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The 28th Legislature
Third Session

Standing Committee
on
Public Accounts

Health
Alberta Health Services

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Third Session

Standing Committee on Public Accounts

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

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

* substitution for Kent Hehr

Also in Attendance

Anglin, Joe, Rimbey-Rocky Mountain House-Sundre (Ind)
Forsyth, Heather, Calgary-Fish Creek (W)
Pedersen, Blake, Medicine Hat (W)

Office of the Auditor General Participants

Merwan Saher	Auditor General
Doug Wylie	Assistant Auditor General
Doug McKenzie	Principal

Support Staff

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

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Standing Committee on Public Accounts

Participants

Ministry of Health
- Susan Anderson, Assistant Deputy Minister and Chief Information Officer
- Janet Davidson, Deputy Minister
- Glenn Monteith, Chief Delivery Officer

Alberta Health Services
- Carl Amrhein, Official Administrator
- Robert Hawes, Chief Program Officer, Finance
- Vickie Kaminski, President and Chief Executive Officer
- Richard Lewanczuk, Senior Medical Director
- Deborah Rhodes, Vice-president, Corporate Services, and Chief Financial Officer
- Ronda White, Chief Audit Executive, Internal Audit and Enterprise Risk Management

8:33 a.m. Tuesday, November 25, 2014

[Mr. Anderson in the chair]

The Chair: All right. Let's get started. Good morning, everyone. I would like to call this meeting of the Standing Committee on Public Accounts to order. I'm Rob Anderson, the committee chair and MLA for Airdrie. I'd like to welcome everyone in attendance here.

We'll go around the table to introduce ourselves, starting on my right with our newly appointed deputy chair, Mr. Young. [interjections] Man, a tough crowd there, Mr. Young.

Mr. Young: Well, thank you. It may be a tough crowd, but we filled the house today, didn't we?

The Chair: Please indicate if you are sitting in on the committee as a substitute for another member. I believe Dr. Swann is substituting for Mr. Hehr, but if there are any others, please let us know.

Go ahead, Mr. Young.

Mr. Young: Good morning. Steve Young, MLA for Edmonton-Riverview.

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

Ms Jansen: Sandra Jansen, Calgary-North West.

Mr. Amery: Good morning. Moe Amery, Calgary-East.

Mr. Donovan: Ian Donovan, Little Bow.

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

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

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

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

Ms Kaminski: Vickie Kaminski, Alberta Health Services.

Dr. Amrhein: Carl Amrhein, Alberta Health Services.

Ms Davidson: Janet Davidson, Alberta Health.

Mr. Monteith: Glenn Monteith, Alberta Health.

Mr. Wylie: Good morning. Doug Wylie, Assistant Auditor General.

Mr. McKenzie: Doug McKenzie with the Auditor General's office.

Mr. Saher: Merwan Saher, Auditor General.

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

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

The Chair: Dr. Swann, you're in for Mr. Hehr today, right? You're substituting?

Dr. Swann: That's right.

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

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

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

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

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

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We've circulated the agenda to the committee. Do we have a mover that the agenda for the November 25, 2014, Standing Committee on Public Accounts be approved as distributed?

Mr. Sandhu: Good morning.

The Chair: Oh, we have someone on the line. Is that you, Darshan?

Mr. Sandhu: No. Good morning. Peter Sandhu, Edmonton-Manning.

The Chair: Thank you, Peter.

Sorry, Dr. Swann. You moved that motion, right? Yes. Those in favour? Any opposed? Carried.

All right. We also have the minutes from our last short meeting that we had the other day, last week. Do we have a mover that the minutes for the November 18, 2014, Standing Committee on Public Accounts be approved as distributed? Mr. Barnes. Those in favour? Any opposed? Carried.

Obviously, today we're meeting with representatives from Alberta Health and Alberta Health Services. The reports to be reviewed today are the Alberta Health annual report 2013-14, the Alberta Health Services annual report 2013-14, the September 2014 report of the Auditor General of Alberta on chronic disease management, and, of course, any other relevant reports by the Auditor General pertaining to AHS or Alberta Health as well as, as always, the 2013-14 annual report of the government of Alberta, consolidated financial statements, and the Measuring Up progress report.

Members should all have a copy of the briefing documents prepared by committee research services and our Auditor General that have been circulated to them. We did have a bit of a complication this time with getting you the document that shows outstanding recommendations by the Auditor General and where they are now with regard to being followed up on by the department. Those will be coming shortly. They were given to our office late yesterday.

Usually we would ask that departments in the future make a very strong effort to get those materials to us far more in advance. This is a relatively new process, though, so we won't light our hair on fire this time, but we do need to make sure that the committee members have proper time to review those documents, and clearly they haven't in this case. I would hope that that be respected next

time. Those documents are being printed out as we speak. They should be here in the next 10 or 15 minutes.

The Auditor General has taken us through some of the recommendations that are still outstanding in the prebriefing we had at 8 o'clock, so at least we've had that opportunity to go over that with him.

Joining us today to discuss chronic disease management, of course, are representatives from both the Department of Health and Alberta Health Services. You may each begin by making an opening statement of about five minutes on behalf of your organizations, and then we'll go to the Auditor General to give some brief comments as well.

Why don't we start with Alberta Health. Ms Davidson.

Ms Davidson: Thank you very much, Mr. Chairman, and good morning, everyone. It's a pleasure once again to meet with this committee.

Before I begin, I'd like to acknowledge members of the Alberta Health executive team who are accompanying me this morning. These officials will also be helping in answering any questions you may have about the general workings of the department as well as the specific issue of chronic disease management. They're Glenn Monteith, who's our chief delivery officer; David Breakwell, who's the acting assistant deputy minister, financial and corporate services; Christine Couture, who's the assistant deputy minister of strategic planning and policy; Linda Mattern, the assistant deputy minister, health system accountability and performance; Miin Alikhan, our assistant deputy minister, professional services and health benefits; Corinne Schalm, who's acting assistant deputy minister for health services; Susan Anderson, who's assistant deputy minister and CIO; Dr. Martin Lavoie, who is deputy chief medical officer of health; and Cameron Traynor, who's director of communications.

8:40

Also with me this morning from Alberta Health Services are Dr. Carl Amrhein, the official administrator, and Vickie Kaminski, president and CEO, and their team, whom they will introduce in their remarks.

Over the past year Alberta Health has reached a number of noteworthy achievements. For example, the ministry has made significant progress in the areas of primary care, which includes developing a primary health care strategy, enhancing primary care networks, and expanded scope of practice for pharmacists to improve Albertans' access to services. We introduced the role of physician assistants to enable physicians to spend more time with patients, negotiated a comprehensive, seven-year agreement with physicians, added $75 million for supportive living spaces, and a number of other achievements which I'm sure you'll be asking us about. Good work has been done, but we know much more is needed, and we're moving forward this year on new initiatives and projects to improve health care for Albertans.

Now, I know the focus of today's discussion is chronic disease management, so I'd like to address this topic in a little bit more detail. First of all, I think it's important to put it in context. Chronic disease management is actually a success story for health care. Over the years public health, of course, has improved the health and life expectancy of individuals. We've also made major advances in the treatment of disease, so many of the diseases that used to be killers like HIV, like cancer, like hepatitis now are chronic. You hear about people living with cancer, not dying of cancer. So it's no surprise that chronic disease is the single biggest challenge facing the system because we have not been previously focused on managing patients with chronic disease. It's been periodic, intermittent confrontations or interactions between individuals and the health care system.

