date, when they finalize their budget, which we expect to be approved in June.

Mr. Yao: You have a budget line here for ambulance services. You've talked outside of this room about how you've increased the budget for EMS and for some of the initiatives that you're providing. With ambulance services, though, what I've had a hard time understanding is that it seems a lot of the parameters for tracking and identifying calls and code reds and code yellows and whatnot have changed or have been removed from a lot of people's ability to identify those. I'm wondering: what measures do you have in place for EMS?

Ms Hoffman: Yeah. I'd be very happy to talk about the EMS and ambulance services budget that we're here to debate today. Is that what your question pertains to, or is it about operations . . .

Mr. Yao: Again, a lot of these measures that are in place, that are unavailable to the likes of me or unknown to me, are affected by the budget. These are the decisions that influence your budgeting team. Again, I ask you: will you be willing to answer questions on some of the specific line items that encompass, as an example, EMS?

Ms Hoffman: Yes. I'm very happy to do so and happy to wait for you to complete asking your questions before I begin responding to them, and I would request the same courtesy, if you would be so kind, in me giving a response.

Ambulance services include patient care, including assessment, diagnosis, and life-saving treatment, patient transportation to hospital and between hospitals, and EMS central dispatch. These new investments will increase front lines, as I mentioned, such as ambulances and paramedics as well as station funding.

Did you have additional questions in that regard?

Mr. Yao: Again, the measures that EMS uses, that they report to you with, they've changed over the last few years. Can you explain those changes?

Ms Hoffman: Those are operational measures, and certainly I'm happy to discuss those at another time outside of the budget. I believe today we're here to discuss the estimates. I'm happy to arrange for opportunities for us to have those discussions in a number of different environments. What I can tell you is that this new investment will help address all measures because we will be increasing investment to front-line EMS providers, paramedics, dispatchers, call centres. They will have the resources through this increased investment to help reduce their wait times.

Mr. Yao: All right. In your business plan, outcome 1, key strategy 1.2: "communities in greatest need." The communities in greatest need are the rural ones who are not getting infrastructure builds or EMS funding, financial support. They're overlooked in health care reviews because of the lack of population density. A lot of your stuff, I noticed, is focused in Edmonton and Calgary. Can you provide a specific list of projects or for, specifically, the new continuing care spaces and the upgrading and replacing that you plan on performing as it does impact EMS?

Ms Hoffman: Thank you very much for the question. We've certainly worked diligently to protect and improve health care services throughout Alberta. It can be challenging where population is declining, but we've made it a real priority, as I think is evident through the fact that we haven't closed hospitals during arguably the most difficult recession in three generations. It's an ongoing commitment to maintaining and improving those vital services.

In terms of the upcoming capital plan, we do have a number of rural projects that we are planning, including rural hospital urgent care design, $2.3 million over the period of this; including support, being a business case for specific projects that aren't yet identified. With that, for example, specific projects would be identified at a later date, but this is about ensuring that we have the resources to do that. We also know that Albertans in rural communities need timely access to that high-quality care within their existing hospitals, and that's why we've protected those.

Another example is the work that we've done in Sylvan Lake to ensure the expansion of the community health centre to include lab, diagnostic imaging, and an increase to operational hours so that people don't need to be spending time on the highway when there's certainly enough demand there. It'll be open seven days a week, 16 hours a day, which is a significant increase. That's one specific example. I'd be happy to discuss more if you'd like.

Mr. Yao: Minister, I know you understand that staying in our communities matters the most, especially in the rural areas where leaving their neighbourhood, their family and friends, their tightly knit network of connections can sometimes feel very alien to people as they leave. That's why it's so important to keep people within the community. Can you tell me your plan to provide class-leading continuing care services for these communities with the greatest need?

Ms Hoffman: Yeah. Thank you very much for that question. Just to reiterate, we have $112 million, or a 19.5 per cent increase, from Q3 for the home care line item in particular. One of the things that I hear throughout my travels in Alberta is that people want to stay at home as long as it's safe to do so, and that requires additional support. That will be allocated based on the actual patient rosters that we see and the nicks and the assessments that are done on the front lines. A 19.5 increase in the midst of a downturn is a significant statement and a significant investment in keeping families intact and in their home environments.

I also want to say that for continuing care, or community care, we have a $90 million, 8.1 per cent increase, $59 million over the

previous budget. This is because of these exact initiatives. We look forward to being able to announce a new capital grant program in the coming months for continuing care to ensure that specific capital investments are made throughout the province. Those details have yet to be solidified, but we are planning on working with communities to expand beyond the already more than 2,000 beds we've begun construction on that will open in the coming months.

Mr. Yao: Let's go to the Health Advocate's office, please, line 1.6 in the budget. Can you remind me what the Health Advocate's mandate is?

Ms Hoffman: Yeah, and it's definitely available on the website, so maybe after the break if you want, I'd be happy to read it out . . .

Mr. Yao: I'd love to hear it from you.

Ms Hoffman: I'd be happy to read it out in detail. The mandate is specifically outlined. We're in the process of recruiting both a Health Advocate and a mental health advocate. I can tell you from our meetings that we have some of the pieces they do on a regular basis from within their mandate. Of course, it's broader than this, but some of the specifics include liaising with patients themselves to help them navigate the system. Sometimes patients feel at a loss, and certainly they have the ability to contact the patient advocate to help them be connected to the right mechanisms to file appeals if that's something they want to do or to access a variety of care types. This certainly is a position that we value and want to recognize in their commitments to the people of Alberta.

Their full mandate is available publicly. I'd be happy to read that after the break.

Mr. Yao: That's fine. Can you confirm how long the office has been vacant for?

Ms Hoffman: It isn't vacant. The Health Advocate is currently filled by one of the staff, but we are in the process of recruiting for a future position. But the Health Advocate is currently occupied and has been for the whole time we've been in government. The advocate's office was established in 2014, and it assists Albertans in dealing with concerns about health services. That empowers them to be effective advocates for their own health in the health care system. It goes on in further detail, but that's essentially the highest level explanation.

Mr. Yao: Can you define the difference between a health advocate and an ombudsman?

Ms Hoffman: Yeah. The ombudsman is more of a technical person. I'm happy to discuss this. I was expecting it to be a little bit more related to the budget. The advocate has a variety of different strategies. The ombudsman, specifically, usually relates to appeals or legal processes that one might take. The advocate, in my experience, is an earlier intervention and rarely needs to get to the appeal process or launch an official complaint because usually strategies are explained and applied to help achieve good remedies for the concerns that have been identified much earlier.

Mr. Yao: Just so you know, I am referring to line 1.6 in the budget. Let me ask you just based on what you said there: isn't it a bit of an inherent failure in the system that there needs to be an external office to assist these patients in navigating it? Shouldn't there be a . . .

The Chair: Pardon me, hon. member, I'm just going to step in right now and remind everyone that this is a committee of the Assembly, and I understand that you and the minister have agreed to combine your respective speaking times; however, all discussion should flow through the chair. So rather than the interruptions I would request that member and minister respond through the chair.

Thank you.

9:30

Mr. Yao: Through the chair, shouldn't navigation systems be done at the doctor-patient level, the person who creates the care plans and is responsible for the patient's treatment through the health system? Certainly, in a lot of the correspondence we get from people, there seems to be a ball dropped, and there's no one held accountable for that. In many cases I can't help but wonder if it's not the health provider that should be held accountable for that.

Ms Hoffman: Just to clarify, the ombudsman responds to complaints of unfair treatment or provincial government authorities and designated professional organizations, so that's the official sort of description of what the ombudsman's office does. The ombudsman and patient advocate roles are something that are very typical throughout North America. Throughout jurisdictions with health care systems in general this is something that's standard, and it is something that Albertans have found productive and useful. I regularly get positive feedback from them, making sure that, obviously, the citizen health home should be with your primary care provider, whoever that is. But there are times where you need a little extra guidance, advocacy, and support, and that's exactly why these roles are created.

Mr. Yao: Okay. But, again, my question was: is it not a concern to you if there's an external office that is required to help patients in navigating our health system when this should probably be done at the ground level, with the physician or with the nurse practitioner, someone who is closer to the patient, that would be accountable and responsible for the patient's treatment? Again, oftentimes we see the ball getting dropped because of a lack of accountability. A physician leaves for three weeks, he's on holidays, and there's no one to give a patient their report that they could have had, that told them to initiate a drug treatment or something like that.

Ms Hoffman: Thank you, Madam Chair. I'd say that for the vast majority of patients and experiences within the health care system, balls aren't dropped. The reason why we have these kinds of checks and balances is that sometimes individuals require additional care. If I were to give another education example, 99 per cent of the time issues around education can be addressed with the teacher or with the principal, but sometimes you do need to be able to go to the superintendent or to some type of mediation mechanism that's set up with many school boards to get a different resolution. But, absolutely, with health, as with most vital services, it is directly with the patient.

The other piece that I should be certain to identify is that each health profession has a college that they report to. So if there are specific concerns with a physician not providing timely response, certainly follow up with the College of Physicians & Surgeons. There are times when this mechanism, this check and balance, is absolutely deployed, and that's the purpose of having these professional colleges that they report to.

Thank you, Madam Chair.

Mr. Yao: You don't believe the system relieves the responsibility of the doctors who meet with the patients and prescribe courses of treatment but then, for all intents and purposes, can wash themselves of the liability associated with that?

Ms Hoffman: Thank you, Madam Chair. Again, as I just stated, the college is the governing body for the individual professionals

within those professions. So if there is a concern with a physician's behaviour, anyone can launch a complaint with the College of Physicians & Surgeons. If there's a concern with a dentist's behaviour, you can launch a complaint with the college of dentists. There are different colleges that help govern the individuals if there are specific concerns about them violating their processes and protocols.

Mr. Yao: Okay. Through the chair, do you not feel that we should have the most patient-centric levels of our health care system, the doctors and nurses and other health care professionals, making sure that the patients they care for are progressing through their treatments and have this thoroughly explained to them? As an example, I notice in Ontario that there's been a proliferation of health navigators, people who are hired privately to help people understand the health system in Ontario and help them navigate through that. It's demonstrated to make patients aware of what they are allowed to access and make sure that they do access all the proper channels and all the proper treatments and whatnot. Where is this province on that?

Ms Hoffman: Sorry. Just to clarify, is that your recommendation, that we request that patients hire private navigators?

Mr. Yao: No. I'm saying that these are the extremes that people have had to go through because of the current systems that are available. Ontario is no different than us – it has the same advocate offices; it has the same structure – but again they're finding that people are having a very difficult time navigating the process. The physicians and nurses are not being held accountable. Offices like the advocate's office, the ombudsman: it's questionable as to how much they are actually providing.

Ms Hoffman: Thank you very much for the question, Madam Chair. There certainly are annual reports and regular updates from those offices, and I'd say that their outcomes are to be commended. I've spoken with a number of Albertans who found resolution by working with these offices and feel that they've helped them through a process that was challenging for them.

Again, I want to say that the vast majority of Albertans, through their patient health home model or medical home model, do receive patient-centred care and have the support that they need in accessing those additional services through their primary care provider.

Mr. Yao: In your business plan under mental health you refer to the Valuing Mental Health: Next Steps. Through the chair, can you give us a progress update on the implementation of the 18 actions that address the 32 recommendations in the committee's report?

Ms Hoffman: To the associate minister, please.

Mr. Yao: The associate minister.

Ms Hoffman: Yeah. Thank you.

Ms Payne: I'll be answering this question. Thank you for the question. There are over 100 activities that are currently under way connected with specific actions that have been identified within the Valuing Mental Health: Next Steps. We're working with community and health partners to take clear, co-ordinated action to improve the integration of health care and make it easier for Albertans to access the help they need when they need it. The estimates contain an ongoing commitment of $40 million for implementation of the Valuing Mental Health: Next Steps, and that funding is spread throughout the budget and some of the operational pieces of the budget.

As you're well aware, in 2015 Alberta Health undertook a comprehensive review of the mental health services in our province, and the Valuing Mental Health: Next Steps response was released in June 2017 with a series of recommendations as well as priority populations, including both short- and long-term actions to work together with partners both inside the health care system and community to address some of those gaps that were identified in the system. We will be continuing these efforts through Budget 2018.

You know, we're really looking forward to fully addressing the Valuing Mental Health report over the coming years. Ultimately, it does take some time to see all of the impacts on a population level, but we are working very closely with partners, including other ministries, Alberta Health Services, and community organizations.

Mr. Yao: Thank you.

Can the associate minister tell us what their priorities are currently in regard to this file?

Ms Payne: Yeah. The four main priority populations with respect to Valuing Mental Health are: improving supports for children and youth, improving supports for people with multiple and complex conditions, supports for indigenous peoples, as well as supports for people living with substance use concerns. In many cases there is an overlap between those groups, so ultimately a big piece of the work is making sure that we have all of the pieces of the mental health system working together, recognizing that there's a continuum from mental wellness to mental illness and supporting Albertans along the way.

Mr. Yao: When does the associate minister feel the projections for all 18 actions will be implemented?

Ms Payne: As I said earlier, implementing the fullness of the report will take some time. That said, we are moving forward on the majority of the recommendations. There are currently over 100 activities under way between government and our partners, with the work being done through the partners being funded through Alberta Health through a granting system. For example, some of the work that we're undertaking includes support for rural communities to help build capacity within rural communities as well as addressing things such as hiring new clinicians to support people in AHS facilities.

Mr. Yao: Okay. Can you tell us when you'll be publishing performance measures on this?

Ms Payne: Yeah. That's a great question. One of the key recommendations from the Valuing Mental Health report was to include performance measures and that tracking. We are still fine-tuning what exactly that system will look like as well as what those measures will be. Each of the grants that have been given to community partners, though, do include specific accountability measures for that particular grant as well as what the outcomes of that particular program are because, of course, the measureable for building resiliency in school settings is going to be a little bit different than the measureable for mental health first aid for seniors.

