Legislative Assembly of Alberta

The 31st Legislature
First Session

# Standing Committee on Public Accounts

Health
Alberta Health Services

Tuesday, January 30, 2024
10 a.m.

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**Legislative Assembly of Alberta**
**The 31st Legislature**
**First Session**

**Standing Committee on Public Accounts**

Pancholi, Rakhi, Edmonton-Whitemud (NDP), Chair
Rowswell, Garth, Vermilion-Lloydminster-Wainwright (UC), Deputy Chair
Gray, Christina, Edmonton-Mill Woods (NDP),* Acting Chair

Armstrong-Homeniuk, Jackie, Fort Saskatchewan-Vegreville (UC)
de Jonge, Chantelle, Chestermere-Strathmore (UC)
Ganley, Kathleen T., Calgary-Mountain View (NDP)
Haji, Sharif, Edmonton-Decore (NDP)
Lovely, Jacqueline, Camrose (UC)
Lunty, Brandon G., Leduc-Beaumont (UC)
McDougall, Myles, Calgary-Fish Creek (UC)
Renaud, Marie F., St. Albert (NDP)**
Schmidt, Marlin, Edmonton-Gold Bar (NDP)

* substitution for Rakhi Pancholi
** substitution for Kathleen Ganley

**Also in Attendance**

Johnson, Jennifer, Lacombe-Ponoka (Ind)

**Office of the Auditor General Participants**

| | |
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| W. Doug Wylie | Auditor General |
| Eric Leonty | Assistant Auditor General |

**Support Staff**

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|---|---|
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| Warren Huffman | Committee Clerk |
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## Standing Committee on Public Accounts

### Participants

Ministry of Health
- Darren Hedley, Associate Deputy Minister
- Chris Nickerson, Assistant Deputy Minister, Acute Care
- Corinne Schalm, Assistant Deputy Minister, Continuing Care
- Kim Simmonds, Assistant Deputy Minister, Strategic Planning and Performance
- Christine Sewell, Senior Financial Officer and Assistant Deputy Minister, Finance and Capital Planning
- Andre Tremblay, Deputy Minister

Alberta Health Services
- Sean Chilton, Interim Vice-president and Chief Operating Officer, Clinical Operations
- Peter Jamieson, Interim Vice-president, Quality, and Interim Chief Medical Officer
- Michael Lam, Acting Vice-president, Corporate Services, and Chief Financial Officer
- Athana Mentzelopoulos, President and Chief Executive Officer

**10 a.m. Tuesday, January 30, 2024**

[Ms Gray in the chair]

**The Acting Chair:** Good morning, everyone. I'd like to call this committee meeting of Public Accounts to order. Welcome, everyone who is here.

My name is Christina Gray; I'm the MLA for Edmonton-Mill Woods. I'll be acting chair of the committee today. As we begin, I'm just going to go around the table and invite members, guests, and LAO staff at the table to introduce themselves, starting to my right.

**Mr. Rowswell:** Hi. I'm MLA Garth Rowswell from Vermilion-Lloydminster-Wainwright.

**Mr. Lunty:** MLA Brandon Lunty for Leduc-Beaumont.

**Ms Lovely:** MLA Jackie Lovely from the Camrose constituency.

**Ms de Jonge:** MLA Chantelle de Jonge from Chestermere-Strathmore.

**Mr. McDougall:** MLA Myles McDougall from Calgary-Fish Creek.

**Ms Sewell:** Christine Sewell, senior financial officer for Alberta Health.

**Mr. Hedley:** Darren Hedley, associate deputy minister of Health.

**Mr. Tremblay:** Andre Tremblay, deputy minister of Health.

**Ms Mentzelopoulos:** Athana Mentzelopoulos, president and CEO of AHS.

**Mr. Chilton:** Sean Chilton, vice-president and chief operating officer for clinical operations.

**Mr. Wylie:** Doug Wylie, Auditor General.

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

**Mr. Haji:** Sharif Haji, MLA for Edmonton-Decore.

**Ms Renaud:** Marie Renaud, St. Albert.

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

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

**Mr. Huffman:** Warren Huffman, committee clerk.

**The Acting Chair:** Thank you.

We'll also go to those joining us online, and I'll ask you to introduce yourselves as I call your name.

MLA Johnson.

**Mrs. Johnson:** Jennifer Johnson, MLA, Lacombe-Ponoka.

**The Acting Chair:** Thank you.

Dr. Jamieson.

**Dr. Jamieson:** Dr. Peter Jamieson, interim chief medical officer and vice-president, quality, with Alberta Health Services.

**The Acting Chair:** Thank you.

Mr. Lam.

**Mr. Lam:** Morning, everyone. Mike Lam. I'm the acting vice-president, corporate services, and CFO for AHS.

**The Acting Chair:** Thank you, everyone.

I'm going to note for the record the following substitutions: myself for Member Pancholi as acting chair and Member Renaud for Member Ganley.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard* staff. Thank you to them. Committee proceedings are live streamed on the Internet and broadcast on Assembly TV. The audio- and videostream and transcripts of the meeting can be accessed via the Legislative Assembly website.