Chronic disease, obviously, is very complex, and it's a growing problem not just in this province but globally. In our province today 30 per cent of Albertans – 30 per cent – have at least one chronic health condition. Amongst seniors that number rises to more than 75 per cent. While these figures represent a small number of individuals because, generally speaking, Alberta is one of the youngest populations anywhere, these Albertans use health services more frequently than others and account for a significant proportion of health costs. So more effectively supporting these individuals while at the same time finding more cost-efficient and effective ways to provide care is our priority and our challenge.

This dilemma is not unique to Alberta, so addressing the issue is a priority for the well-being of those Albertans struggling with these health outcomes and for the sustainability of our health system not just in this province but globally.

In September the Auditor General issued a report about chronic disease management in Alberta and how it can be improved. We've accepted the Auditor General's recommendations and will be working with our partners in the years ahead to implement the report's recommendations and suggestions. It is important to note that these changes will take time and that a long-term approach is required.

I'm pleased to note that the Auditor General has in fact recognized that Alberta has developed a number of positive chronic disease management initiatives, but at the same time he pointed out where there are significant opportunities for improvement. Much of the work that lies ahead involves enhancing and building upon these efforts.

In closing, I'd like to emphasize that improving how we manage chronic diseases is a critical part of our efforts to create a patient-focused, sustainable health system, and it is central – central – to enabling us to improve Albertans' quality of life.

Thank you for your time, Mr. Chairman, and I'd like now to invite Dr. Amrhein to provide his comments.

Dr. Amrhein: Thank you, Janet. I'm very pleased to be here today, and I look forward to the discussion.

AHS President and CEO Vickie Kaminski is with me to discuss the organization's response to the Auditor General's recommendations related to chronic disease management and the AHS financial statement audit, but first I thought I'd share a few words about my goals as the new official administrator of the province's health system.

Minister Mandel has made clear that he wants to create a proper governance model for AHS, one that will sustain the organization for years to come and one that will enable the organization to make substantial improvements in areas that matter to Albertans. This is my second week on the job, day 7, to be precise, so the work on developing the new governance model is still in its early stages, but we've already had some important meetings in Calgary last week with the council of the chairs of the health advisory councils. I do know that a new governance model must enable AHS to better measure its efficiency and effectiveness so that we can determine whether the health system is truly meeting the needs of all Albertans. I look forward to devoting all of my efforts between now and June to make this happen.

I would now like to turn it over to Ms Kaminski.

Ms Kaminski: Thank you, Dr. Amrhein. Mr. Chairman, I'm pleased to discuss Alberta Health Services' response to the Auditor General's recommendations and, in particular, the report on chronic disease management. Last September the OAG

released a report that recommended AHS take action to better identify those Albertans with chronic disease and to better co-ordinate and enhance the services that are needed to support them. I know that effective management of chronic disease is critical to improving the overall health of Albertans and the long-term sustainability of our health system. That's why AHS continues to put resources toward initiatives that identify and support all those Albertans who are living with chronic disease.

We're expanding the Alberta healthy living program, which gives people opportunities to learn how to manage chronic disease through in-person education and exercise classes in nearly 100 communities across the province. We're also introducing collaborative care models that will enable individuals and families to access comprehensive care that is integrated with other health services and community programs. The goal is to build robust, interprofessional health care teams that will improve access to care, keep people out of hospital, and prevent and help manage chronic disease.

AHS can do more. We're developing a detailed action plan to implement the OAG recommendations on chronic disease and will share that plan with the OAG at the end of the year.

AHS has also addressed a number of financial recommendations made by the OAG from previous years. The Auditor General has confirmed that six financial recommendations have been fully implemented, and he acknowledged that AHS has made satisfactory progress regarding an outstanding recommendation dealing with the monitoring of payroll activities. He also repeated a recommendation around IT controls and framework. Overall, AHS has 37 outstanding recommendations from the Auditor General, including six new recommendations in 2014. Action plans exist, and progress is being achieved. AHS takes all these recommendations seriously.

We at AHS are coming out of a period of significant change. With clear direction from the ministry and a renewed focus on what needs to get done, I believe AHS is well positioned to transform into the health system that Albertans need and deserve.

Thank you very much for the opportunity to be here today.

The Chair: Thank you for being here, and thanks for your comments.

I'd like to hand it over to our Auditor General. If you could comment, too, in your remarks, Mr. Auditor General: are there any outstanding recommendations that we should be specifically looking at? Are you satisfied with the update that we've been given in the follow-up to these recommendations, the kind of summary that we've received? If there are any specific ones that need to be focused on, please let us know.

Mr. Saher: Thank you, Mr. Chairman. Maybe I'll just tackle that first. The information that you've been given on the status of outstanding recommendations is accurate. There are none that I believe today I should draw particularly to the committee's attention on the basis that the committee should spend time pursuing discussions on the status. In the listings you'll see a large number of recommendations outstanding with respect to mental health. That's a follow-up audit that we have under way and we intend to report on publicly in February. So that work will I think make significant inroads into the list of outstandings.

8:50

If I could now just turn to chronic disease management, our audit report on chronic disease management was released publicly on September 9, 2014. Albertans should be doubly interested in the subject. It's about our health, and it's about huge sums of money. This audit report is a call to action by health care administrators, physicians and other providers, and Members of the Legislative Assembly on behalf of Albertans.

Mr. Chairman, chronic diseases are arguably the largest challenge facing our health care system. More than any other health problem, chronic diseases shorten people's lives and make their lives more difficult. Chronic diseases are also the largest drivers of health care costs. In simple terms, effective chronic disease management requires that individuals with chronic disease have access to a family doctor, a care plan that is actively managed, and a care team. Effective management can help to reduce the health impacts and costs of chronic diseases. It treats these diseases in primary care before patients require emergency visits or hospitalization. It helps patients maintain their health. It also reduces the cost of treatment because primary care is less expensive than acute care.

Our overall conclusion is that Alberta provides some excellent care for individuals with chronic diseases. However, that care tends to be fragmented. No entity has overall responsibility for ensuring that all the parts work together well, that all patients receive the same level of care, and that providers are making good use of available resources to understand chronic diseases and manage patient care.

Our key findings are summarized on page 5 of the report, and we make eight recommendations. In summary, we've recommended that the department assert leadership in setting expectations for the delivery of chronic disease management services by those it funds and establish systems to measure whether this care is effective. We've recommended that the department and Alberta Health Services determine who has chronic disease so they can allocate and co-ordinate resources appropriately across the province. We've said that care plans need to be used more effectively. Lastly, we've recommended advancing the use of information technology to provide better information to providers, patients, and health care managers.

We recognize that improving chronic disease management across the province will take time. For example, changing what is expected of service providers will require negotiation with professional regulating bodies. Patients will need to learn how to use new tools to better self-manage their chronic diseases. Systems to better use health care information and assess effectiveness need to be developed at both the provider level and for the health care system overall, but strong actions are required now.