9:40

Mr. Yao: Okay. I'll give the Health minister a break and stay with you, Associate Minister. Can we talk about dementia? Outcome 1, key strategy 1.3 is: "enhance care for persons with dementia." Can you tell us what the plan is, with tangible steps that you will take to enhance care for persons with dementia?

Ms Hoffman: Do you want me to start?

Ms Payne: Yes.

Mr. Yao: Oh, I was trying to give you a break.

Ms Payne: Sorry.

Ms Hoffman: We did launch the dementia care strategy just a few months ago, in fact, through a south-side PCN. One of the reasons is because dementia care usually does begin in primary care.

I just do have a few more details around the navigator piece that I'll share if that's okay. One, we do have cancer care navigators and tumour triage navigators because, of course, we know how difficult that time can be and that it's important to have somebody supporting those – those are provided publicly through AHS – as well as cardiac care navigators. The other piece I just wanted to say is that with those specific navigators, the other big investment that we're doing, of course, is around IT solutions and e-referrals. That is intended to help create greater transparency in working with patients around the referral process. I just wanted to get that on record.

In terms of the strategies around dementia care we did release that full strategy publicly. It includes, of course, significant investment in dementia care, DSL level 4D beds, because we know that those are of utmost importance, but also increasing opportunities in the community for greater interventions, greater education, and greater research. The strategy action plan was released in December. It addresses dementia as a larger societal issue, one that government continues to work with Albertans to address. Expected outcomes of the strategy include increasing understanding of the impacts of dementia; support for Albertans and their caregivers, who are giving to those folks living with dementia; timely diagnosis, which is an important one; and treatment management throughout continuing care.

One other brief example is that calling 811 anywhere across the province now is available to have an early high-level assessment done, which we know that in rural communities having access to those supports has been a challenge. So that's one of the reasons why we added it to 811.

Mr. Yao: To the Health minister: can you clarify the performance measures that you're going to use to track the outcome progress? For example, is it going to be, like, declining trends in individual diagnoses? Are you going to measure based on lifespans? What quantifiable improvements in life can you measure in this regard?

Ms Hoffman: Thank you very much. Of course, we know that the numbers continue to grow, so we have more work to do. But there are some measures that are already in place, including expanding the First Link program. That was a $1.95 million investment in an early intervention program to connect patients with caregivers as soon as a diagnosis is available. So we can certainly track diagnosis and connections to surrounding supports.

As well, there is mental health first aid for seniors. I believe that the associate minister mentioned some of those initiatives. That's $530,000 to focus on that area. There's free public training on how to respond to a mental health issue as it develops, the seniors' health strategic clinical network at $4.1 million, and several projects continuing under way with AHS. I mentioned Health Link, community innovation pilots. There are eight pilots under way, including programs that integrate exercise, music, and dementia care with other measures.

These are some of the areas of investment. With these investments come measures related to uptake in participation and some of the individual outcomes for individuals as well.

Mr. Yao: Okay. The Health minister mentioned IT. Let's go to our integrated health records, outcome 4, key strategy 4.5: "enhance a patient-centred, integrated health record." Now, for the record when you announced this, you'd budgeted half a billion towards this IT project for a new integrated health record. Can you give us a status update?

Ms Hoffman: Yeah. Thank you very much for the question. I think this is something that the vast majority of Albertans – for example, I met with the Price family recently, and we were talking about this in the context of, of course, their beloved son who passed away. One of the biggest issues from the HQCA report was lack of follow-up and lack of connection, that a referral would be made and then it would be several weeks or even months before potentially a follow-up call was given, that their son didn't know where he was in the system, and it made it, certainly, more difficult for him to be a partner in his care. This is one of the reasons why it's so important for us to make these investments.

I understand why they weren't done in the past. It's a significant investment, as you've just noted, as well as it's really a lot easier to cut a ribbon around a building than it is to celebrate a significant public investment in something like having a seamless flow of information. But it is vital to make sure that patients get the right care.

Yesterday HSA was present. More than 70 per cent of the health care decisions in this province are related to diagnostics. If you don't know what your diagnostics are, how are you to know what the outcomes are?

In terms of the project itself, as you've mentioned, more than $400 million was committed through capital funding over five years for what we're now calling connect care. Connect care is that platform that I mentioned.

The first installation of CIS will be done at the Walter Mackenzie campus in November of 2019. We've already moved forward with securing standards, guidance, ensuring that AHS providers have access to contribute the same information through that common confirmation system. I think that last year in estimates we talked about the more than 1,400 different software programs that are currently available. So that's the first one.

Then, as well, a $32 million investment in the procurement and initial licensing for the hardware upgrade updates was already done in the last fiscal. So we've done that piece.

Alberta Health will be investing $80 million in '18-19 towards the procurement of enterprise content management licensing for release of content management changes, completion of workflow design and build, completion of wireless development for waves 1 through 3 of deployment schedule, completion of application testing and data centre infrastructure. Approximately 50 per cent of the capacity will be ready within this fiscal year.

Mr. Yao: Minister, will you be trialing this software currently anywhere in the province? You've purchased an established software program from a provider that has sold this product to other government health institutions and whatnot. Do they have a working product that we are working with now, that we have a trial going on now?

Ms Hoffman: Yeah. I brought up software because of the 1,400 different components we talked about last year, but it's actually so much more than that. It's about a mainframe. It's about having the technological supports in place.

Because of the complexity I'm actually going to ask Deputy Minister Sussman if he would like to elaborate on that. I'm unsure

on the procedure. Do we call on designates? Can I ask one of the ADMs who's responsible for the project?

The Chair: You absolutely can.

Ms Hoffman: Okay.

The Chair: Just identify their name, and then have them come to the microphone.

Ms Hoffman: Thank you very much, Madam Chair.

The Chair: You're welcome.

Ms Hoffman: ADM Kim Wieringa.

Ms Wieringa: Thank you.

Ms Hoffman: Maybe, Kim, if you can just touch a little bit on the processes in other comparable jurisdictions or how we're doing this through a seamless way to ensure that patient safety is protected.

Ms Wieringa: Thank you, Minister. My name is Kim Wieringa. I'm the ADM of health information systems here in Alberta Health. Connect care is a software product that Alberta Health Services purchased through a one-year procurement process, with the fairness advisor overseeing it. Epic is a product that was developed and maintained in the United States. It is deployed throughout the world. In Canada it is currently being deployed in the children's hospital in Ontario. There are other Canadian sites that are looking at it right now.

Now that we've got the licensing, which was just signed in October, the business pieces around the business workflow and the business processes are being worked with across the whole AHS organization to define their business requirements and how they want the system configured. That configuration will take about a year, and they'll spend another year testing it to make sure that we do not have inappropriate information attached to the wrong people and that everybody understands it. So we will have an operational system in two years' time. It does seem like a long time, but we're talking about reducing 1,300 systems to less than 200. This is a critical tool for service delivery at the medical and clinical level, so we want to make sure it's accurate.

That is an operational tool. It'll go across the whole organization of AHS, which is over 110,000 people – clinicians, physicians, and administrators – many of whom will touch it in some way or another. It's a huge transformation in that organization. Outside of AHS other care providers will leverage that to order test results such as lab and diagnostic.

The Netcare system, our electronic health record, which is a little bit different, is a consolidated view of the patient-centred record. It includes information that AHS will contribute but also includes other care providers' contributions and allows clinicians outside of AHS to access common information.

9:50

Mr. Yao: In my conversations across the province I hear about various software programs and databases that were working regionally. Why did this government choose to buy a new system entirely rather than expand one of the existing systems that the physicians say worked fine for their regions?

Ms Hoffman: Thank you very much for the question. Would the member be able to elaborate on whether it was acute care or community-based care or what types of software he might be referring to?

Mr. Yao: With the family physicians in particular.

Ms Hoffman: Okay. Yeah.

Kim, if you'd be so kind as to elaborate on the relationship between community-based care and acute care.

Ms Wieringa: Thank you, Minister. As many of you are aware, the health system is a very complex environment of many moving parts. Our physicians operate on a clinic basis, and we have been working for several years to have them work broader in a PCN environment. They are responsible for their legal record of care, which they record within their electronic medical records they purchase and operate at a local level.

Alberta Health Services is a regional entity under legislation to operate for acute and ambulatory services, so they are a different organization. They have a different legal framework and a different set of responsibilities.

When we look at dentists and pharmacists and chiropractors and doctors and all the other care providers that help serve the patients and Albertans as they move through their lives, they do have different corporate responsibilities. Honestly, we wouldn't want one system across the entire province. That puts us at risk. We spend 15 years implementing it, and then potentially if that failed, we would spend 15 years recovering.

You did ask why we didn't just use the existing 1,300 systems in Alberta Health Services. Did you want an answer for that one as well?

Mr. Yao: Why didn't you make a decision and choose one?

Ms Wieringa: In Alberta Health Services or in the province?

Mr. Yao: Certainly, there must have been something that was being used that could have encompassed all of the requirements, again based on conversations with various physicians that were using software. Why did you choose to go with a new one versus that?

Ms Wieringa: There isn't one prominent software that we are using in Alberta Health Services. We went through a full procurement process to make sure that we had a common platform, and there isn't one software company that can do everything for everybody for every possible clinical activity. That doesn't exist. So Alberta Health Services looked at their common framework. We spent a year assessing the viability of whether we would take one of the other products that they currently had in one part of the geographic area and roll it out. All of them needed upgrading. None of them actually served as a common base for the multiple services. There was Epic. There was Cerner. There was Allscripts. There were a number of other products that AHS used, and none of them in their current state and in procurement legal contracts could actually extend and actually serve the needs of the organization.

Mr. Yao: Thank you very much.

Ms Hoffman: Thank you very much, ADM Wieringa.

Mr. Yao: Speaking of legal contracts, a key component of software purchasing is the ability to manipulate the code, and with that comes a certain ownership. When the government was negotiating this half-billion-dollar deal with the software company, do we own the code?

Ms Hoffman: Thank you very much for the question. Again, this is an AHS facility component. I'll be very happy to call on ADM Wieringa again to elaborate on the flexibility and integration. One

of the big drivers – if I can just introduce it, and then, ADM Wieringa, please elaborate around the ownership of the code.

For example, to use one more education analogy, could you imagine writing tests, never getting them back, and having your teacher say, "Don't worry; no news is good news"? Of course not. We wouldn't expect that for our children. As parents we want to know where our students are at, where our children are at educationally.

This is about taking the components from acute care, from hospitals, and from labs and being able to combine that with the work that's done in community and then giving patients access to their own information. There are 1,300 different systems, as was identified, throughout Alberta related to health, finding ways that they can interface, that they can share information so that patients can actually access it and understand where they are at with their health and so that other health care providers as well can know what has happened to that patient throughout the journey.

ADM Wieringa.

Ms Wieringa: Thank you, Minister. The contract between AHS and Epic requires that we install and operate that software here in Alberta. They are required to keep code in escrow should there be an issue, and we are training the staff in AHS to actually maintain that software because it's a configurable product. So AHS has put every step into the contract to ensure that we are not potentially at risk of not being able to operate.

Mr. Yao: So we own the code?

Ms Wieringa: We own a licence to the code. It's different. You know, software is a proprietary product. That's why it's a private business. We own the right to use the code, and we own the right to install it and maintain it over the life of the contract.

Mr. Yao: Thank you.

Compensation models for physicians. In the strategic context of the business plan you mention new compensation models for physicians, and then once again in outcome 3, strategy 3.2. What will be the changes to the physician compensation models?

Ms Hoffman: Thank you very much for the question. We are in the midst of negotiations right now, so it wouldn't be something that I would be able to discuss in this venue. We are certainly working with physicians to develop sustainable funding models.

I can talk about our goals through the negotiations, of course. Our goals are similar to those through the amending agreement, ensuring that we have sustainability, ensuring that we have a reasonable rate of increase that's matched with demand as opposed to just increasing costs and the same level of service being provided. We are working to ensure a sufficient, efficient deployment of those resources to help address patient need throughout our province.

Mr. Yao: Does the Health minister anticipate any changes to the physician compensation? You know, nurses' wages have been frozen, as have those of other public servants, and pharmacists are experiencing dramatic cuts, as you know. They're very vocal about that. What was the reason that you're saving money in those other areas? Is that simply so you can support the physicians at their current rate?

Ms Hoffman: As I mentioned in the first response, we're at the table with physicians right now, so it would be inappropriate for me to comment on our intent for specific outcomes at that table. As you have mentioned, we have been achieving reasonable, sustainable agreement with our health partners, including UNA, allied health professionals. We did sit down and work with pharmacists to come up with a model that does see an increase to the overall pharmacy budget but that being focused on the actual increase in demand rather than increased rates of compensation for existing procedures.

Mr. Yao: I see.

Business plan outcome 3, key strategy 3.1: "Enhance the delivery of primary health care services through patient attachment to providers and health care teams, increased integration of services, timely access, and improved quality and safety." Wow. That's a great, great, feels good, sounds great statement. Can you explain what you mean by patient attachment to providers and health care teams?

Ms Hoffman: Yeah. Again, if I were to go back to the HQCA report and to the Price family in particular – I imagine you've had an opportunity to meet with the family. What they specifically spoke about in their experiences and what the HQCA report highlighted is that there was a lack of connectivity. Whether it was through the individual encounters through urgent care or medicentre offices, whether it was waiting for referrals, it's about ensuring that the patient health home is the centre of that engagement.

The increase will largely be used for anticipated volume increases as more patients continue to join primary care networks. These elements in the budget involve enhancing team-based care to Albertans. For example, many patients don't need to come in for that second follow-up to a visit. They can connect with a nurse over the phone around what the results were for their tests and that type of thing. As part of our goal for more community-based care Alberta Health is working with PCN physician leads and AHS and our primary care providers to support changes in how PCNs operate. These used to act as individual islands, in complete isolation. Now they're trying to work in a more collaborative way throughout the zones that align with the AHS zones so that they can share resources and information to focus more around the patient.