Mr. Chairman, today's meeting allows the committee to engage in a discussion of chronic disease management directly with health care leaders from the department and Alberta Health Services. It's an opportunity for you to review our findings and an opportunity for you to test the value of our recommendations with those who will in large part be responsible for implementing them. In fairness, they cannot move the health care system on their own. This is the first of two meetings. The second meeting, next week, will be an opportunity for the committee to hear first-hand from stakeholders whose members are care providers with the ability to deliver the necessary changes directly to patients.

Thank you.

The Chair: Thank you as always, Mr. Auditor General.

I guess we'll open it up for questions. We'll start with the PC caucus for the first 16 minutes, and then we'll move over to the Wildrose.

Mr. Young: Thank you, Mr. Chair.

Janice Sarich.

Mrs. Sarich: Thank you very much. What a perfect segue. We're absolutely pleased that we have the two perspectives today to help

us understand the complexity of the overall health system and also to help us drill down to some of the key findings by the Auditor General, which, he has eloquently pointed out, are listed on pages 5 and 6 of his report.

The Auditor General has set the expectations and results very high for both organizations. In review, for example, there's an expectation for results: improve delivery of chronic disease management services; the same for improving support of patient-physician relationships; also, thirdly, improve the physician care plan initiative; improve delivery of the pharmacist care plan initiative; strengthen electronic medical records systems; and lastly, improve Alberta Health Services chronic disease management services from that perspective. I'm wondering: from both of your perspectives, do you believe that the Auditor General is correct in pointing this out to you, that these are the things that you need to focus on for overall improvement for Albertans?

Ms Davidson: Thank you. It's a very good question. I do believe that that's the way we need to go. As I mentioned earlier, chronic disease is what health care is about for the most part now, and to have a system that is effective and efficient in dealing with what is the majority of the patients who are in our system, I think, is critical. It serves as a good outside review and recommendations about things that we think are important so that we can focus on what are the key initiatives we need to look at.

The other thing that I think it does well is identify the distinction between: what are the roles and responsibilities of the Ministry of Health, and then what are the roles and responsibilities of the delivery agency? They have to work together. If they don't . . .

Ms Kaminski: I would agree. We support fully all of the recommendations made by the Auditor General in the report. I think that if we look at access to primary care, that's one of the first things that we have to ensure for all Albertans because that really becomes their medical home, if you will, where they take their problems, take their issues, and get first crack at being able to be moved into the system of specialists or other interdisciplinary team members.

It's important to have care plans that document what's happening and what needs to happen and to involve them in that planning as individual patients and family members so that they take some control over their health as well. Electronic medical records have long been one of the things that are going to help us, I think, integrate the system right across.

Mrs. Sarich: Thank you. Each of your organizations was asked to provide the Standing Committee on Public Accounts and we received this morning from Alberta Health the status report for the outstanding recommendations from the Auditor General of Alberta. I appreciate the complexity of the system. However, when I look at some of the recommendations that stem all the way back to 2001 or 2006, there seems to be a problem of continuity, when there are changes within both of the systems, in the oversight and monitoring to ensure that the Auditor General's recommendations are being dealt with. I mean, I can point out to you today: from Alberta Health Services, page 1, there was a recommendation stemming all the way back to 2001, repeated in 2014, and the progress report here is suggesting that the sign-off would be in 2017, so virtually waiting 17 years for something to transpire within a very complex system, and this one is on the surgical services. I'm very concerned that something is happening in terms of monitoring, oversight, and perhaps governance as well.

So do you have a comment? This one is being directed to Alberta Health Services and also Alberta Health because at the end of the day Alberta Health and the minister are responsible.

Ms Kaminski: I'll start with the response. You're right. That is something that has caused us some concern. We have gone back to do a tracking of all of the recommendations that are outstanding. Ronda White, who is here with us today, is our internal auditor. She is keeping us onside with a number of the recommendations. Part of it is that there isn't always an end point in the recommendation, that it really is something that's truly evolving and will continue to evolve; for example, a contract for surgical services. Every time we add another contract for surgical services, we start the process again.

So we're keeping them alive to be able to keep track of those pieces that are important, and we have had some significant changes at AHS. So as I said, with some stability now, with a renewed focus from the ministry, and with clear direction I think you'll see a number of these begin to get resolved.

I could perhaps ask Ronda to make some comments.

9:00

Ms White: Hi. Ronda White, chief audit executive. On the nonhospital surgical facilities report one of the key matters to note is that there is monitoring in place. The OAG has asked us to enhance that. The plans take us further into that, developing a clear strategy around the facilities, and we'll be working with the department. In respect to the ongoing process we monitor the results every six months and are in a position to report to the department and the Public Accounts Committee when necessary on all of the recommendations.

Mrs. Sarich: Just in follow-up. There is an expectation – and the inquiry comes from Public Accounts – that you have a three-year cycle to try your very best to complete all aspects of the recommendation. I appreciate the comment about the complexity and some things may continue over a period of time, but certainly the core of what is trying to be addressed needs to be signed off in that three-year period. I would ask and encourage both systems to really strive for that standard.

Thank you.

Ms Davidson: I agree with you. In fact, one of the things that we've developed now in the department and working with AHS is a tracking system, and we're actually reviewing it actively at the executive committee level so that we regularly review it. We have recommendations from the Health Quality Council of Alberta, Accreditation Canada, various other accrediting bodies, the Auditor General, and a variety of others. We're actually trying now, working with AHS, to put all of these together into one document so that we can monitor exactly what is happening with all of them. I agree with you. We aren't doing as good a job of that as we should be.

Mrs. Sarich: Thank you for your comment. I'll close with this. It also raises an interesting question about your internal control.

Thank you.

Mr. Young: Thank you, Mrs. Sarich.

Fred.

Mr. Horne: Thank you. Good morning. I'm not sure how much time is left in this segment, so I'll put my questions on the table, and then I'll leave it to you to try to answer them.

I guess, first of all, by way of context – I think it's important, and you may want to comment on this – until very recently

primary health care programs in Alberta and the electronic medical record were actually part of the government's agreement with the Alberta Medical Association. What that meant was that every time the government or the health delivery agency wanted to make a change in those two areas, it required an actual negotiation with the Alberta Medical Association. Now, those two items were removed and there was a negotiated end to the POSP program when the new agreement was signed last year, but I'd be interested in having primarily the department, I think, comment about some of the other barriers that you face in terms of implementing these recommendations or others in the report, because not all of the incentives in the health care system are aligned with the goals that are here, and fee-for-service is but one example.

The second area I'm hoping that you could talk a bit about is the primary health care strategy, specifically the extent to which that document intended to lay out a plan to deal with chronic disease management in the province. My understanding is that that was by far the largest part of the strategy, recognizing that about 5 per cent of Albertans use about 65 per cent of health care resources and most of that 5 per cent are people that are in fact living with chronic disease.

I'd be interested in your comments on both of those areas.

Mr. Monteith: Thank you very much. Let me address the first one on sort of the historical journey in the previous agreement. We had a unique environment with the trilateral master agreement when we had the regional health authorities, and at the end of it Alberta Health Services was part of that. The Alberta Medical Association and the Ministry of Health were equal partners in a very comprehensive agreement that included the beginning of the primary care network journey, the beginning of formal funding and design of electronic medical records to be used in physician offices, and a variety of other initiatives that were under way, including the establishment of the comprehensive annual care plan coding system for family physicians to deal with, essentially, five primary care oriented chronic diseases.

Each of those started off quite well: good thought, best intentions, and strength. The challenge was that any time you wanted to change it, every party essentially had a veto, so it was very hard to move directionally without it starting to either expand the scope beyond what the agreement was intended to do or, in fact, cost additional dollars beyond the repurposing of our current dollars. One of the benefits that we do have now in the new agreement, which is significantly pared down in terms of its governance and its controls around the compensation, is that it is largely about the rates and prices we pay physicians for services. However, Alberta remains, by far and away, the largest physician compensation system dependent on fee-for-service as the primary means of rewarding physicians for the work they do.

You will find in any high-performing chronic disease management system – you can pick Kaiser Permanente, you can pick Geisinger, you can pick France, Scotland, et cetera, every one of those systems – that a critical element is that the physicians are actually not paid in a fee-for-service environment. They're paid in a very different and fundamentally different way that allows for the team, which includes registered nurses and other providers, to be much more actively engaged. If you think about it from just the way the compensation works, if the physician doesn't see the patient, how does the practice get funded? In a fee-for-service world it can't. So these are the challenges that we were borne out of.

I want to bring this to where we are on the primary health care strategy. So the primary health care strategy, in fact, is the critical vehicle for us as the ministry to start delivering on many of the recommendations that the Auditor General brought forward on improving chronic disease management, including how you organize care, how you establish the teams, what type of electronic health record and medical record access you're going to create in that space, as well as the accountability framework for primary care networks and family care clinics, identifying their patients with chronic disease and also measuring what that journey is. That's where we believe we have a better opportunity, and more of the policy levers are within the ministry now, with our partner Alberta Health Services, to move at a more rapid rate of system reform. But it will be difficult because physicians are independent contractors to the system, and we have to bring them all along on the same journey.

Mr. Young: Thank you very much.

Fred, do you have a follow-up?

Okay. There's a minute here, and I'd like to ask a question. I'm just going to preface it with: in the AG's report it talks about some critical pillars for successful, high-performing chronic care management programs. One is the physician-patient relationship; the other one is care plans, information or electronic medical records. In the AG's report it talks about at least 12 different electronic medical record systems. We had a program, and I think it cost $300 million to get people on board there. Unlike the Auditor General, I've got no problem with how many people have different systems; however, I do have a serious problem with them not being able to talk.

Perhaps this is for Ms Anderson or yourself. It doesn't matter. Why aren't we going to a standards-based approach for electronic medical records? There are well-established best practices in NIEM and HL7, and we're just simply creating 12-plus silos, not just in each physician office but all the different support services. What is the value of that $300 million in creating silos? I invite your comments.

Ms Anderson: Thank you. You are correct that the government has invested approximately $300 million in community electronic medical records up to the completion of the physician office system in April of 2014. This represents about 72 per cent of all of the community physicians in that regard. There's been a very specific focus in terms of integration of electronic medical records with the Netcare electronic health record. Today many of these community EMRs are downloading both lab and diagnostic imaging reports that are centrally collected in Netcare and then distributed to the EMRs.

9:10

We worked with the College of Physicians & Surgeons to identify a specific minimum data set for information to be published from the electronic medical record into what we call a shared health record in the Netcare environment, to be visible. To date the vendor community – as you've identified, there are approximately 12 vendors in the community – have been reluctant to move on what we've identified as the standards for that publication. We're very specifically working with one of those vendors, that represents about 60 per cent of the community EMRs, in terms of establishing the standard protocol which uses HL7 V3 standards to publish data. The college agreed to support the minimum data set of the event information immunization data. There is some reluctance on the part of community providers to expand beyond that data set currently.

We recognize the very important need for sharing of care plans not just between the physician and the patient but provider to provider as we have an expanded number of interdisciplinary care

members, including not just physicians but pharmacists as well now, that have input to that critical care plan for chronic patients.

Thank you.

Mr. Young: Thank you very much.

We're done with our time.

The Chair: We will go over to the Wildrose. You have the next 16 minutes.

Mrs. Forsyth: Thank you. Page 136 of the AHS annual report shows that the total value of severance paid out in 2013-14 was over $7 million for 219 people. Can you provide a breakdown of who the people that received severance were and the positions they held and how many of these were formerly classified as executives or CEO direct reports?

Ms Kaminski: Deb Rhodes is here with finance and corporate services, and she's just saying that we can get you that full report. I don't have that detail right here, right now.

Mrs. Forsyth: Okay. Could you provide that through the chair, please?

Ms Kaminski: Yes.

Mrs. Forsyth: I want to reference page 145, the footnotes to the consolidated schedule of salaries and benefits for the year ended March 31. You have a footnote that says: "AHS has implemented a new titling structure." I'd like to ask the question in regard to – under the former organizational chart AHS employed 80-plus VPs, and on page 136 of the AHS annual report there are 15.82 FTEs classified as executive and another 30.61 FTEs classified as management reporting to CEO reports. Were any of these 46-plus FTEs formally titled as VPs, and what changes in there were for compensation of these former VPs that were at one time VPs and now you've titled them as something different?

Ms Kaminski: It's not as straightforward as just having retitled existing. There's been a whole approach to the organizational chart that was undertaken as a result of the official administrator being appointed when Ms Davidson was the official administrator the first time, looking at an organizational chart review and streamlining a number of the management responsibilities.

We also at the same time undertook, through some extensive work, a review of all of the pay scales for those various job positions. So we've had a number of changes. In the job rates, for example, the vice-president rates have significantly been decreased as has the CEO rate as have senior levels below. So the management salaries have come down, and the wage compression that we're seeing now that exists between the front line and managers is far smaller than it used to be. So the wage compression: unions always coming up, non-union out of scope coming down.

The Chair: Mrs. Forsyth, could you repeat the question? Because I'd like to get some specific numbers as well, and I didn't hear anything specific whatsoever there. Can you repeat the question?

Mrs. Forsyth: Okay. On page 145, under Executive, it says that "AHS has implemented a new titling structure." My question through the chair is: under the former organizational chart AHS employed 80-plus VPs. On page 136 of the AHS annual report there are 15.82 FTEs classified as executive and another 30.61 FTEs classified as management reporting to CEO reports. Of the 46 FTEs formerly titled as VPs, was there a change in compensation for those former VPs under their new positions? What I am trying to understand – and I have to say that we have put two FOIPs out on this – is where those VPs are, what their new titles are, what their responsibilities are, and what their salaries are.

Ms Kaminski: I am going to ask Deb Rhodes to give us some additional information.

Ms Rhodes: Hi. Deb Rhodes, VP corporate services and chief financial officer for AHS. Yes, some of those 46 were definitely former executive vice-presidents, and some of them were former senior vice-presidents, and some of them were former vice-presidents. We have had that titling construct change, so some of the former executive vice-presidents now hold a title. For example, my position formerly was an executive vice-president position. It is now a vice-president position, similar roles and job responsibilities with a decreased pay structure. We can actually get you the entire details. I don't have those with me right now, but we can absolutely provide that.

The Chair: That would be great. If you could provide that to this committee. Just to be specific, you had 80 vice-presidents. How many of those positions were cut? How many became different positions with lower salaries? Could you send us a document to outline that?