10:00

Mr. Yao: Can you explain what you mean by increasing integration of services?

Ms Hoffman: Yeah. Part of this has to do with when you're a member of a PCN. Most of us around this table are members of PCNs, if not all. We might not know it because it's actually our physician that's attached to a PCN, so by choosing a physician, if your physician is connected – and more than 90 per cent of us would be – we would have a connection.

So integration of services. For example, if I'm going and I am receiving a diagnosis – one of the areas that most of the PCNs have done a lot of work around is around diabetes care, for example, with the increased rates. There you can get counselling from a pharmacist. You can get special support from a nutritionist or dietitian. You can get special support through social work. They have this team-based model around the condition that an individual patient may have, but the team and other health care providers, including the nurses and physicians who work within that PCN, would work with that patient around where they're at in their health care needs. It really is about having a greater connection and focus around patients' needs rather than going to individuals in a variety of different settings. You could be connected through your primary care provider to the right allied health professionals to support you in that journey.

Mr. Yao: Integration of services: certainly, that's a key understanding in our health system, that we have to incorporate

everything together and give people more wholesome treatments. It is in the mandate of the primary care networks. I noticed it's also in the mandate of our public health units. Can you explain the difference between those?

Ms Hoffman: Between a family physician or nurse practitioner?

Mr. Yao: No; public health.

Ms Hoffman: Public health. Yeah, absolutely. Maybe I'll call on – just because I haven't called on you yet – my deputy minister, Milton Sussman, to talk about that a bit. His experience is extensive in both acute care and the governance side.

Milton, please.

Mr. Sussman: Thank you. Public health deals primarily with population health requirements, so it will look at things like immunization, maternal services follow-up after birth, those kinds of initiatives. It will deal with outbreaks. It also deals with things like food licensing and food safety and other environmental health pieces. It has more of a broad population, but it links to all of the other parts of the system, and that's really where the integration needs to take place.

Immunization is clearly linked to primary health care. As primary health care, there are significant links between primary health care and specialists and diagnostics and acute care. The integration is really trying to have those different components of the health system trying to work more as one system rather than as separate silos.

Mr. Yao: Thank you.

Can we go to continuing care? In your business plan, outcome 1, performance measure 1(a), the target for the fiscal year is 58 per cent of the clients placed in continuing care within 30 days, up from 56 per cent, yet AHS's third-quarter stats show that the wait times have grown to 52 days now. Can you explain what's going on there? Despite your best interests we're getting a reverse trend. Is this simply a matter of a step back for two steps forward kind of thing?

Ms Hoffman: Thank you very much for the question. I've definitely probed this item quite a bit because, of course, we want to get people placed as quickly as possible. We also want them to be placed in the facilities of their choosing and their family's choosing. Weighing both sides of that coin, sometimes they're in conflict because if we said, "You're in need. We're going to get you out of hospital. We're going to get you out of your home and assign you a space," it may not work with the family in terms of location. It may not work in terms of preference or the type of provider.

For example, my own grandmother really wanted to be in a Catholic facility run by Covenant Care, and if she were to be assigned to a facility that wasn't, it wouldn't have respected her choice. So one of the challenges is that we've allowed more choice within the model in recent years than we had in the past, and it has provided some challenge to achieving those targets, but definitely a deficit of capacity is the biggest driver as well as the aging population.

We know that we need to bring more spaces online. That's one of the reasons that in the first two quarters we did bring on, I believe, over 700 spaces last year and why we are on track to open over 2,000 new long-term care and dementia care spaces throughout the province but also why we need to bring forward, hopefully in the next couple of months, our new capital plan to be able to work to increase capacity even beyond that 2,000 that we are already on track to achieve. The targets have been set at 61 and 64 to reflect further investment in home and community care, and the target is continuing capital care, of course, as I mentioned, with the new plan.

It's important to remember that not all patients waiting for continuing care spaces are waiting in an acute-care hospital, as I mentioned. Many are in transition beds or subacute beds or in rural hospitals where system flow pressures and patient acuity are not quite as intense. Obviously, the ultimate goal is to ensure that everyone is living in the right care facility for their needs, whether that's at home, independently, or whether it's in a building of some sort. Making sure that we're investing in these and making the important investments in lodges and expanding care options throughout the province is going to continue to be a priority for us.

Mr. Yao: The business plan refers to gender-based analysis plus to ensure health-related policies. I have to be honest with you. I'm not as familiar with how it is encompassed into Health. I was wondering if you could explain that to me. I mean, for the record, I am a strong believer in equal rights for all. There should be no discrimination, no bullying of any sort. People should be judged on their quality, not their sexuality. But I don't understand how this affects Health. Could you explain, please?

Ms Hoffman: Yeah. This is an initiative that we've undertaken in all components within government. Perhaps at estimates for the Ministry of Status of Women would be the most detailed response. I can tell you that from a high level, from conversations we've had, systems haven't always historically acted in a way that has been ensuring that it's based on qualifications or it's based on attributes rather than on gender. GBA is an analytical tool that's used in assessments of how diverse groups of women, men, gender-diverse people may experience policies, programs, and initiatives, and a GBA plus model acknowledges that gender-based analysis goes beyond sex and sociocultural or gender differences. They have multiple identifying factors that intersect to make us who we are. GBA plus also considers many other identifying risks like racialization, ethnicity, religion, age, mental or physical disability.

For example, when you look at the health outcomes for individuals in the province, we break down work that we've done around indigenous Albertans. We have huge discrepancies between nonindigenous and indigenous health outcomes. We have discrepancies between women and men. This is about making sure that we have systems that acknowledge that there are differences and that equity drives our decisions.

If you would be so inclined, the associate minister would also be able to elaborate on this.

Mr. Yao: Okay.

Ms Payne: Thank you. What I wanted to add was around, for example, the impact of GBA plus analysis on some of the work we're doing on Valuing Mental Health. By doing the GBA plus analysis on the Valuing Mental Health program, one of the things we were able to identify was that a higher proportion of the amount of the strain around a family member's mental health does tend to fall to the women in the family, particularly mothers, as caregivers. As we move forward with some of the development of Valuing Mental Health: Next Steps, it was really critical for us to take into account how we could support caregivers as well as the individuals.

Another way that it emerges in mental health is, for example – and we've had studies to this effect from the U of A recently – that transgender and gender-diverse youth are massively disproportionately more likely to experience depression, suicidal ideation, as well as anxiety, bullying, and other mental health complications. Ultimately, for us it's very critical to make sure that we take into account some of the inherent discrepancies that exist for different populations and that as we do our work in health care, we're able to offer the appropriate supports to those individuals.

Mr. Yao: Thank you.

To the Health minister. Under children's health in the business plan, outcome 2, key strategy 2.4, improve maternal, infant, and child health. The Stollery Children's Hospital Foundation is trying to move forward on a new facility. We're talking about bricks and mortar. It is included in your capital plan, with over $44 million dedicated over five years in total. Can you tell us what stage we are at with this centre of excellence, please?

10:10

Ms Hoffman: With the new Stollery tower specifically?

Mr. Yao: Yes. Is that what your funding amount is, the $44 million?

Ms Hoffman: It's not for Stollery. In terms of the line item, the $44 million, we'll pull out my detail page on that.

What I do want to say is that we followed the advice of David Dodge, formerly with the Bank of Canada, to ensure that we had the right investments to support stimulus in our economy as well as catch up on deferred maintenance and lack of infrastructure throughout the province. I'm proud of the fact that we are building facilities such as the Calgary cancer hospital, a new hospital in southwest Edmonton, Grande Prairie regional hospital, and the list goes on.

In terms of Stollery, currently the project consists of developing the existing Stollery PICU 3A2 and 3A3 and NICU by redesigning and redeveloping within the adult cardiovascular intensive care unit. It's not a stand-alone tower, but it is investment at the Stollery itself. The continuing PICU and NICU space is to create 16 beds of each type and common nonclinical care activities. May 2020 is the construction completion date for that, and the total project cost is $64 million. Currently we're in construction phase 2, so we're definitely making significant progress there. But it isn't a stand-alone tower; it's repurposing and giving new life to existing space to address the needs that are in place there.

Thank you.

Mr. Yao: It's good to see the investments in pediatric care. A lot of it is for infrastructure, if my understanding is correct, then, based on what you said.

Ms Hoffman: That was specifically capital, yes.

Mr. Yao: Like, you know, with the labs you're building a stand-alone infrastructure there. Is your goal to have a stand-alone for the Stollery as well ultimately?

Ms Hoffman: I know that that is the Stollery foundation's request within the current campus, that they would like to stay on the U of A campus. Obviously, there are a lot of connections between research and good health outcomes in these types of care. Somebody told me the other day that you've got to cut the suit from fabric you've got. Certainly, we have fabric at the U of A campus, and we have opportunities to repurpose it. That's what we're doing there.

We're also working to have satellite hubs. You may have seen that recently we announced in St. Albert, for example, that there will be a new NICU unit there, which St. Albert has never had, so that we can keep those neonatal intensive care patients and their moms together in their communities. There's definitely been a demand there. Stollery is supporting that site as well. They are engaging in some satellite work with us, and we really appreciate that. Rather than everyone having to come to Edmonton to receive excellence, we're finding ways to have Stollery come to communities and support them as well.

I do know that there is still an ongoing desire to have a brand new tower on the U of A campus. I understand that that is more of a longer term goal, but we are working to ensure that the work of the Stollery can continue to expand and serve families throughout western Canada.

Mr. Yao: Certainly, pediatric care is very important across this province, and you stated it exactly. A lot of people, including Fort McMurray as an example, have to go to the cities. There are hundreds and hundreds of people, actually in the low thousands, that do have to commute multiple times annually to get treatments for their kids. Is there a push towards emphasizing satellite operations as well as using technological advances? I did challenge the Stollery on that. The only telehealth or video link communication we have is within the boardrooms of AHS. What initiatives does this government have to focus on providing treatment, patient-based supports to enable access to health?

Ms Hoffman: Thank you again for the question, Madam Chair. I have to say that throughout my visits we've seen an increased expansion of telehealth, and that is so important. For example, there's a Panda baby warmer in High Level. All of the different sensors that are in the baby warmer – and these are for some of the tiniest, lowest birth weight babies – directly interface with the physicians at the Stollery, so they can see as soon as that baby is born and connected to this machine whether or not the baby needs to be transferred. Transfers from there to the Stollery are by air ambulance. Transfers have actually reduced by about 50 per cent because we were able to bring that physician directly to the community rather than having to move the baby and the family to Edmonton all the time. Telehealth continues to expand, especially in the areas of mental health and cardiac care. These are some of the areas.

We are doing ongoing maternal health specifically in Fort McMurray. In 2017 we recruited 10 new doctors to Fort McMurray, including pediatricians, anaesthesiologists, family physicians practising low-risk obstetrics, and psychiatric care as well. We have on-call pediatric care available 24/7 now in Fort McMurray. We expanded beds in the maternity unit as well, and we have two pediatric cardiologists regularly supporting Fort McMurray and the care that we're providing there. We're certainly proud of those increased investments in that area.

Mr. Yao: Okay. I . . .

Ms Hoffman: I can talk more about telehealth if you want. I've got lots.

Mr. Yao: No. Sorry. I'm just stumped. The chair told me that I have 10 seconds left.

The Chair: Twenty-six.

Mr. Yao: Oh, 26 seconds left. I'll pass.

Ms Hoffman: In terms of telehealth we have supports through addictions and mental health, cardiology, neurology, stroke, pulmonary, pediatric, chronic disease, diabetes, arthritis, rehabilitation services, palliative, seniors' homes . . .

Mr. Yao: Will this be available online? Will people be able to access that through their own personal computers?

Ms Hoffman: It is, yeah. It's a link on the AHS website that I'm reading.

The Chair: Thank you. I hesitate to interrupt; however, the time allotted for this portion has expired.

I would now like to invite Mr. Clark from the third party opposition and the minister to speak for the next 20 minutes. Mr. Clark, are you wanting to combine your time with the minister?

Mr. Clark: Thank you, Madam Chair. I would like to do that very much. Minister, associate minister?

Ms Hoffman: As would I.

Mr. Clark: That would be great.

The Chair: Go ahead.

Mr. Clark: Thank you very much. Thank you to you both and all of your officials both at the table and beyond for being here. I very much appreciate it. Many questions, so we're going to dive right in. This past weekend I had a town hall in my constituency, and what struck me was the number of people who wanted to talk about health care and the importance of that as an absolute priority. Their focus was on high-quality, accessible health care. They specifically wanted to see shorter wait times, and that was a very important focus for them. They did want better value for money. There's a perception that there's a lot of money already in the system, and they feel like we don't always necessarily get good value for that.

But they really did want to focus on the human side of things. The one piece, the quote that struck me was: I want to see our health care system humanized; I want to see you put the patient first. You made some comments about that earlier, but I just wanted to share that with you, Minister and your associate minister and your deputies, just to hear that that's the focus that people would like us to bring.

I'll just give you a couple of moments if you have some specific information on wait times specifically, if there are initiatives in terms of reducing wait times that I can report back to my constituents on.

Ms Hoffman: Yes. Thank you very much, Madam Chair and to the member for the question. Reducing wait times is certainly a priority for us and for all Albertans, I would assert. Alberta is a top-performing province on wait times for hip fracture surgery, bypass surgery, radiation therapy, but we certainly know there is other work to be done in other areas. Government is working with AHS to improve access to health services, including better management of folks who are in the queue for surgeries using specific wait time targets and reallocating OR time according to the areas of greatest need. I know sometimes that can be frustrating, if you've been waiting for surgery and you find out that you've been bumped because somebody with cancer is at the top of the list, but I think once people talk about how if you were diagnosed with cancer, the urgency, people understand it. It is frustrating, though, if you're waiting and you're in pain, in particular.