Ms Rhodes: Yes, absolutely. We can put that together.

The Chair: Thank you.

Mrs. Forsyth: Thanks.

Page 146 of the AHS annual report explains that Dr. Eagle's term as CEO and president ended on October 16, 2013. He then became a special adviser for a year, a position that ended last month. His total compensation for the 2013-14 fiscal year was $651,000 according to page 139. I'd like to know what project Dr. Eagle was involved in during his term as special adviser. What deliverables did he produce?

Ms Kaminski: Dr. Eagle was the special adviser appointed by John Cowell, who was the then official administrator. He actually did some work with Dr. Cowell on some reorganization of the pay scale, for example, that was under way. There were no specific deliverables that he transferred to me when I took over as president and CEO in May of this year or when he left in the middle of October. He did do a number of reviews of some of the quality reports that had come through HQCA, looking at our approach to quality, and had worked with Dr. Yiu on the quality program. He was also involved in a number of lectures across the time that he was with us as a special adviser. He worked with the University of Alberta and the University of Calgary.

Mrs. Forsyth: Okay. One of the things that you mentioned, Vickie, if I may, was about pay scales. That is something else we've been trying to get through FOIPs. I hope that you can provide his report though the chair in regard to what he did in regard to the pay scales with Dr. Cowell. That would be very interesting, please. I know Janet did one, and then there was another one through the University of Alberta. So if you could provide that through the chair. Then I guess I am disheartened to hear that you really didn't have any specific deliverables for a position that was paid significantly well for a year.

The Chair: Could you please provide that report through myself, Vickie?

Ms Kaminski: He was a special adviser. I am not sure that we'll find a document with his handprint on it to say: here's his report. We can provide you with the pay scale adjustment and the new job rates.

9:20

The Chair: Okay. All right. We'll go there, then.

Mrs. Forsyth: What was the total cost of legal fees paid by AHS and Alberta Health in the fight to withhold the severance from former CFO Allaudin Merali?

Ms Kaminski: We'll also have to respond to that one through the chair, if you will. We haven't finalized all of those records and bills. We just are tallying them.

The Chair: Okay. Thank you for providing that.

Mrs. Forsyth: Page 128 of the AHS annual report shows almost $38 million in deferred revenue for facilities and improvements in 2014. Can you please explain what infrastructure maintenance projects and facilities and improvements less than $10,000 were deferred over the last fiscal year?

Ms Kaminski: I'm going to ask Robert Hawes to respond.

Mr. Hawes: Right. Robert Hawes, acting chief program officer, finance. The question is looking for the list that's less than $10,000. That's a long list of many items, and we'll provide that to you in writing.

The Chair: Thank you very much.

Mrs. Forsyth: In May 2013 AHS put out a press release touting the 2013-16 health and business plan, with a commitment that hiring limits would ensure that the total number of AHS staff did not increase in 2013-14, yet page 136 of the annual report shows that the number of FTEs at AHS increased by 1,110 during the 2013-14 fiscal year. Why did AHS back away from that 2013 commitment?

Ms Kaminski: I can't answer why they backed away from it. I can tell you, however, that on a go-forward basis we have a very tight vacancy management that we've put in place. We have a number of unfunded positions that we're looking at to see whether or not we should be terminating those positions or adding them to the overall budget. There is a very tight control now for all vacancies on a go-forward.

The Chair: There were a thousand new FTEs added last year when there was supposed to be a freeze there?

Ms Rhodes: I'd just like to add one additional comment, and we can provide some additional details back in writing. We also continued to open the South Health Campus, so there were a significant number of new FTEs that were hired into positions to support the opening of the South Health Campus.

Mrs. Forsyth: If you could provide a breakdown of those employees. I mean, you know, it's a huge increase. I understand the South Health Campus. Honestly. I live in that area.

The same May 2013 press release says that the administrative costs will be reduced by $35 million over three years. What progress was made during the 2013-14 fiscal year towards that goal?

Ms Kaminski: We are on target for meeting that goal over the three-year period. For the '13-14 period I think that Deb can answer.

Ms Rhodes: Yes. We did make substantive progress on that goal. We actually reduced our travel costs quite significantly as well as consulting and professional fees. We can provide further detail of that as well.

Mrs. Forsyth: One of the things that has been a hot pocket is the sole-source contracting that AHS has undertaken over the last several years, obviously. I'd like to know the cost of sole sourcing for the last fiscal year. If you can send that also, please.

Ms Kaminski: Yes.

Mrs. Forsyth: What maintenance projects at the Misericordia hospital were deferred in the 2013-14 fiscal year? What was the total value of deferred maintenance projects at the Mis over the past fiscal year?

Ms Kaminski: That would be part of the deferred maintenance programs that you'd asked about earlier, that we will provide in that report through the chair.

Mrs. Forsyth: Okay. I'd like to talk on the Auditor General's report on chronic disease management. In this report the AG says that the government and AHS have essentially abandoned chronic disease management to the PCNs and physicians themselves. He states that Alberta Health and AHS "have not taken sufficient responsibility for directing and coordinating [CDM]." There seems to be a recurring theme with the AG report on the health care system, confusion over who's responsible and what roles the department and AHS should be playing. Why after six years of existence does AHS still not have the system and structures in place to deliver chronic disease management services at the level of a high-performing health care system?

Ms Kaminski: I think what the AG was reporting on was a system that's very interconnected, with varying roles and responsibilities right across all of our portfolios, not just AHS, and looking at some of the issues and problems with connecting due to patient care plans, due to health records, due to some of the independence of primary care practitioners and not having a full interdisciplinary team. I think we have at Alberta Health Services made a number of very positive steps. We have programming in place at Alberta Health Services to support chronic disease management. We are addressing the gaps. We've recognized those, and we will continue to work on them.

We do have with us today two representatives of the primary care program, Heather Toporowski, who is the senior program officer, and Dr. Richard Lewanczuk, who is the senior medical director. They've been doing an awful lot of work directing AHS in primary and community care.

It is not one that's going to be fixed quickly. I think that when you look at the complexity of the system, then it's understandable that there are going to be pieces of it that will move more rapidly than others, but our goal has to be to get it all together.

I don't know, Dr. Lewanczuk, if you want to add anything.

Dr. Lewanczuk: Yes. Thank you very much. Dr. Richard Lewanczuk, senior medical director for primary health care for Alberta Health Services. We are very aware of and worked closely with the Auditor General's office in the development of the chronic disease report. What we know is that 80 per cent of primary care activity is chronic disease management, and previous to now we haven't had the ways in which we can interact and support primary care to enable that chronic disease management. Over the last couple of years, primarily through primary care network evolution,

what we've been able to do is to put in place our own internal governance structure with the primary care physicians, about 3,000 Alberta full-service family physicians that provide day-to-day family practice care, to enable us to work jointly in partnership with them to set priorities and to determine roles and responsibilities. In fact, at our most recent joint venture meeting we actually had that direct discussion with primary care, with the official representatives of each of those 3,000 physicians in PCNs, to say: "What is it that you want to do? What is it that we should be doing? Let's agree upon that. How can we as Alberta Health Services work to support you in providing chronic disease management patients?"

The Chair: Thank you very much.

Go ahead, Heather. You still had another question.