Because of that, AHS will be able to invest approximately $40 million in targeted investments to reduce wait times, including addressing backlog in out-of-window cancer surgeries, zone specific investment in cardiac surgery, hip and knee replacements and other orthopaedic surgery, urgent cataract surgeries, and other quality improvement initiatives. We have increased investment in this budget of $40 million to help address that.

Mr. Clark: Thank you very much. The specific concern as well that was expressed to me was people getting sicker while they're on the wait-list, that perhaps it not only reduced their quality of life but also increased costs going forward. So I'll just put that out there.

I would like to move on, then. Just some specific questions about your department itself. Do you have any data you can share on the number of positions in your department, Alberta Health, that have been vacant for more than six months? Do we have that data readily available, or if not, could it be tabled?

10:20

Ms Hoffman: We'll work to table that.

Mr. Clark: Thank you.

I'll ask the same question, please, about AHS. How many positions in AHS have been vacant for more than six months? If you don't have that data handy, I would appreciate it if you could table that.

Ms Hoffman: I definitely don't have that handy. I'll do my best to find some information that we can share around that. As we've talked about in the House, obviously we want to ensure that all necessary positions are filled when there are vacancies, particularly that are achieved through retirements or other moves. We are examining every position to ensure that it is the right place to fill that position rather than just doing it rote. We know that it's important for us to strike the right outcomes for patients and also to achieve that path to balance. So we will get some information that we can table at a later date.

Mr. Clark: Good. Thank you.

I'll move on to the personal health record, which you refer to on page 81. We talked about it earlier. You used your school test example, and I think that was a good example.

Ms Hoffman: Thank you.

Mr. Clark: It was interesting. It just so happened that I had my annual physical with my GP here last week, during constituency week. I'm fine. I'm sure you're glad to know that. I asked him, from his perspective: what's happening? Is there a project under way? I said exactly that.

So if you run some standard blood work, and I'm interested in what my cholesterol level happens to be, will I be able to go online, just like I can go online at my bank, and see this information? That's my question to you, Madam Minister, through the chair. Is that system we're talking about AHS only? Is this going to be extended out to GPs? I think that, especially for the investment we're making, that would be the expectation of Albertans, that our health information, regardless of where it comes from, that sort of information would be available to us online. Is that what we're doing here?

Ms Hoffman: Thank you very much, Madam Chair and to the member for the question. Certainly, that is the ultimate goal, for everyone to have the right information to inform them around where they're at in their health journey. The personal health record will enable Albertans to manage their health and well-being, providing them with a secure place to store a copy of their health information and interact with the health system digitally in one place.

Making the platform available with mobile devices has been a real priority for me. I think this started a few years ago, before mobile devices were as dominant. I imagine that most of us have two on us at most times. By the end of 2018 the platform will be ready to roll out to the public. But, obviously, we'll start with

whatever information is most easily able to integrate, and then we'll expand it for other physicians.

As we mentioned, currently there are 1,300 different systems incorporating Netcare, information that's available on Netcare. Often our family physicians will put some of their own information on to try to interface with it, but Netcare, I believe, right now is focused mostly around acute care and testing that's done more centralized. That's what easiest to access right now.

Mr. Clark: I appreciate that. I have come from an IT world, so I do appreciate the complexity. I recognize that this is a particularly complex area, when we're dealing with privacy. You know, there's a lot of complexity. But I think Albertans have an expectation that it's our job as legislators and as, ultimately, the government in the broadest sense to manage that complexity on their behalf. They just see health care. They don't really know that their GP is not part of AHS, and they don't frankly care, especially as we focus and should focus not just on acute care. I will just say that I think our acute-care system is among the best in the world, and in certain areas we are the best in the world. There's a lot to be proud of there.

But a focus on wellness and an ability for Albertans to manage their own health care, I think, should start and focus on PCNs, should focus with your primary care providers. Do we have a pathway with a timeline that's going to get us to a place where when I go to my GP and he orders some tests, I will be able to go online and look up those tests? Really, the fairly direct question is: when are we going to roll GPs into this?

Ms Hoffman: The short answer is yes. The longer answer is that over the next five to six years will be the full CIS rollout. It will allow AHS to create a single electronic health record for every single Albertan, ensuring that AHS providers have access to the same information. So that single source of information, as you mentioned, will support team-based care.

The easiest information in the first stage will be to take the information that's available through AHS and import it into our own records. In terms of the individual doctor's offices, for the early stages it will likely be that some of us need to, when we're with our physicians, say: so what medications am I on? Then we can enter the information ourselves because that interface won't necessarily be able to integrate it automatically, but we certainly can take a role in putting that information into our record that we keep as patients as well.

We're continuing to expand Alberta Netcare to secure an online tool that currently provides over 60,000 registered health providers – these are many of the health providers in the community – with patient information to support their decision-making and point of care. Netcare e-referral projects are another piece, too. I know that when I was referred for surgery on my wrist a few years ago, I didn't know what the average wait was to see that type of plastic surgeon. I didn't know if it was reasonable to wait for a year or six months or three months to be in the queue. Having information around ensuring that the referral went through, that you are in the average wait time – because it wasn't an emergency.

Mr. Clark: I'm sorry. I apologize. I hate to cut you off, but we're very short on time here.

Ms Hoffman: Continue, please.

Mr. Clark: I'm going to move to the dementia strategy. Some of these are questions that have come directly to my constituency office from my constituents, that I've committed to pass along. There's a great deal of frustration with the specifics of what, I would respectfully say, feels like a lot of re-announcements around what you've called the dementia strategy.

There's a great deal of frustration. One of the specific questions is: what are you doing to address the two to three year wait-list for dementia care? One constituent says:

> Some people die before they have AHS care facility support. If one had cancer, one certainly would not be asked to wait! But because this horrible disease has no cure/no hope at all, it seems that the government thinks waiting for 2-3 yrs for AHS support is appropriate. This is a travesty!

What are you doing specifically to address that wait-list issue with dementia care?

Ms Hoffman: Thank you for the question. I'll start by saying no to the first part of the question around: is this because there isn't a cure currently? Not at all. There is sort of a four-pronged approach. Again, the expected outcomes are understanding the impacts of dementia, supporting Albertans and their caregivers who are living with dementia, timely diagnosis, and then treatment management throughout the continuum of care.

Obviously, when the condition is at its most extreme stages, some type of care facility is usually the next step. That's one of the reasons why we really prioritized long-term care and dementia care spaces in the beginning of our term, to ensure that we have the right mix and the right volume, to be frank, of dementia care spaces. The numbers continue to grow. We've also worked to expand that First Link program for early interventions.

I understand that the beginning of your question was: it seems like there are a lot of different components being rolled up into one strategy. To be very frank, that is part of this because dementia isn't something that just started when we started work on the strategy. It's something that our communities have been dealing with for generations. And, yes, the numbers are getting higher and the acuity levels. Sometimes patients are living longer with more severe dementia. But this is about taking a number of different actions and making sure that we're intentional about how those actions actually help fulfill the goals of the strategy.

Mr. Clark: Yeah. I've got to say that from the community level there is a lot of frustration. It doesn't feel like there's certainly enough money going into it or enough focus. So I would really encourage you, please, to double down on that.

You mentioned the First Link program funding. Just a quick yes or no: is that going to be enhanced and supported into 2019 and beyond?

Ms Hoffman: My understanding is that it's $1.95 million for early intervention programs to connect patients, and that's already been allocated.

Mr. Clark: That is the first one.

Ms Hoffman: Yes.

Mr. Clark: Okay. Thank you.

Is there a plan for funding of the dementia-friendly community pilot project?

Ms Hoffman: For a specific building you're referring to?

Mr. Clark: Well, there's something called the dementia-friendly community pilot project. I believe it's in Calgary.

Ms Hoffman: Yeah. We'll have to get back to you on the details for that specific project. My apologies.

Mr. Clark: Thank you very much. I appreciate that.

All right. What portion of funding for implementation of the Alberta dementia strategy is going to be spent around awareness and reducing stigma, which prevents people potentially from receiving a diagnosis?

Ms Hoffman: Interesting. When I think about reducing stigma, I often think about stigma that patients and their family members have talked to me about, their reluctance to be in community when they know they have dementia because they're worried about how people will interact with them. But the flip side around stigma, around being afraid to even get a diagnosis is – thank you for highlighting that complexity.

It is one of the four pillars around increasing understanding of the impact of dementia and reducing that stigma for family members and individuals. One of the women I spoke with in Calgary not that long ago talked about how they made cards for when they go out with their dad – I think his name was Brian; I can't remember exactly – and they say: "Hi. This is Brian. He's living with dementia. Thank you for your patience and understanding when you're talking with him." They help him have some of the tools to feel confident in engaging in the community.

10:30

Mr. Clark: Thank you. I'd certainly encourage you to focus on stigma reduction. I think that is a very wise investment and not a huge cost either.

Is there any funding specifically towards increasing the skills and knowledge on dementia within the broader workforce and also specifically within the dementia workforce itself? How much professional development is contemplated specifically around awareness of dementia and how to address it?

Ms Hoffman: Thank you very much for the question. This is definitely something we've talked a lot about with the Alzheimer Society of Alberta and with AHS as well. This is one of the areas within the strategic clinical networks as well. There is a specific pillar connected to dementia care, and this is one of the outcomes that they're certainly focused on.

Mr. Clark: Thank you very much.

I'm going to try to go quickly through the next couple here. Some of the feedback I've heard is that there's a clear need for modernization of policies around home-care supports to ensure they reflect the needs of the individual and not the needs of the system. This is something I've observed more broadly in government but in health care in particular. That, I think, ties into where a patient moves from community care to hospital, continuing care, home care, or even palliative care, to ensure that there's a seamless transition. I've heard a lot of feedback that people feel like they fall between the cracks or that they kind of fall off a cliff, where a system is focused on itself, not necessarily thinking about what happens to a patient either before they enter that particular part of the system or where they go in the next step in their journey. How much work is under way to knit those things together in a way that's seamless from the patient's perspective?

Ms Hoffman: Thank you very much for the question. With the increased investment in community-based care and, as we mentioned, a 19.5 per cent, I believe it was, increase specifically in relation to home care, this is a growing area of need and also a growing area of increased members of the workforce. It's interesting when you talk to individuals who work in home care. It's incredibly fulfilling. It's also really challenging because you're not in a standardized work environment; you're in somebody's home. Sometimes home-care nurses talk to me about things like pets. It creates a whole new dimension when you're talking about occupational health and safety.

Increasing funds for training and education and having more seamless integrations: often home-care offices, in rural Alberta in particular but sometimes in urban centres, are in the acute-care facility itself, so the home-care workers get to know the patient when they're in hospital and get to know the family when they're in hospital before they go back home and develop their care plans then. So this is definitely something that's positive . . .

Mr. Clark: My apologies. We have such a short time, so I'm just going to move on to my next topic if that's all right – I think it's a question for the associate minister – licensing around, in particular, addiction treatment facilities. One of the great challenges that we face in dealing with the opioid crisis – and it is absolutely a crisis. There are organizations that are accredited by very credible organizations like Accreditation Canada, and those organizations provide tremendous services.

But I was very surprised to learn that there are no rules that prevent anyone from hanging a shingle and calling themselves, quote, unquote, addiction treatment. We have had some incidents: in Sundre, I can think of in particular, not that long ago there was a very unfortunate outcome. I asked this in the House in December, and the words I heard in response were that a licensing regime is coming, quote, soon. That is reiterating a commitment that was made months before that. I really just want an update as to where we are. This has gone on too long. I think it's very, very important that we accredit addiction treatment and, if there is not an accreditation, that those facilities that are not accredited in quality are shut down.

Ms Payne: Yes. Through the chair, thank you to the member for the question. The work is currently under way in that regard. As you may have heard in the throne speech, we will be introducing legislation in the fall session to create that regulatory framework for addiction treatment centres. We are also working quite closely with the counselling therapists through FACT-Alberta around regulation for their profession as well. Tying that back to the estimates, there is some of the department's work that is being undertaken to try and make sure that those frameworks are available, but also we're working with providers in these fields to ensure that we are providing the best health care possible for Albertans.

Mr. Clark: Thank you.

Just so I'm clear, I heard you say also "the counselling therapists." Are you looking to create a college of counselling therapists?

Ms Payne: Yes. That's the work that's being undertaken currently with the department. They're currently in consultation with some of the related colleges on that matter.

Mr. Clark: Okay. Thank you. That's very good news. I'm sure they'll be happy to hear that.

I'd like to just move on, then, in my last minute here and start a discussion on pharmacists. One of the specific concerns I've heard from pharmacists in my constituency is that pharmacists provide about 50 per cent of the flu shots. Have you looked at the cost of potentially unintended consequences with the changes that have come as it relates to pharmacists' funding? Have you looked at the cost of AHS increasing flu shot clinics to make up for a potential and likely reduction in pharmacists, who may not be finding that it's economically viable to continue providing that service?

Ms Hoffman: Thank you very much, and I appreciate the question. Through the amending agreement it was identified that it was important to pharmacists that they still be compensated at a rate that was tied with the highest in Canada, so that's what we've landed at with a $13 injection. It's still going to be the highest in Canada. It just won't be the highest by a 50 per cent margin. We don't anticipate pharmacists dropping the service, but we certainly are prepared to increase opportunities through public health for increased immunizations if that's required. We didn't reach capacity in public health administering flu shots last year, but we certainly appreciate the flexibility in the community through pharmacists being able to do that in their facilities as well. If it comes to that, we will certainly respond, but at this rate we're still tied with the highest in the country.

The Chair: Thank you.

At this point I would like to call the agreed-upon break. We will be reconvening at 10:42. It's a five-minute break.

Thank you.

[The committee adjourned from 10:37 a.m. to 10:42 a.m.]

The Chair: I would like to call the meeting back to order and would request that all members take their seats.

At this point in the rotation for the next 20 minutes I would like to invite Dr. Starke from the Progressive Conservative Party and the minister to speak. Dr. Starke, are you wanting to combine your time with the minister?