Mrs. Forsyth: Yeah. Thanks. I've got several, but I know my time is limited. I have to tell you that over the last four years as the health critic for the Wildrose I have met some unbelievable health care professionals out there working very, very hard, and I've seen some hugely successful models. Crowfoot Village comes to mind. One of the things that I found very interesting was the certified diabetes educators and how their outcomes for chronic disease have shown a huge improvement at a very low cost. How many CDEs do you have employed right now?

The Chair: How about if you provide that through the chair because we're at the end of our time here with regard to that. Thank you very much.

Why did you go so easy on them, Heather? Holy smokes.

We'll move it over to the Liberal caucus for the next eight minutes. Yes. Dr. Swann.

Dr. Swann: Thanks very much, and thank you for being here, all of you. I am the Health critic for the Alberta Liberal opposition, and it's my role in government, it seems, to talk a bit about prevention because nobody seems to want to either fund it or do any more than talk about prevention. Part of the problem with chronic disease management, of course, is that we have failed to prevent much of what is preventable in this society. So I always like to preface some of my questions with comments about why we're still only spending 3 per cent of $18 billion on preventing the many lifestyle and mental health and behaviour problems that continue to plague the health care system and add to the tremendous wait times and frustration that both professionals and patients have in a system that is as complex and demanding as we have.

9:30

The key message I got from the Auditor's report is that we don't have a plan for chronic disease management and that the first step has to be putting in place goals, targets, measurables, and then bringing people around the table to ensure that we all have the same goals, targets, and measurement indicators. Clearly, that is a complex thing where we're dealing with hundreds of thousands of people, not even to mention getting patients or the public to co-operate with some of our approaches. Recognizing that, I hope that this report will be taken seriously and that we will see in the next year more sustained and effective collaboration with the various stakeholders in the chronic disease continuum.

One of the big issues that keeps coming up is value for money. If you don't have any indicators of what is success, we can't ever come to the point where we can say that we're getting value for investment. For example, I read recently that you have approved pharmacists to manage vascular disease. What aspects of vascular disease? What kind of testing are pharmacists going to be doing? What kind of treatment will they be giving for vascular disease? I presume those are hyperlipidemic drugs. Are they going to be working with doctors on these drugs? Who's going to decide which drug? If the doctor doesn't agree with the pharmacist, how is that going to be dealt with?

It's not clear to me that we've thought through some of the decisions around expanding the scope of pharmacists, which certainly could be expanded. There's no question that pharmacists could play a larger role, but it's not at all clear to me that it's going to work in the best interests of the patient if we don't have a stronger sense of how that is going to be part of a team, not individuals vying for patients, which is already a problem in a fee-for-service system.

Another question, I guess, and I'll ask for some response maybe at the end: how do you propose to move physicians from fee-for-service to alternate payment plans? What is your plan to help us move to a more cost-effective system through physician reimbursement?

Maybe we could stop there for now and hear some responses to some of those comments.

Ms Davidson: Thank you very much. I mean, you've raised a number of points. Not in any particular order: with respect to alternate payment mechanisms for physicians we've identified that that is something – we have an agreement in place right now, but we've initiated talks with the AMA about looking at the sort of payment systems we want to get the outcomes we need, so that is a role that the department is now looking at very seriously.

What is the funding system we want to put in place both to pay people and to pay organizations, for example like AHS, to get the outcomes that we want to achieve? Currently, as you would know very well, the way that outcomes are described and funded is pretty loose, and that's not unique. In this country it's a challenge, so we are working on that.

I think the issue of patients and families is very critical because, as a number of people have pointed out, individuals live with their chronic disease 24 hours a day. They interact with the health care system maybe an hour a week. So in any chronic disease management system the strategy that we put in place, they actually have to be at the centre of it. If you look at some of the stuff, for example, that Europe is doing now, they're talking about patients and families as coproducers of value so that they are actually – you cannot develop a system if they aren't considered integral to delivering, making decisions about it, and then developing the support mechanisms in the community that will extend way beyond what we consider to be the professionals that are helping. So that is something that we're now starting to look at.

Where are we with respect to a chronic disease management strategy? I think you put your finger on it. We're doing bits of different things. We've got some that are embedded in primary care, others embedded in continuing care. But to say that there's an overarching strategy for chronic disease management: no, we do not have one, but we're working on it. That's all I can say at this point.

Dr. Swann: And the pharmacist issue?

Mr. Monteith: With regard to the pharmacist issue in the standards of practice for the pharmacists, if they were to change any medicine, including the stopping of a medicine, they have an obligation to report that to the physician. In fact, we even have a payment system where if they're on a drug that perhaps they shouldn't be on, they can actually decline to fill it and deal with it but, again, notify the physician.

The piece that we struggled with was that the College of Physicians & Surgeons' standard for dealing with the pharmacists hasn't been as current as the College of Pharmacists' standard has been with physicians. So what we've done is this first step. We've actually introduced a billing code for the physicians so that this transference of information that goes between the pharmacist and the pharmacy and the physician and the physician's office is understood and put into a transactional mode so that they actually track it because they can then see it go into their system accordingly.

We're working with the College of Physicians & Surgeons to ensure that their standard of practice is now adjusted to be more current as we're moving other professionals into a sphere that was more traditionally physicians'. It's not perfect. I know that the Auditor General's report commented on this, so that's why they both have care plans. Ideally what we would want them to be working on is the same care plan, and in order to do that we need to get them on the same information platform, and we don't have them there yet. We have pieces – we have sharing of data opportunities, as Susan Anderson talked about earlier – but we are needing to get them there.

I think, to Janet's point, the final piece that hasn't come up in the conversation so far: we're leading the country right now. We're about halfway through, maybe 40 per cent through the personal health portal. The opportunity that that will present is for patients to see in a secure way their own information so that they are better prepared to go out and have their interactions with the health care system as well, as opposed to sort of walking into the physician's office with the pharmacist not really knowing what's going to happen.

Dr. Swann: Thank you.

Just one quick follow-up if I may.

The Chair: Sure. Go ahead.

Dr. Swann: You identified that the fee-for-service system is a problem. You just created a new fee-for-service system for pharmacists. What sense does that make?

Mr. Monteith: Again, part of the challenge that we have is that physicians are virtually a hundred per cent paid in the public system; the pharmacist's world is not. In fact, about 60 per cent of payments to the pharmacies are private and cash, not government at all. So in order to deal with the workflow in which they're set up in their IT/IM systems that they're currently using – that was just determined to be the way in which it would best integrate with what they're currently doing. But I would agree with you. In the ideal world we need to put a complete capitation kind of model for that. In order to do that we need to have the tools in place to assign all the drug costs to a patient irrespective of payer, and we don't have that today.

Dr. Swann: How long do you expect that to take?

The Chair: I'm sorry. The time is up on a very interesting discussion, and Dr. Swann, obviously, has a great background in this.

To the ND caucus. Mr. Bilous.

Mr. Bilous: Thank you, Mr. Chair, and I'm going to ask if you can give me a one-minute notice when I get to the end of my time so I can read some questions in.

The Chair: You betcha.

Mr. Bilous: Thank you to both your organizations for being here. I'm going to focus on three different areas. I want to focus on mental health, PCNs, and infrastructure.

Mental health issues, particularly depression, are listed as chronic conditions in the AG's report on chronic disease management. The 2013-14 AHS annual report shows that mental health readmission statistics have remained largely unchanged in the five years that the agency has been tracking them. Are the Ministry of Health and AHS working to ensure that mental health concerns are being mainstreamed in the broader plans to manage chronic diseases?

Ms Kaminski: Yes, we are. There is a lot of work to be done in addictions and mental health right across Alberta Health Services. It is one of the areas where I think we need to pay some particular attention coming up in the next three to five years. We are looking at readmission rates, we are looking at discharge rates, we're looking at our outpatient successes and where we're not so successful with outpatient care and treatment. Over the course of the next short while we're making some changes to how we structure addictions and mental health services within Alberta Health Services so that we can bring forward some of the issues and concerns that we have around our ability to make a difference.

9:40

Mr. Bilous: Okay. Do we have ways of monitoring currently the success or failure as far as efforts?

Ms Kaminski: We do in terms of whether or not patients come back, so recidivism in any of the programs. Again, some of the challenges that we've got with patients with addictions and mental health issues are that they don't always check in and report back and do the follow-up. It's hard to track some of their success, but we are going to look at those measures where we do have some control.

Mr. Bilous: Okay. Thank you.

Ms Davidson: At Alberta Health we've actually been working with some of the other ministries. For example, we found that for individuals with some mental health issues homelessness can be an issue. We've actually worked with Municipal Affairs and with Human Services to say: are there ways that we can actually fund housing for people with chronic and persistent mental illness? Some of the results that I've heard anyway are that the use of the emergency department among that group goes down significantly because they actually have a place to live.

Mr. Bilous: As far as the work and the resources that you've spent working crossministerially, the outcomes of that, or the strategies that have come up: are those going to be made public, or are those made public somewhere?

Mr. Monteith: The short answer, sir, is yes, but they will show up in different ministries' reports. We'll have to figure out a way to consolidate some of the services – we'll have a piece, Municipal Affairs, et cetera – so we'll figure out crossministerially how to do that and report back.

Mr. Bilous: Please. That would be fantastic. I'm going to keep trucking along. Sorry; my time is very short.

In the '13-14 AHS annual report there's mention of future work in mental health that would include the development and implementation of a sustainable model for addiction and mental health service delivery for family care clinics throughout Alberta. How does the cancelling of the planned FCCs impact the development of a comprehensive mental health care strategy in this province? In a short answer, please.

Ms Kaminski: We still have to do the work that we had identified for addictions and mental health. We have got some primary care networks that we can use, and we're looking at, through our mental health and addictions strategic clinical network, how we can broaden that scope and use the existing structures.

Mr. Bilous: Okay. Thank you.

What's being done to ensure that mental health resources are available to rural and indigenous Albertans who may not have access to the chronic disease management networks that we might expect to see in urban communities? Are there ways in which this can be improved, and how?

Ms Davidson: Obviously, it can be improved, but we have some direct relationships between AHS and aboriginal communities on identifying what are some of their top priorities with respect to mental health, and those are both rural as well as urban. For example, there is an initiative going on in Edmonton right now on the 5-65, the 5 per cent of the population that uses 65 per cent of the resources. In the downtown core of Edmonton there's a significant utilization of a requirement for mental health services among aboriginal people, so actually working with them to say: what are the specific services they need? So we are trying to focus on tiering the types of programs they need. It's not just a blanket "These are mental health services, and here you go."

Mr. Bilous: Are there processes in place to properly deal with other chronic mental health issues that Albertans might be facing such as PTSD?

Ms Kaminski: We do have a number of programs in place to deal with that. We are looking at capturing information around what the most prominent chronic diseases are within addictions and mental health – and as you identified, depression is one of them – so we are then going to focus all of the programming that we're doing on being able to manage them differently and better. As we get that information, we'll be happy to share it.

Mr. Bilous: Please.

Jumping over to infrastructure, the AHS annual report shows that there's actually been an increase in hospital-acquired infections as well as an increase in the number of surgical patients who are readmitted within 30 days of their procedure. Is this a result of degrading hospital infrastructure like we've seen at the Mis, or is it a result of other factors like overcrowding, understaffing, or improper systems management?

Ms Kaminski: When we look at hospital-acquired infections, the single biggest cause is lack of handwashing. Hand hygiene has been a challenge, and at Alberta Health Services we have seen some pretty low compliance with normal and expected hand hygiene protocol. So we put a very concerted effort on it and have come back with some improvements in a number of areas, some significant improvements in some areas, moderate improvements in others. We are targeting a hundred per cent compliance with hand hygiene, and that has been shown world-wide to be the single biggest factor in reducing hospital-acquired infections.

Mr. Bilous: Okay. Thank you.

How does the issue of deferred maintenance of existing health infrastructure impact the Ministry of Health and AHS's capacity to properly implement the recommendations of the AG's September report?

The Chair: One minute.

Mr. Bilous: Okay. You know what? Instead of answering that question and what I'm about to read to you, if we could get a response in writing, that would be greatly appreciated.

My last question on infrastructure: how does the cancelling of the promised FCCs impact the capacity to properly implement the recommendations of the Auditor General?

Under primary care networks the recommendations to AHS from the July 2012 Auditor General's report have still not been implemented, particularly recommendations surrounding the evaluation of the system's performance. This coupled with the fact that only 74 per cent of Albertans have access to care through these networks makes it appear as though the system is still not functioning in a transparent and usable way. In fact, if I wasn't on this committee as an MLA, I wouldn't know that I belonged to a PCN.

What does the 74 per cent figure in the ministry's annual report actually denote? Is this the number of people who are actually aware of PCNs and utilizing them, or is it the population estimate for catchment areas in which PCNs are located? What can be done to improve awareness of PCNs? Has the system been analyzed for intensity and scale of use? If you have a number, I'm curious to know. I was talking to the independent member about how many Albertans have access to a PCN, and I'm especially curious about our rural Albertans and indigenous Albertans in remote areas.

Thank you.

The Chair: Thank you very much.

Last minutes for the PC caucus.

Ms Jansen: This question is for the Auditor General. I'm wondering if you can help me out a little bit and just give me a sense of the scope of your examination, especially when it comes to chronic diseases. Do you use other countries as benchmarks? When you were looking at the overall picture in Alberta, did you compare it to other provinces, other countries? In what I'm assuming was an examination that was fairly in depth, did you find examples of best practices that we would want to model ourselves after?

Mr. Saher: Thank you for the question. I'll provide the introductory answer, and then I'm going to ask Doug McKenzie to supplement. I'm going to go straight to what I believe to be appendix A of our report. It's at approximately page 43. Appendix A sets out the attributes of a high-performing health care system with respect to chronic disease management. That's a compilation that we did looking in specifically at literature and evidence, talking to practitioners. Where in the world does chronic disease appear to be best managed in terms of its outcomes, in terms of the quality of the care, and connected with cost?

The simple answer to your question is yes. We did base our work by looking at best practice elsewhere in the world and trying to compare that with what we saw today in Alberta.

Doug, can you supplement that?