Dr. Starke: Yes, please.

The Chair: Minister?

Ms Hoffman: Yes.

The Chair: Go ahead.

Dr. Starke: Well, thank you, Chair. Thank you to both the minister and the associate minister for being here today. I really appreciate it and appreciate your efforts on behalf of Albertans. Minister, I appreciate your attendance at the Humboldt vigil on Sunday night. As someone who has coached young athletes many times and has boarded many, many buses with them and, in fact, many times was the driver of a 15-passenger van, including one very memorable trip that was about a week after the crash in New Brunswick that affected the basketball team, I can tell you that it was a very difficult weekend for many of us.

I do want to move on to some questions. I'm going to move around a little bit, you know, and you'll have to forgive me. I'm trying to not repeat questions that were made by other members. I'm going to start perhaps with some very local issues. On page 64 of the fiscal plan, in the capital plan for the Health department, under Health Facilities and Equipment, included in the $858 million of expenditures there is a line item for the Lloydminster continuing care centre for $2 million this year and $3 million next. I know I will get this question when I return home.

I know that we are slated to demolish the south and central wings of the existing Dr. Cooke extended care centre. Minister, you and I have had many conversations about that, and I attended meetings in Lloydminster that secured local support for that initiative. But a big part of that initiative was also to proceed to the next step, and that was the development of a continuum-of-care facility, and there's a lot of work that needs to be done on that facility. I notice there is $3 million in the budget for next year capital, but I'm just wondering: is that for preliminary planning for that facility? Is that for some other purpose? If it is for some other purpose, when might we expect the Health department to start working with the people of Lloydminster on developing that facility?

Ms Hoffman: Yeah. Thank you very much for your question and for your support of your community and working with us as responsible health care providers to ensure that community voice and needs of the community are the driver here. The money that is in the budget over both years, I believe, is actually for the demolition piece because the decommission, the decanting of the two sections in the heating units, could stretch over two fiscal years. So it's the ability to have that flexibility. If it's able to be done more quickly, in one fiscal year, that would certainly be the goal, but right now it's in the two because that's what the best information is. Funds for the capital plan as well – oh, there is a piece for renovations, I imagine, where the connection is to the existing unit, so that's that piece.

In terms of working with the community on out-years, we'll certainly continue to be partners in that. We're proud of the fact that the first building is open to address that space, but making sure that we have a plan with the community around the ongoing investments is important.

Dr. Starke: Minister, I would really encourage that. The support that was received by the local advocacy group that provided eventually sort of the, "Yes, we will stand down on our objection to the demolition of the building," was largely predicated on Alberta Health Services assuring the local community that planning would proceed virtually right away on the high priority of providing some form of facility that would include a number of different miscellaneous seniors' services that right now are being provided on a somewhat piecemeal basis. You and I have discussed that. So I would really, really encourage Alberta Health officials to get in touch with, well, the biprovincial planning group that we have in Lloydminster to discuss, you know, moving forward with that.

Another local issue – and I'll turn this question, then, to the associate minister – has to do with the Thorpe Recovery Centre. Associate Minister, you and I have also discussed this facility, which was opened in 2012 with quite a bit of Alberta government support, not nearly as much from Saskatchewan. Sadly, this facility, which is certified, stands about two-thirds empty. With the severe need for treatment beds both for addictions and for mental health and with the capacity that is there, you know, I've urged the department to at least look before you expand and build new facilities or open new facilities in other communities. We have a state-of-the-art, relatively brand new facility in Lloydminster. I'm just wondering. I understand that one-year temporary funding has been provided for four additional beds, and that's certainly encouraging. I'm just wondering: is there at least some investigation or something moving forward to look at something on a longer term basis? I think this is an area, quite frankly, where there is definitely need – we've identified that – and the folks at this facility are more than capable and more than willing to meet some of those needs.

Ms Payne: Yes. Thank you to the member. We have in fact discussed this particular facility, and ultimately we do know that there is a need for additional public recovery beds throughout the province. Certainly, the opioid crisis has really highlighted the need for addiction treatment across our province, and there's quite a demand, as was noted. Part of what we are going to be investing in in the coming year is around expanding public residential treatment options across the province. An important piece of that as well, though, is going to be looking at where the need exists across the province in terms of the demand and what is currently available

both in terms of spaces that are ready to come onboard, as is the case with Thorpe, versus what would have to be created. Ultimately, with the urgency that exists, that will be something that is taken into consideration as we move forward with this.

Dr. Starke: Okay. That's great. Certainly, you know – I'll say it again, and I've communicated this to you before – the folks at the Thorpe centre are more than willing and extremely capable. They have a long track record. They've been operating for over 40 years in this area.

A little bit of a shift, and this may be a little bit out of the blue. With regard to the opioid crisis and the underlying mental health concerns, we continue to watch as the opioid, you know, deaths continue to increase. A number of measures have been taken to try to provide, I would call it, a safety net to try to assist people. One that I wanted to ask you about arises from, actually, a radio program that I heard with regard to availability of naloxone kits. I know they've been widely distributed, whether it be through emergency providers, through pharmacists, through addictions treatment centres, through supervised consumption sites. I've got one that's way out there: what about MLAs? Why aren't we provided naloxone kits? The reason I say that and the reason I suggest that is because we are in the public a lot. We are out there a lot.

10:50

Now, we may not all feel qualified, necessarily, to administer naloxone. I get that, that we won't all be comfortable to do it. But I can tell you that if I was at an event and somebody was in an overdose situation, I would feel perfectly qualified to treat them, and I wouldn't have a naloxone kit to do it. I'm going to actually suggest that that's an initiative. We've got 87 of us. We go all over the province. You know, it's entirely possible that only a small percentage of us would want to do this, but it's something that I would absolutely want to have the capability of doing. I'm just wondering if that's something you'd be willing to consider.

Ms Payne: I think that's a really interesting idea. Ultimately, an important part of the response to date has been – and we'll be seeing it expanding across communities throughout Alberta in the coming months – expanding the access for naloxone but also expanding the areas in which training and support are being given for the administration of naloxone. For example, there's a group called Indigo Harm Reduction, that received a grant through our government, that will be doing a lot of training and support in the nightclub and entertainment industry as well as working with festivals.

Interestingly, the first music festival that approached them was actually a fiddling festival. I think that really just highlights the extent to which concerns around overdoses and overdose prevention really have reached all areas of our province and all walks of life. Certainly, we are evaluating other ways that we can help ensure that there are naloxone kits more widely available so that everyone who wants to have one will be able to get one.

An important key component of that as well is the training on how to use the kits.

Dr. Starke: Of course.

Ms Payne: Each individual that is given a kit is also receiving some training along with that around how to use it, how to recognize signs of overdose and the like.

Dr. Starke: Okay. Thanks, Associate Minister. One should never ever underestimate the forward-thinking nature of fiddlers. I'm actually surprised that the accordion players' festival didn't beat them to it, but we'll be there soon.

I want to shift gears a little bit to something that is in the planning stages, and I just wanted to make sure I have it on the public record. Minister, I know that the mayor of Vermilion has approached you with regard to the critical need for a level 4 facility in Vermilion, and I wanted to make sure that I also reinforced that need on the public record. We have a gap. We have a serious gap in Vermilion, and we have a very hard-working group working with local officials, working with AH and AHS with regard to that.

I guess my question a little bit is a question that we've run into a couple of times and you sort of referenced it a little bit earlier, and that is that just before New Year's, you indicated that you're not planning on building additional facilities or beds with the ASLI program. I guess my question is that some people in your department have speculated to me that there is a son of ASLI or daughter of ASLI coming soon. I'm just wondering when we might have those details. The reason that there's considerable interest in Vermilion is because we see the potential that the facility that we need in Vermilion may well fall under that, and we want to make sure we have as much preparatory work done before that's announced.

Ms Hoffman: Thank you very much, Member and Chair, for the opportunity to respond. I have had conversations with the mayor and commend her for her ongoing advocacy for her community and for the health needs of every resident who lives there. It's a fact that there are many communities throughout our province that don't have the continuum of care that they deserve, and certainly we're working diligently to try to catch up and fill that gap. This isn't something that we've been able to completely remedy in the first three years. Much has been done, but more will be to come. And, yes, we hope to have a new grant plan available. I think I mentioned in my introductory remarks that we're hoping to be able to launch something this spring. I wouldn't call it by the name that some might.

Dr. Starke: I have very little doubt that it'll have a different name, Minister.

Ms Hoffman: But it will be probably a very different type of program because, certainly, as you saw through the review we did early on, we had some concerns with the criteria, or lack of criteria, that was used under the former program.

Dr. Starke: Yeah. I guess my other question is somewhat related to that. A couple of times I've heard you mention the 2,000-beds number for continuing care spaces. I thought I heard you say at one point that you plan to expand beyond the 2,000 beds that are already built. If the 2,000 beds are already built, I'm surprised by that. But if they are, fantastic. I'd be curious to know distributionwise where they have been built or where they've been planned. I guess there's a lot of interest, certainly from my constituents, with regard to just the timing of bringing those beds on stream, where they are located, and if they are mostly operated by Alberta Health or operated by private or not-for-profit or other facilities. I don't expect you to have that list right now.

Ms Hoffman: I can give a response, though.

Dr. Starke: Okay. Sure.

Ms Hoffman: Certainly, we are on track to open 2,000 spaces by the end of this term that will be dementia and long-term care spaces throughout the province. Those are through a mix of different

providers, including some that were levelled up through the ASLI process, that were originally intended to be other types of care, lower levels of care. We are moving those forward. We opened, I believe, about 700 in the first two quarters of the fiscal, and we have many more on track.

We also have announced the Norwood, Bridgeland, and Willow Square projects, that are not going to be open by the end of this term but that are certainly under way. Then we'll be moving forward with our new continuing care strategy this spring.

Dr. Starke: Okay. You mentioned Norwood, Minister. I wonder. This doesn't have to be right now, but one of the things I'm hearing about the Norwood project is cost escalations, that the cost of constructing the Norwood facility is literally skyrocketing in terms of the cost per bed, that it is significantly higher than what most other facilities have been built for in the recent past. Again, I don't expect a response right now. If you could at some point give me an estimated original budgetary cost for the Norwood facility and what the new projected budgetary cost for the total facility and the cost per bed is, I'd really appreciate that.

Ms Hoffman: I'd be happy to answer now. The details around the projected were, of course, available publicly through our news release on that item. Obviously, when you're developing a facility in the core of the city as opposed to in an area where there's land that's already available, in a new development, for example, there will be some factors around acquiring land and those types of things that influence the project's cost. We will be happy to roll out updates around that project in the weeks and months to come.

Dr. Starke: Okay. I want to shift gears a little bit. Minister, on pages 81 and 82 of your business plan there's a discussion around outcome 1, and that is the improved health outcomes. It specifically talks about tobacco usage both amongst youth and amongst adults. I have a concern that there are large sections of the tobacco reduction act, that was passed in 2013, that remain unproclaimed and that because of the statutory – it's some legislative things for acts that if they're not implemented or they're not proclaimed by a certain time, there's a sunset clause. I just am wondering. The sections that remain unproclaimed or unimplemented seem to have been set aside as we face down the deadline in a few months for the legalization of recreational cannabis. I'm concerned because, certainly, tobacco use is significantly higher than cannabis use, and as you well know, tobacco use has a much higher impact on our health care system than cannabis use does. So is there a plan to proclaim and to move forward with these unimplemented sections of the tobacco reduction strategy? If so, what's the timeline going to be for that?

Ms Hoffman: Thank you, Madam Chair, for the opportunity to respond. We did move very quickly on some of the unproclaimed pieces and proclaimed them as soon as we did form government in 2015; for example, the menthol piece that was in the original legislation but that wasn't proclaimed at that time.

Dr. Starke: Yeah. No, I'm well aware of those. I guess I'm just wondering about the timeline for the unproclaimed sections.

Ms Hoffman: Yeah. I do want to highlight that we have proclaimed pieces that weren't part of previous government's proclamations.

The main piece that remains, I believe, is around tobaccolike products, and that is set to potentially expire at the end of this year. But we have an opportunity to determine if these provisions should be extended, if they should be expanded into the future or proclaimed at a future date. We are undergoing some consideration and planning some consultation in that regard because these are specifically with regard to what are typically referred to as hookah facilities and establishments, and we certainly don't want to embark on that hastily. We think it's important to have conversations to drive timelines around that piece.

11:00

Dr. Starke: Okay. Then another topic was raised earlier by both Mr. Yao and Mr. Clark, and it had to do with wait times. One of the concerns expressed to me on a regular basis in Lloydminster is wait times. Specifically for orthopaedic procedures, hip and knee replacements, the wait times are now exceeding a year. In fact, in some areas they're 14 to 18 months for hip replacements. I would be doing my constituents a disservice if I didn't ask why those wait times continue to increase.

Another area that I'd like you to comment on is the wait times for accessing endoscopy services after a positive FIT test. My understanding is that the Canadian Cancer Society has a guideline of I believe it's three months to get an endoscopy procedure done after a positive FIT test, but the wait time, in Edmonton at least, is eight months. The wait time in Vermilion is six weeks. I'm curious to know, because I've talked to patients in Edmonton who, you know, are concerned about an eight-month wait time after a positive FIT test, why they're not given the option of having that test done in Vermilion, where there's a six-week wait period.

Ms Hoffman: Thank you very much for the question and for highlighting this. Certainly, I've heard from some folks around the quality-of-life issues when your joints, hips and knees in particular, are deteriorating and how it's challenging to live in pain, knowing that you're a candidate for surgery, any longer than the day that you're put on the list. My mom has had both hips done over the last five years or so, and I can say that it has been a tremendous benefit to her quality of life.