Mr. McKenzie: Yeah. We did extensive research heading into the project. We called it a knowledge-of-business phase. We engaged a consultant, who is a senior director with Bridgepoint health in Toronto and has experience across North America. We consulted with the department and Alberta Health Services. During the course of our audit we met with nine primary care networks from around the province as well. We presented our criteria to all of these groups. We got general acceptance from the department and Alberta Health Services that the practices that we'd identified as

health care system were valid and appropriate and were implementable in Alberta.

Ms Jansen: Thank you.

Mr. Young: Okay. The next question, Jason Luan.

9:50

Mr. Luan: Thank you very much. Just a quick follow-up on this. When you talked about the best-practice models – I happened to have read your report here – you referenced the model of Kaiser Permanente. This is a question to our Auditor General, but also I need to hear a response from our health care experts here. When I look at the Crowfoot comprehensive model that you commented on in your report, it is very similar to this best practice model you were referring to earlier. It focused on patient-centric, focused on team approach, talked about care plans, talked about a team sort of specialist approach to this.

Let me tell you that before I became an MLA, I had no clue that we had this wonderful Crowfoot family care clinic there. But during the door-knocking, there were so many people saying: Mr. Luan, you should pay a visit there; you should check it out. Eventually, I moved on my own to be a member there. Let me tell you that everything I've read about it, everything I've heard about it is all true.

My question is to both of you. We have a best practice here, very closely reflecting the literature you're referring to. What's stopping us from making it widely spread all over the province?

Mr. Saher: I'll go first, and I cannot answer your question. Our job was to identify through establishing best practices how our system is comparing. You've raised a particular PCN. Your research staff in their briefing to you gave you further information on that PCN, and you've outlined your personal experience. I think part of what we were trying to do is to make the point that although this is complex, there are examples of where it is possible to take something that's complex and translate that into practical activity that makes a difference both to the quality of care and cost.

Ms Davidson: I'll make a few comments. First of all, yes, the U.K. would agree that these are the principles. But if you look at primary care in the U.K., I'll tell you that you can go to one area where it's just fine and the next area is, quite frankly, lousy. The veterans administration in the U.S. now is under a huge, big scandal because of a lot of the mess that they made with things. I think the key point in all of this is that there are good attributes. The point is that they're not always universally agreed to.

So I would follow up on the Auditor General's comment. I think the example you gave is very good. Others may not necessarily agree that that's the way they want to implement things. Because health care is a human endeavour, we have to spend a lot of time working with individuals to say: this is appropriate for your community, your patients, and let's see how we can work together to make this better. One of the things that we've been focusing on, too, and through Alberta Health Services is actually sharing best-practice information with others so that somebody can say: "Well, I'm thinking of doing this. Where is there a good example in the province right now?"

Mr. Luan: If I can follow up with a very quick question. Yes, I understand what you're talking about. We have a variety of models to facilitate the community to pick and choose from. But I also ask you as professional experts in this area. We need a co-ordinated strategy to move forward on this, and if we simply just leave it for people to develop and think about, we have a long way to go to really turn around. I'm not trying to blame you or any of you for not solving the problem. I believe we collectively own the issue here. If we can't figure out the different ways of delivering our health care services, there's no way we can sustain what we have currently. So I'm interested to hear your comments and the overall strategy you might be ruling out.

Ms Davidson: I would refer you to our primary health care strategy, which was released last year. I mean, we can certainly provide you with a copy of that document. That's really intended to be the framework under which we are rolling out primary care.

Ms Kaminski: Further on that, at Alberta Health Services the strategic clinical networks are the focus for us delivering best practice. There are a number of SCNs that exist. They're going to look at every opportunity where best practice exists to ensure that we actually roll it out right across Alberta and that we begin to have that model of care that we so desperately need.

Mr. Young: Okay. Thank you very much.

We're going to go to Mr. Horne and then Janice if we have some time left at the end.

Mr. Horne: Thank you very much. This question really follows on the last two, the one that had to do with primary care networks and then Ms Kaminski's mention of the strategic clinical networks. Just by way of introduction, there are a couple of areas where I certainly agree very much with the findings of the Auditor General. The answers to the questions that we're facing in our system around chronic disease management have to do with leadership, and they have to do with accountability for how the resources are used.

The Crowfoot clinic is interesting, but what is perhaps more interesting is that that clinic predates the primary care network program in Alberta. It only exists because physicians who are members of that clinic agreed as professionals practising together that they wanted to, as a group, adopt a different way of delivering care, and they saw it as their initiative, at least in my understanding, to negotiate this pooling of what would otherwise be fee for service, pooling of those financial resources, and then use that to actually fund outcomes like access to evening hours care and access to other health professionals.

So I guess my question is: an earlier report of the Auditor General dealt with primary care networks in Alberta, and the report expressed a lot of concern about lack of accountability and lack of standardization among best practices within the PCNs. What is the department of Health currently doing to standardize practices within PCNs and to bridge that gap between what we know based on best practice and evidence and what we actually pay for in the health care system?

The Chair: You have exactly one minute to answer that question. Sorry.

Mr. Monteith: I think we're actually implementing that exact kind of framework for accountability in the primary care networks, embedding it in their business plans going forward, and that has actually started this October. In fact, the first reporting period begins in 2015-16.

Mr. Young: We'll quickly jump to Janice Sarich. She's going to read in some questions she'd like, just to close.

Mrs. Sarich: What I've heard this morning is a commitment for a comprehensive chronic disease management plan. I'm wondering

if you could address a commitment to increase from 3 per cent in health promotion and wellness in that plan so that over the next 10 years we would see an increased dollar commitment so that these issues can be mitigated by health promotion and wellness.

The Chair: Thank you very much. Thanks very much to our guests for being here today. We really appreciate your openness and willingness to produce all the documents for all the questions. I know it's a massive file. Obviously, we all know that, so thanks for taking the time.

Please do follow up. Our committee clerk will be following up with you, but please do supply the answers to the undertakings that you gave today so that we can see those as a committee as soon as possible.

Our committee clerk posted a draft version of this committee's 2013 report on committee activities to the internal committee website. The working group looked over the draft at its meeting back in September. Does anyone here have any proposed changes to that report?

Do we have a mover that the Standing Committee on Public Accounts Report on 2013 Activities be approved? Mrs. Sarich. Those in favour? Any opposed? Carried.

Is there any other business committee members wish to raise at this time? Mrs. Sarich.

Mrs. Sarich: Yes. Thank you very much, Mr. Chair. There was an abundance of questions asked by committee members today. I'm wondering. You made a commitment to take back into the working group the template that was submitted. I'm wondering if maybe we could test drive that template, given the questions that were asked today, so that we would at least have a working model to kind of make adjustments.

The Chair: Yeah. We're going to accelerate that. We weren't going to have a working group meeting until a few weeks from now, but I think what we'll do is bring that template to the next PAC meeting next week, and we'll get approval of the template. I think that's a great idea. We'll deal with that motion then, Mrs. Sarich, and I'll be supporting it.

Any other business?

Our next meeting is scheduled for Tuesday, December 2, with the College of Physicians & Surgeons of Alberta, the Alberta Medical Association, the College and Association of Registered Nurses of Alberta, the Alberta College of Pharmacists, the Alberta Pharmacists' Association, and the Health Quality Council of Alberta.

Would a member like to move this meeting be adjourned? Mr. Allen. Those in favour? Any opposed? Carried. Thank you very much, everyone.

[The committee adjourned at 10:00 a.m.]

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