We have some areas in terms of wait times where we are certainly not at the national average or leading, and we want to be at or above in all categories, of course. This is one of the reasons why we've made this $40 million targeted investment to AHS wait times. One of the areas that they will be prioritizing is zone-specific investments in cardiac as well as hip, knee, and other orthopaedic surgeries. This is definitely a priority for us.

In terms of the proctoscopies and other types of surgeries, you're right that there are many rural facilities that do them faster. I believe that McLennan was one.

Dr. Starke: We'll let you park for free, too.

Ms Hoffman: That, too.

They are definitely moving forward in increasing opportunities outside of the urban centres to be able to provide those. In facilities where they aren't necessarily outfitted to do emergency surgeries but they do have OR space that could be used in this regard, it's a good way for us to achieve those greater benchmarks.

Dr. Starke: I'd like to see those options expanded, and I'd like to see, you know, a situation where, with the availability of those options, especially to patients in urban centres that have longer wait times facing them, they are made aware of those.

Thank you.

Ms Hoffman: Thank you.

The Chair: For the next 20 minutes I would like to invite members from the government caucus and the minister to speak. Ms Luff, are you wanting to combine your time with the minister?

Ms Luff: Yes, please.

The Chair: Minister?

Ms Hoffman: Yes, please.

The Chair: Go ahead.

Ms Luff: Thank you, Madam Chair. Thank you, guys, for being here. I just have a few questions about the business plan. Largely based on experiences I've had with folks who come into my office or who call me or who I talk to in the community when I'm out door-knocking, health care is something that comes up when you're talking to people. It's almost always if not number one then number two in terms of things that I hear about.

I do have a lot of seniors in my community, and key strategy 1.2 talks about developing "a targeted approach for new continuing care spaces." I hear from many of my constituents about when the time comes that they have to move out of their home. They certainly appreciate the increased investment in home care, but sometimes the time comes when you have to move out.

I recently did have a gentleman in my office who is a primary caregiver for his wife, who has dementia, but he is experiencing health issues as well. They're looking at probably both of them having to enter a facility of some kind, but it's unlikely that they'll be able to enter the same facility. We hear about this issue of separating people. So when you're looking at a targeted approach for new spaces, are you looking at models where multiple levels of care are available in a single facility so that couples and friends and family don't always have to be separated?

Ms Hoffman: Maybe the associate minister can start, and then I might supplement.

Ms Payne: Yeah. Thank you, and thank you to the member for the question. That is a really important piece, you know, ensuring that Albertans are able to receive care close to home, close to family, close to the communities where they've established their lives and have those really important social connections as well as that historical connection throughout their life. It's so very critical, particularly when we think about enhancing well-being for seniors well into old age. It's a key component of mental health and mental wellness as well as that it ties in quite closely with the impact on the individual's physical wellness and how their quality of life continues.

An important piece for us is that we're really working on emphasizing an adaptable and flexible design to support aging in place for as long as it's safe for an individual to do so and also that there will be different levels of support and care available within the community. Also and, I think, more critical to your point is ensuring that as we work with providers such as lodge operators and continuing care facilities, we make sure that those varying levels of care are there, not just so that a senior couple can be kept together if they have differing levels of care but also to acknowledge that over time an individual's required level of care may change. Particularly for seniors living with dementia, that transfer to a new facility can be quite traumatic and have a very detrimental effect. Looking at the research around that as well as the desire to support Albertans and help keep them healthy for as long as possible: those are all factoring into our decisions.

Ms Hoffman: The only anecdote I'm going to add is that sometimes those double-occupancy rooms – I usually think about them for spouses. I visited a facility recently where it was sisters who had always lived in the same neighbourhood, and when it was time for them to move, they decided to be roommates again. Making that change was challenging enough, to move from living in your own home, but doing it with somebody that you care about and who can support you through that transition – they did have different levels of care needs, but the facility that they were in had enough space so that even the person with the lower level of need was able to occupy that space and support that transition. So it was a win-win.

I have to say that having somebody there who maybe isn't a level 4 need often is an ally in providing good care, right? That sister helped with nighttime routine and those types of things, so the staff were very happy to have them together. It was better for patient care and also created a more family-like environment, which is always the goal.

Ms Luff: Awesome. Thank you. Yeah, it's definitely not always couples, for sure. There's a variety. You know, people just want to be with people whom they love, right?

I'm just going to move on a little bit to talk about mental health because it is something that I hear about with frequency, whether that is, you know, suicide prevention or access to services or just making sure people have access to mental health treatment. As mental health becomes something that we talk about more, which I think is awesome, more people are out there seeking help. Just a very broad question to start off with. I'm just wondering if you could tell us where you are in terms of implementing the 18 actions in the Valuing Mental Health document.

Ms Payne: Yes. Thank you to the member. There are over 100 activities that are currently under way within government, within Alberta Health Services and other ministries outside of Health, as well as with community partners that support those 18 actions in Valuing Mental Health. Within those 18 actions, in addition to the four priority populations that I'd noted earlier, we also have four kind of key areas where we think we can have the most impact moving forward in the nearest future.

The first of those is improving the co-ordination of addiction and mental health services through over 21 grants contributing nearly $18 million from the last fiscal year that will be operationalized over the coming year. Some of that includes expanding 211 service across the province so that Albertans who are looking for supports have a kind of centralized place to come find out what's in their community – what's offered by AHS, what's offered through private practice as well as what's offered through community groups – and, additionally, supporting community groups who help vulnerable Albertans to navigate the system. Ultimately, it's really key to recognize that addiction and mental health so often go hand in hand, and it's really challenging to separate the two, but we also need to make sure that we're looking at the system as a whole.

As a second key area we're also strengthening primary care supports for substance use and mental health by funding grants that will create additional supports and counselling not just to vulnerable populations such as, specifically, children and youth, victims of sexual assault, seniors, and indigenous populations – those are ones we've really focused on – but also include increasing access through primary care networks. We know that most Albertans' first point of contact with the health system is through their family doctor, so we want to make sure that within their family doctor's primary care network they're going to have access to some of those supports that they may need and that initial level of support and assessment and then, from there, referrals on to higher levels of support as needed.

11:10

We're also focused, as a third area, on prevention and early intervention to make sure that the supports and treatments are available sooner in a patient's journey as well as closer to home and closer in the community, so working with Education to develop K to 12 resources, including some supports for teachers on building resilient communities within their classrooms as well as supporting students with mental health and mental wellness.

We're also working very closely with Children's Services around developing and implementing a youth suicide prevention plan. We know that death by suicide is a great tragedy when it happens to anyone but particularly young people.

We're also, as a fourth area, really focused on improving integration across services and sectors and making sure that those transitions are easier. We hear from so many families about, you know, how their child turns 18 and then the services that are available change rapidly. So we want to make sure that we smooth out those transitions for individuals or the transition from discharge from hospital to care in the community. We want to make that as seamless as possible for the individual because we know that when someone is having mental health challenges, it's particularly tricky to navigate a system if it's not well co-ordinated.

Ms Luff: Awesome. Thank you. There's, like, a lot of stuff in there.

Just as a follow-up – and I think you maybe touched on it in your answer – the PCN that covers most of my riding is Mosaic PCN, and they do offer mental health supports, which is awesome. I mean, it's not something that everybody necessarily knows about. When I've talked to the mental health therapists that do work within that system, basically the network offers people six sessions with a mental health therapist through a referral from a doctor, and those mental health therapists are saying that the wait times are getting longer for those sessions. They used to be able to get people in right away, and now because of the demand increase they can't necessarily do that.

Then also, when I talk to people about mental health supports, the access that they have to those therapists is highly valued, but they feel like six sessions are not enough to address their concerns. You spoke about how there were some grants available for primary care networks to sort of maybe expand those services. What else are you doing to make sure that those crucial mental health supports are available within primary care networks?

Ms Payne: Thank you to the member for the question. I would say that the Mosaic PCN is a really great example of how a PCN has incorporated that variety of health care practitioners within their practice and within the services that they make available to their patient roster.

I think it's really important to recognize and to remember that mental health exists on a spectrum, not just for individuals but within the community. We have mental wellness on one side; then we have critical mental illness on the other side, much like what we have for physical health. An individual might be at any point in that spectrum, so their care needs change as they go through. For some individuals, you know, the six counselling sessions through a PCN can act as kind of a bridge until more intensive and longer lasting therapy or more therapy sessions are available through, for example, AHS or other community partners. But for other people six sessions is perfect. It might even be more than what they need.

A big piece of the funding support that we're bringing forward through the Valuing Mental Health: Next Steps work is to make sure that those supports through the doctor's office, through the PCN are available to Albertans across the province but also that we're able to make sure that they're appropriate for the community. As you noted earlier, we're seeing more people talking about mental health and mental illness. More people are coming forward with their stories, and more people are seeking help. I think that's a good thing. In many ways it does present a bit of a challenge for our system to ensure that we're able to offer people the supports as quickly as possible, and we're certainly working with our partners in health care on that. But I think that in many ways it's a good thing because the sooner that people seek support, often the less negative an impact it has both in their lives as well as in the lives of their communities.

Ms Luff: For sure. Yeah.

Just to move on to maybe a different area, key strategy 4.4 talks about setting system expectations through a focus on patient experience. Certainly, the vast majority of the time when I talk to people about health care, they talk about how great their health care experience has been, right? Depending on what they're doing, whether they've had a baby or they've had a surgery or they've been to their family doctor, most people comment that they're happy that the health care system is there for them and that it is doing good work. However, I do often hear stories where maybe people feel like they're lost a little bit within the system, and they're not being treated, you know, as much as a human as a case, whether that's that they weren't called when their parent fell in a hospital or they felt they haven't been communicated well with if a spouse has passed away for some reason or that they've been told that they have to bring their own diapers when they have a baby that's born.

I'm just wondering, you know, given that you're setting expectations with a focus on patient experience, can you expand a little bit on what's being done to ensure that consistent principles of care, information delivery, and accountability exist throughout our system and are being applied across all facilities in Alberta?

Ms Hoffman: Do you want to go?

Ms Payne: Yes, please. Thank you to the member for the question. I think that that really does highlight an important piece, you know, that Alberta's health care system is complex. It's made up of a series of systems, including primary care, acute care, continuing care, public health, as well as IT and the health workforce. Making sure that those systems are integrated and working well together and in alignment is really critical, but at the end of the day, I think it's really important not to get lost in the system and instead remember to focus on the patient and the individual at the heart of the system. To that end, we've been working diligently to make sure that Albertans have access to high-quality health care services and that it's easy for them to move through the system so that for the individual they know that wherever they go, they're going to be getting that same level of care, whether that's in Calgary or Edmonton or Lloydminster or Milk River or Peace River or anywhere in between.

For us a key piece of that as well and I think one of the benefits that we have here in Alberta is that by having a province-wide system, it does give us a little bit more ability to make sure that the levels of care are consistent across the system and to work towards making sure that, you know, the north zone and south zone and everywhere in between have a lot of continuity.

But it's also important to make sure that we focus on providers as well so that they can focus on their patients. A key piece of that is making sure that they have the right information, whether it's their patients' test results or the information about patients who've, you know, been to hospital and then have been discharged. It sometimes happens that when they're discharged from hospital, an individual is told to make a follow-up appointment with their

doctor. We want to make sure their doctor has that information. That's why those investments in the information system are so important.

Then another important piece of that, of course, is the emphasis on community-based care, making sure that Albertans are able to access the health care that they need, whether that's physical health, mental health, tip to toe, really, that they're able to access that care as close to home as possible and with their care providers being able and confident to share the relevant patient information amongst one another so that that individual doesn't need to keep repeating their individual health story and that information is consistently available to all of that individual's practitioners.

Ms Luff: Awesome. Thanks very much.

Chair, I'm going to pass to my colleague MLA Shepherd.

The Chair: Thank you.

Go ahead, Mr. Shepherd.

Mr. Shepherd: Thank you. I appreciate the opportunity for a bit of dialogue on this here today. Following along the same lines, I guess, talking about access to care where people need it and where they would like to have it, I know that, you know, in talking with many of my constituents and indeed a number who work in emergency care and in acute care and certainly in my visits at the Royal Alex hospital and talking with many who work in those areas there, I do regularly hear about some of the pressures on our acute-care facilities. I know that hearing you talk about where some of the major costs in our system are coming from, I think that certainly we recognize that part of the problem we're facing is too many people are sort of trapped in our acute-care system when they could be receiving help through other means. They're facing wait times in emergency departments, waiting for loved ones to be placed in appropriate care settings.

I do see that outcome 1 in your business plan talks about a number of system-wide initiatives. You state in key strategy 1.1 that expanding home care is intended to reduce some of those pressures. I was wondering if you could give us a sense, then: in this budget what investments are you making towards home care, and in particular how are those funds going to reach individual patients and ensure that they are able to get quality of care?

11:20

Ms Payne: Yes. Thank you. As you noted, the Budget 2018 includes an increase of $48 million, or 7.5 per cent, for home care compared to Budget 2017. In particular, planned investments include an increase in the number of Albertans receiving home-care services by an additional 3 per cent to the budget line item, which will significantly increase the proportion of clients who are able to stay in their homes longer with those added supports.

What that also means and I think an important impact that that has on the rest of the health care system, particularly the acute-care settings that you'd highlighted, is that by having people able to stay in their homes longer, we'll see an increase in the number of people who are entering our continuing care facilities from home settings as opposed to from our acute-care settings.

We'll be investing $13.4 million to further expand integrated community paramedic and EMS initiatives for home-care clients as well to make sure that that support is there for individuals so that, you know, we're going to be reducing some of that need for a hospital transfer by allowing a paramedic to be able to administer some services and health care to a patient in their own home or in a lodge setting.

There's also going to be an expansion to services provided by specialized interdisciplinary care teams in the community. Ultimately, this all speaks to the goal of trying to have people, again, receiving that care as close to their home as they can and, you know, making sure that as much as possible we're able to safely provide health care services to people outside of those acute-care settings so that it helps to ease some of the burden and some of the pressures that we have on our acute-care facilities.

Ultimately, we know that Albertans want to be able to receive the health care that they need when they need it. An important piece of that is making sure that we have the appropriate levels of care. I'm sure you've heard myself and my sister minister say it many a time, you know, that it's really about the right care at the right place and the right time with the right information.

Then I would also note that over the years the number of home-care clients has increased. We had about six years ago about 97,000 clients, and in '16-17 we have had 118,000. So clearly this is something that Albertans are interested in, and we think it's important to support that level of care in the community.

Mr. Shepherd: Thank you, Minister. I think we are coming up on the end of our time here, so perhaps we'll just . . .

The Chair: Ten seconds.

Mr. Shepherd: Ten seconds. Thank you. I look forward to chatting a bit more in the next go-round.

The Chair: Thank you.

Ms Payne: I would just add that we're expanding access to rural communities as well.

The Chair: Thank you.

For the next 10 minutes I would like to invite Mr. Gill and the Minister to speak. Mr. Gill, are you wanting to combine your time with the minister?

Mr. Gill: Yes, please.

The Chair: Minister?

Ms Hoffman: Sure.

The Chair: Go ahead, please.

Mr. Gill: Thank you, Madam Chair, and thank you, Minister, to you and your team for being here with us. I have a question regarding the ministry's overview on page 80 of the business plan. It refers to continued investment in new continuing care spaces. The $241 million worth of capital investment in this budget for 344 publicly funded and operated beds equates to almost approximately $300,000 per bed. The project you have announced in Fort McMurray is, for example, coming in at close to $700,000 per bed. That is, like, approximately 10 times more expensive than the average cost of beds under the previous ASLI program. If we had built those, used that $241 million under ASLI, we could have built approximately 3,700 units. Can you explain the discrepancy and why there's a difference in price, like 10 times, than the previous model, please?

Ms Hoffman: Yeah. The math actually doesn't add up the way that you've asserted. We can certainly table or provide more details around some of the math. But I will talk about Willow Square. One of the things that we're really proud of and I think all of us should be proud of is that we're moving forward on this project after it was desperately needed for many, many, many generations. I have had a chance to visit some of the current residents of the long-term care

in the hospital, and it definitely isn't the most appropriate place for them to be: no access to the outdoors, those types of things. We did work with the community and with the local MLAs to identify that the best site was downtown rather than in a new area of subdivision, where there would have been lower costs because it would have been a completely new area where there wasn't construction. But it was important to the community and to the local MLAs that we build it in the right place, so we are happy to do that.

There are a number of factors that relate to the cost of continuing care, including that projects that are further away from Edmonton or Calgary typically have higher costs for getting materials there and less economies of scale. That's one, I think, that's important to consider. As well, smaller buildings, where there are, again, less economies of scale, have a higher per-unit cost, but we know it's important to build in communities in addition to Edmonton and Calgary. We can't expect all seniors to move to Edmonton and Calgary.

Some of the supports that are offered in the individual facilities or the parcels of land: again, this parcel of land is downtown and has some additional constraints on it as opposed to the site that was further away in a developing neighbourhood, but it was important to the community that it be close to where other services could be co-located.

Then, of course, timelines are one piece, too. We don't want the seniors living in hospital to do so for another decade. We want to get this facility built and open as quickly as possible.

Mr. Gill: Thank you, Minister.

Now, you have asked if you can table it, so I'm asking: if you can table those documents, that'd be great so we can . . .

Ms Hoffman: We'll give you some of the information around the cost piece that you itemized and what the actual cost would be.

Mr. Gill: Perfect. Thank you very much.

You were saying, through the chair, that the land cost is kind of a big component of why this is coming in at, like, approximately $700,000 per bed for that particular Fort McMurray unit.

Ms Hoffman: This $700,000 is the incorrect math, and we'll be happy to provide a breakdown as to why the numbers you've presented aren't factual. We can do that at a later date.

But I do want to say that it is important for us to build the facilities where they're needed, not where they're cheapest. It's important for us. The difference between some of the former agreements that were done with private or nonprofit contractors as opposed to a public build is who actually owns the site at the end of the relationship agreement. It's kind of the difference between renting a house or buying the house. It's also some differences in terms of whether it's done in an urban centre or whether it's done closer to the community where people live. These are some of the factors as well as the location and the calls that would be done to make sure that we've remedied things like flood plain and those types of things. We want to make sure that this facility is safe, that it's where it's needed in the community, and that it's there for future generations.

Mr. Gill: Thank you, Minister.

Now, you've said, like, $700,000 per bed is not correct. Can you please provide us . . .

Ms Hoffman: That's what we're going to – we're going to help you work out some of that math, and we'll be happy to follow up with you on that.

Mr. Gill: Perfect.

Now, you said, like, this particular project in Fort McMurray is due to the logistical proximity from a major urban centre, from Edmonton or Calgary. That's why the cost is higher, and part of that is land and other factors. Now, even the one project that was announced in Bridgeland: it's also costing close to $400,000 per bed. Correct me if my numbers are wrong. I mean, there's, like, a big difference, 10 times or five times, from the previous program. We just want to know. Like, the previous program, a partnership with the public and private, was working well. Is this the direction of the government, to go completely public and, going forward, disregard partnerships with the private operators?

Ms Hoffman: Thank you for the question. Some of the differences: I wish I could say that it's apples and oranges, but it's more like apples and mangoes. It's a completely different project. When you look at some of the ASLI projects – and we did fulfill some of those ASLI projects, many of them, and built many of the facilities. We did so making sure that we were assessing the needs of the communities, the level of care that would be provided there, the quality of the care that would be provided as well, and the ability to deliver a homelike environment.

Again, though, it's a different model when you're looking at doing something with a private entity that will, at the end of the day, own that building or with a public entity. At the end of the day, the people of the province, all people of the province, will own it. There's a different ownership structure in place.

11:30

I understand what you're saying around the upfront costs and the other differences. Typically, from my understanding of working on this file for the last three years, where the private sector was interested in stepping up, those contracts were provided. Where the private sector wasn't interested in stepping up, which is, for example, where the costs would be higher to secure land or the complexity of care for patients or the location of a facility or the lack of having the economies of scale, that's where the public builds happened.

Like I said, they're not comparable because in the past so much was provided by the private sector that the only facilities that were done publicly were the ones that weren't financially of benefit to the provider. So they're quite different facilities.

Mr. Gill: Thank you, Minister.

Through the chair again, can you please tell me a little bit about what's going on with the Edmonton Buddhist Research Institute? It was announced under ASLI for 106 units. Apparently, we're hearing – and correct me, again, if I'm wrong – that it is in litigation and that the Alberta government is suing them. Is it true? And if that's the case, how many other similar projects are in litigation with the government?

Thank you.

Ms Hoffman: Yeah. Thank you. Just to clarify, it's not in litigation. This is the only one that's under a review through the Ombudsman, but it is being reviewed through the Ombudsman's process. In 2017 the institute raised a concern with the Ombudsman's office. We respect that process, so the department is co-operating with the Ombudsman on the review of this process, and we'll be able to comment further once that's complete.

Mr. Gill: Okay. Thank you, Minister.

Now, again, I think my calculations are a bit off. In 2015 or before, 2,600 beds were announced by the previous government, and this government is on track to deliver 2,000 long-term care

beds. Out of those, 1,600 beds are to be completed under the ASLI program. If my math is correct, does that mean that this government has cut 600 beds from the previous government's announcement?

Ms Hoffman: No. What we are doing, though, is that many of those announcements were not for the highest level of care. You said that they were for long-term care. Many of them were for lower levels of care, typically level 3. What we did is that we worked with those people who were in process under previous announcements, not contracts, though, that were committed to. There were just announcements in the pre-election period. We worked with them to identify the needs of the community, the ability to deliver on a sustainable contract, the quality of the care, and to upgrade many of those facilities to either supportive living dementia-level care, so again this high level of need, or long-term care spaces. So the quality and delivery of care in these facilities we'd be able to sort of level up to receive those higher levels of care. We're making investment in those through those spaces.

As well, as you mentioned, we have three public builds that are under way: Norwood, Bridgeland, and Willow Square.

The Chair: Thank you.

I would just like to remind members that all conversation should flow through the chair.

I would also ask the minister to try and keep responses concise. We're just running through a tight timeline in terms of timing for the rest of this meeting.

For the next 10 minutes I would like to invite Mr. Clark and the minister to speak. Are you wanting to combine your time?

Mr. Clark: I'd like to go back and forth, Chair, if that's all right with the minister.

The Chair: Go ahead.

Mr. Clark: Thank you very much. I'll take the first five minutes and hand the next five to my colleague here. Again, if we can get some quick responses.

Does any part of this budget support work to study or implement universal pharmacare?

Ms Hoffman: This is something that we're doing primarily through the Pan-Canadian Pharmaceutical Alliance, which definitely is a component within our pharmacy budget, as well as through the work that we're doing with the federal-provincial-territorial ministers. Definitely, work that we do within the department would be a piece of that, but this is something that is a larger topic of consideration than one fiscal year's budget.

Mr. Clark: Okay. Thank you very much. I appreciate that.

Just back to my previous question on flu shots and pharmacists, again, have you actually looked at the cost, potentially, of increasing AHS delivery of flu shots versus pharmacists?

Ms Hoffman: The AHS costs are in line with what the new rates will be through the amending agreement. AHS costs are quite efficient. One of the reasons why we felt this was an area that we needed to get some restraint over was that they were delivered far more efficiently through the AHS clinics.

Mr. Clark: Okay. We keep hearing about the 4.3 per cent budget line item around pharmacy, and that is in the budget, very clearly. But that is misconstrued often as pharmacists themselves receiving 4.3 per cent more money. Actually, their actual take-home pay is less because that includes a lot of hard costs, which simply come in one side and go out the other, if you will. Other provinces like Manitoba are a bit of a different story because Alberta's scope of practice is much broader. The concern that's been raised to me by pharmacists in my constituency is: are the changes that have been brought in as a result of this amending agreement intended to reduce the scope of practice of pharmacists?

Ms Hoffman: No.

Mr. Clark: Okay. Thank you.

I have a pharmacist in my constituency who manages patients with chronic conditions like diabetes. One example he told me about was helping a person from a vulnerable population manage their blood sugar, which clearly kept that person out of the emergency room, but he feels that it will be very difficult for him to continue to provide that level of service because of the changes. Have you calculated the potential knock-on costs to the overall health care system from those sorts of situations?

Ms Hoffman: What we reached through the discussions is a cap of 12 recall visits per year, and it's per year. It's not saying one per month or those types of things. At the beginning of a diagnosis you may have more frequent interactions. Most jurisdictions either don't allow billings for those full-out conversations or cap it at three or four. So 12 is still far greater than any of the other comparators across Canada.

Mr. Clark: Okay. Thank you.

That fits very nicely into my next question. There are some cases where patients on certain things like perhaps opioid replacement therapies would only be given enough medicine, say, for one week. There'd potentially be some risk if they were given more than that. Seniors with perhaps dementia or other cognitive challenges would not be given much medicine due to the risk that they'd take too much. Have you given consideration to an exception process, perhaps having two physicians sign off where warranted? This is for those rare cases where perhaps the 12 visits or the two dispensing fees per patient really don't fit a specific situation. Is there an exception process, and if not, have you given thought to creating one?

Ms Hoffman: To answer the first request, around opioid dependency treatments, there have been no limits put in around that. We know that it's important to have potentially daily administering while somebody is adjusting to a change in their medication and lifestyle. We know that that's an important transition period. So that's how that's been put in place.

In terms of other components, we're in discussions with a few specific facilities or pharmacies that have raised specific concerns; for example, the ACE program here. We have been in conversation with them and have another meeting lined up again for next week. So there are a couple of specific situations that we know may need to have conversations on the side, and we want to make sure that we consider that.

Mr. Clark: Thank you.

In my last 30 seconds I'll just ask the Associate Minister of Health: on the Valuing Mental Health report, one of the actions initiated in the follow-up is on creating a child and youth mental health website. It's now more than two years after this report was issued. Has that been done?

Ms Payne: Yes. There's a website called help4me.ca.

Mr. Clark: Okay. Thank you.

I'll hand this over to my colleague for the last five minutes. Thank you.

Ms McPherson: Thank you very much. It's very nice to see so many people in pink today for pink day.

I want to ask some questions about the Royal Alexandra hospital regional fertility and women's endocrine clinic and the announcement that was made in November that the procedures wouldn't be done there any longer. Of course, it closed in February. There has been quite a bit of confusion and, I think, maybe some misinformation. I don't think it's intentional, but I know that a number of patients are left quite confused by the whole process. One question I do have is: do we understand how much money will be saved by the government by closing down this clinic?

Ms Hoffman: Thank you very much for the question. We know how personal this challenge with infertility is for families, and for those who want to have children, it can be extra challenging. We also know that it can be a really stressful time for patients. I want to reiterate: any of the noninsured services are the pieces that won't be delivered there. But the insured services, including diagnostics, additional counselling services, will be covered.

11:40

We're also covering the cost differential between the AHS clinic and the other clinics of the patient's choosing through a transition period, two hours of access to mental health counsellors, the cost of transfer of frozen materials. Money is not a driver, for sure, in this first year in particular because we want to ensure a smooth transition, but this is about things that are covered publicly being delivered in public facilities and having the expertise within that facility to provide the public piece and the pieces that aren't and have never been covered publicly that have been through additional payments outside of scope being done in a different facility.

Ms McPherson: I do understand right now that some of the patients are being charged by AHS for blood work, and my understanding from the information that was given to the patients was that that was one of the things that would be covered for the patients. I'm wondering if maybe that's something that can be looked into on their behalf.

Ms Hoffman: If you're willing to connect them with us, there might be pieces around the diagnostic upfront versus ongoing pieces after a different treatment. We'd be really happy to work with them through the case to identify the issues there.

Ms McPherson: Okay. Now, I'm also aware that some of the physicians from the private clinics are working with government to develop regulations, and my understanding right now is that in the private clinics women who have a BMI over 40 are being turned down for service. They're not being accepted as patients for infertility treatment. They were previously being accepted. It seems like there's a grey area, and if that's an area of development of regulation going forward, I think it's really important that the patients be aware of what might be coming down the pike and to remove as much confusion and misinformation for them as possible. I don't know if that's something that the ministry is aware of at all.

Ms Hoffman: We are looking into the blood work issue. I want to reiterate that. I'm not aware of public clinic policies, but I can tell you that there aren't government regulations that are driving this. The private clinics or clinics in general may have policies around decisions around patient access and outcomes based on, I'm assuming, medical best practices. Policies within their own clinic that are related to uninsured services wouldn't be something that government is involved in.

Ms McPherson: I think that could be an area where it would really be beneficial for people who are receiving fertility treatments to have some regulations around it so that there's an even playing field and they know what to expect even if they are seeking treatment in private clinics. It gives them a more, I guess, realistic view of what they're likely to encounter.

There are also a number of patients that are seeking treatment outside of Alberta and some that are seeking treatment outside of Canada as well, and I'm wondering if there's been any analysis done of the costs of keeping infertility treatments within the province and actually looking at publicly funding infertility treatments versus what's happening right now and if there's an understanding of any cost benefit that might be realized by keeping those treatments within Alberta, within our health care system, within the publicly funded realm.

Ms Hoffman: That's a pretty complex question, and certainly I want to, again, honour all of the folks who are struggling with fertility for a variety of different situations. I know that it can . . .

The Chair: Thank you.

For the next portion of this meeting I would like to invite Dr. Starke and the minister to speak. Are you wanting to combine your time?

Dr. Starke: Actually, Chair, I'm going to speak for five minutes, and then I'll ask the minister to respond.

The Chair: Thank you. Go ahead.

Dr. Starke: Thank you, Chair. In my final section here I'm going to focus mostly on communications that I've had in recent months with the pharmacy association and their concerns. How this relates to the budget, of course, is that this is one of the most highly touted areas where the government has claimed that it is saving taxpayer dollars. While there is a saving on first blush, there's no question that in the long run this will cost Albertans much more than it will actually save.

The consultations that were undertaken with the pharmacy association were undertaken not in a spirit of co-operation but in a spirit largely focused on cost containment. While I can understand the need for cost containment, I know the pharmacists were extremely bothered by having to sign a nondisclosure agreement. Now, the minister has indicated that this is standard procedure, yet when the medical association is negotiating with Alberta Health, I receive nearly weekly updates from the president of the Alberta Medical Association indicating what the latest progress on those talks are. The pharmacists were not allowed to communicate to their profession in the same way, and as a result a number of the things that ended up in the final agreement, once the pharmacists actually learned of what had been agreed to with, I will point out, a third-party hired negotiator, were extremely distressing to pharmacists.

Pharmacists, I'd like to stress, are front-line health care workers. Now, they don't belong to a union, and they are private businesspeople in large measure, but they are front-line health care workers. The pharmacy network and the pharmacy funding framework that we have in the province of Alberta is a leader amongst all provinces. It was developed after extensive consultation directly with one of your predecessors, Minister, through Minister Horne and the pharmacy association after the consequences of lowering the prices of generic drugs that was brought forward in 2012 and 2013.

Alberta pharmacists led the charge in terms of expanding their scope of practice and allowing them to work to a greater extent directly with patients as pharmacists are the most accessible health

care professionals in the community. Ninety-five per cent of Albertans identify pharmacists as being the most accessible health care professionals in communities. In many communities pharmacists have been there for many generations and have stayed longer where there has been a much greater turnover of other health care professionals.

Another area that is changed by this new framework is the advanced prescribing authority. This was one of the innovations that was brought in recently, and pharmacists across Alberta, about one-third, would take the additional time and incur the extra expense of obtaining advanced prescribing authority, and for that they were compensated at a differential rate. The new framework eliminates that differential. My question to the minister amongst others is: why as a pharmacist would you go to the extra time and expense of achieving advanced prescribing authority when now there's no difference in what you charge for it?

Alberta and its leadership position, as far as I'm concerned, are being absolutely questioned by this new agreement. One of the most distressing areas is the whole area of risk sharing, which was a bargaining chip that the pharmacy association placed on the table and was eagerly gobbled up by the government's negotiator. In return they gave nothing, as far as the up to 40 recommendations that pharmacists made for cutting of costs.

I've already highlighted with the minister in question period – and I notice she just mentioned it – with regard to the services to vulnerable populations and programs like ACE. ACE, Minister, has an estimated annual cost of approximately $500,000, and their estimate is that it saves the heath care system some $3 million. Now, I'm really glad to hear that you're planning on meeting with them again because as recently as a week ago the last communication I had with them was that there were no ongoing discussions between ACE and the government and that the discussions that were held were only concerned about the cost of the ACE team.

The pan-Canadian framework has also resulted in an unintended consequence of a lack of ability of generic drugs; for example, metformin, one of the most common diabetes, type 2, oral hypoglycemic agents. As a result of that, pharmacists are now having to dispense the brand name drug at many, many times a higher cost, and those additional costs are being borne by the taxpayer.

Minister, I want to make it clear and I want to be on the public record that I support our pharmacy profession. Our pharmacists are professionals, and they are concerned with the health care of their patients. They do it because they care about their patients. This latest funding agreement is an affront to the pharmacy profession, and I urge the minister to reopen the negotiations directly with the pharmacy profession.

The Chair: Thank you.

Go ahead, Minister.

Ms Hoffman: Thank you. I want to also state on the record that I absolutely respect the pharmacy profession and the individuals who provide service in this regard, including pharmacists and their technicians and other staff in this area.

This is one of the reasons why, even though it was completely within our jurisdiction to impose a fee schedule and to impose a rate of compensation, we decided instead to sit down at the table. This is not standard practice across Canada. What we did is that we sat down with our budget, which is a 4.3 per cent increase, and we said: "We know that the increase that was negotiated under a previous government would probably see a 12 per cent increase. We know that that's not fair or sustainable, and we want to work with you to come up with a model that does in fact land in a place where that 12 per cent increase wouldn't happen but the 4.3 would, and that it would be focused on patients and patient outcomes." So for members who regularly speak in the House about cost restraint, this is exactly the way that we achieve restraint without impacting patients.

11:50

We are happy with the fact that when we sat down at the table with our proposal, many amendments were made to it, which means that many of the components – for example, as was mentioned, the holdback piece was something that they did to say: here's the insurance that we're going to live within the parameters that we agreed to, and if we don't, then there's the holdback; but if we do reach the agreement and the parameters that we've set, then this won't be required. I want to say that that's an important piece to note, that when we sat down, they said: it's really important to us that the dispensing fees stay as high as possible. So there was only a 15 cent reduction to dispensing fees, and instead there was movement on some of the other items like immunizations for flu.

I also want to clarify that there wasn't a third-party negotiator. It was an ADM from the Ministry of Health who did the negotiating on behalf of the people of Alberta, so I really do need to set the record straight on that.

In terms of the NDA there was within the NDA a provision to allow the RxA to not only disclose information regarding the consultation to its board, the association's professional advisers and consultants but also to allow RxA to exchange with any other persons that they felt it was necessary for them to share information being discussed in the consultations, subject to a confidentiality agreement that was put in place. As with the AMA, regularly they will say: "You know, we think it's important for us to tell our members that there are some pieces that we're discussing that I don't want to keep from them. We're planning on sending out a president's letter, and these are some of the key things that we're going to talk about from the discussion." These are the kinds of consultations that typically take place.

I understand that there has been some push-back, but I want to say that I am incredibly proud of the process that we undertook. Instead of imposing something on these professionals, we asked their professional association, the RxA, to join us at the table and come up with something that was sustainable. A 4.3 per cent increase, I think, is something far greater than any of the opposition members would be proposing given their proposals for billions of dollars of cuts. We're investing in increases in this area, and we did it in a way that is going to reach far greater sustainability.

Government is responsible and needs to take careful control of pharmacy costs while making sure that high-quality services are still available to Albertans. All health professionals – doctors, nurses, dentists – have a role to play in terms of sustainability of the public health care system. I understand that there were many agreements made under previous governments that saw escalators in excess of 10 per cent. Part of me can't help but wonder if the intent was to put these pressures in place so that public health care would not be successful in the long term. Certainly, I hope that that isn't the outcome, but my responsibility is to ensure sustainability, ensure a public system that can be here for future generations.

Having a 4.3 per cent growth item that's focused on the people of this province as the primary charger and doing it in a way that reached an agreement, at the end of the day, with the RxA rather than imposing one that is done across the country, I think, shows that we honour the professionalism of the experts in this area. With these changes Alberta still compensates pharmacists more than the national average by far, and when it comes to dispensing fees,

clinical services, and administration of publicly funded vaccines, we're higher than most other jurisdictions within our country.

Alberta will see out-of-pocket savings for individuals. For example, 8,700 seniors will save more than $100 a year. In some cases individuals will save more than $500 a year because we put caps on the number of times that people can be required to come in to see the individual for certain prescriptions, for example. I think the individual member may have been one of the MLAs who has brought up that sometimes in assisted living facilities there were requirements that prescriptions get filled daily or weekly rather than being able to have a prescription that you've been on for years filled in a larger volume.

The Chair: Thank you.

I'd like to invite Mr. Shepherd and the minister to speak for the remainder of the meeting. Are you wanting to combine your time?

Mr. Shepherd: Yes, please.

The Chair: Go ahead.

Mr. Shepherd: Thank you. We just have a brief moment, so I'll go quickly. I just wanted to take a moment to quickly talk about performance indicators 1(a) and 1(b) on pages 81 and 82 of the business plan. Now, those are related to substance use, and they do show an increasing trend. Those are indicators in terms of measuring outcomes related to alcohol and opioid use and, in particular, access to emergency services.

I know, Minister, you recently visited the Royal Alex hospital with me. I had the chance to meet, as I'm sure you have in the past, with Dr. Kathryn Dong of the ARCH team, who are doing some incredible work in impacting this particular area, you know, providing targeted wraparound services to individuals who are heavy users of emergency services, to help reduce that. We really appreciate their work and think it provides an excellent model we might consider elsewhere. In regard to this in the budget I was wondering if you could give me a sense, then, of how we are using, I guess, these measurements to try to bring down some of the costs, to try to sort of measure how we're reacting in that respect, and if you can give us a sense of where you might see this increasing trend coming from.

Ms Payne: Thank you to the member for that one. Alcohol and substance misuse result in significant disability, illness, and death in Alberta every year. We hear a lot on the news about opioid overdose deaths, but alcohol and tobacco both have serious negative health impacts and can lead to death. By monitoring trends for alcohol and substance misuse as well as cigarette smoking, it allows us to have a better indicator of whether or not the programs and services being offered by government are having an impact and whether we may need to do things differently, you know, programs that work around cessation as well as treatment and supports for individuals as well as some of the awareness in early intervention programs that we offer.

Mr. Shepherd: Thank you, Minister. Looking at key strategy 2.3, that's also related in a similar way to the opioid response, I was wondering if you could give us a sense of how the funding for that is allocated. Which line is that in the budget? I know there have been a number of programs that have come forward due to recommendations from the minister's task force and some other things. Where is that being apportioned in the budget?

Ms Payne: Thank you. Opioid overdoses and deaths are clearly a devastating public health crisis in Alberta. A growing number of people and families are being impacted. In Budget 2018 we've allocated $63 million of funding for the opioid response, which is a $7 million increase from last year's budget.

It is allocated as follows. We have $39.7 million included in addiction and mental health, which is element 5, largely for the adoption of the recommendations from the opioid emergency response commission. Those would be recommendations from '17-18 as well as forthcoming recommendations. There's also a $14.4 million increase in AHS base operating funding, element 2, which addresses some of the counselling as well as opioid dependency treatment clinics. We also have an $8.9 million increase in the drugs and supplemental health benefits under element 4, which includes ensuring access for low-income Albertans to drugs such as Suboxone and methadone.

Included in this budget is also expansion to the take-home naloxone kit program. If I may, as well, with respect to the suggestion that another member had made earlier, any MLA who is looking to pick up a naloxone kit or receive training in it in the interim is more than welcome to go to a local pharmacy. If you google "get naloxone in Alberta," you'll actually get a list of a map across the province of all the pharmacies that signed up for the program and you can receive both the training as well as a kit free of charge. Should one need to use their kit, you can go back and get another one.

Mr. Shepherd: Excellent. Thank you, Minister.

Recently I was able to join you for the announcement of some of the opioid public awareness grants, so I know we've already mentioned Indigo, who is going to be, I think, a great partner in delivering some of that. Certainly, some other groups in my constituency – Fruit Loop, the Edmonton Men's Health Collective, and some other folks – are going to be helping deliver that. I know that for that program you ended up having a much larger than expected number of applications and so increased the funding. Is there the possibility we might see further expansion of that in the future?

Ms Payne: Certainly, the opioid emergency response commission was responsible for reviewing those grants and, ultimately, I think that, you know, in the coming year we'll see some more recommendations coming from the commission. To date there have been 26 recommendations that have been made, and all have been posted on the opioid website. Each of them is in the process of being implemented. So I think that in the coming year we're going to begin to see some of those impacts of both awareness programs as well as expansion in services for treatment and harm reduction across our province. Certainly, our response to the opioid crisis will continue to be guided by the work of the commission.

Mr. Shepherd: Excellent. Thank you, Minister.

I think we are coming up on time here, so I will just take this opportunity, then, to say thank you.

The Chair: Thank you.

I would like to remind the committee that we are scheduled to meet next on Thursday, April 12, 2018, at 9 a.m. to consider the estimates for the Ministry of Service Alberta.

Thank you, everyone. This meeting is adjourned.

[The committee adjourned at 12 p.m.]

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