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Hon. members, we're going to start with approval of the agenda. Are there any changes or additions to the agenda before us today? Seeing none, I'll ask if a member is prepared to move that the Standing Committee on Public Accounts approve the proposed agenda as distributed for its January 30, 2024, meeting. Is someone prepared to move that motion? Moved by Marlin Schmidt. Is there discussion? Seeing none, all those in favour? Online? Thank you very much. MLA Johnson is not a voting member. All those opposed? Thank you. The motion is carried.

We also have on our agenda the minutes from the December 5, 2023, meeting of the committee. Do members have any errors or omissions to note from those minutes? Okay. Seeing none, I'll ask if a member can move that the Standing Committee on Public Accounts approve the minutes as distributed of its meeting held on December 5, 2023.

**Ms Lovely:** So moved.

**The Acting Chair:** Thank you very much. Is there any further discussion? Seeing none, all those in favour? Any opposed? Thank you. That motion is carried.

Now I would like to welcome our guests from the Ministry of Health and Alberta Health Services who are here to address the ministry's annual report 2022 to '23 and the Auditor General's outstanding recommendations. I will invite officials from the ministry and Alberta Health Services to provide opening remarks not exceeding 10 minutes. I will turn that over to you now.

**Mr. Tremblay:** Thanks, Chair Gray. On behalf of Alberta Health and AHS, I really appreciate the opportunity to provide the committee with an update on the Auditor General's outstanding recommendations and our '22-23 annual report. I'm joined today by several of my colleagues on the department side: Darren Hedley, associate DM, and Christine Sewell, our SFO, and Athana Mentzelopoulos will introduce her officials in a few moments when I turn it over to her. I have a number of officials also in the gallery, and that's just a reflection of how we feel the importance of this committee is. We want to make sure that we have officials available to answer as many questions as we possibly can today.

I'd like to thank the office of the Auditor General for its desire to improve the Alberta health system. It is a desire that is shared by our ministry and AHS, and I'm pleased to provide an update on how we are implementing the OAG's recommendations.

Alberta Health currently has 15 outstanding recommendations. Six recommendations specific to chronic disease management and

two recommendations specific to primary care networks have been implemented and are being currently evaluated by the Auditor General. We are continuing to implement the seven remaining recommendations, which focus on health care process, the use of publicly funded CT and MRI services, COVID and continuing care facilities, and seniors' care and long-term care facilities. We will continue to work with the office of the Auditor General and our partners and stakeholders on implementing all of these recommendations. I look forward to providing future updates on those as work unfolds.

I'd now like to spend a few minutes discussing our annual report that's up for discussion today. As detailed in our annual report, Alberta Health is focused on achieving three primary strategic outcomes.

The first, an effective, accessible, and co-ordinated health care system built around the needs of individuals, families, caregivers, and communities and supported by competent, accountable health professionals and secure digital information services.

Number two, a modernized, safe, person-centred, high-quality, and resilient health system that provides the most effective care now and in the future for each tax dollar spent.

Three, the health and well-being of all Albertans is protected, supported, and improved, and health inequities among population groups are reduced.

The Ministry of Health is comprised of talented, hard-working individuals and teams that are committed to the health and well-being of Albertans, and we are making tremendous progress towards achieving our outcomes. We have a lot to be proud of, but here are some highlights for your consideration. The health action plan was released to ensure immediate improvements in key areas and to build a better health care system for Albertans. Alberta's government spent $590 million to reduce EMS response times, and $646 million was spent to support population and public health initiatives to maintain and improve health for Albertans.

We established an Indigenous primary health care advisory panel to provide advice and recommendations on improvements to the primary care system to ensure First Nations, Métis, and Inuit peoples have access to high-quality, culturally safe primary health care. Alberta's government reached an agreement with the Alberta Medical Association during this reporting period that includes more than $250 million over four years for initiatives targeting communities and physician specialties facing recruitment and retention issues.

Additional results. More than 292,000 surgeries were completed during this period and 22,000 cancer surgeries. We also completed over 520,000 CT scans, and over 231,000 MRI scans were completed in the province during this period; 871 new continuing care spaces were created during this period to meet the needs of Albertans as well. We also had 341 new paramedics enter the system, and the ministry's regulatory and administrative requirements were reduced by 36.1 per cent from a red tape reduction perspective.

They are just a few of the many highlights detailed in the annual report. There are many more that could be discussed and highlighted, which is a testament to the hard work of our colleagues and health care workers in every corner of the province. We are continuing to make progress towards achieving our goals while also supporting the government's key priorities.

In conclusion, Alberta Health is focused on strengthening and improving Alberta's health care system. We are finding ways to innovate and to drive solutions to better support Albertans while ensuring we create value for every dollar spent on health care in this province. I look forward to the conversation today.

Now I'm happy to turn it over to Athana to introduce her officials and to provide some remarks from AHS if that works. Thank you.

**The Acting Chair:** Yes. Thank you. You still have four minutes and 30 seconds.

**Ms Mentzelopoulos:** Thank you, Madam Chair. I'm Athana Mentzelopoulos from Alberta Health Services. My colleagues have introduced themselves. Like the deputy minister, I have other colleagues here today to help in the event that I'd like an answer supplemented. My goal today is to share the results of our performance in '22-23 as well as actions we have taken on AG recommendations to improve health care.

***10:10***

I would be remiss if I didn't start by saying thank you to everyone who works at Alberta Health Services. They are dedicated, and they impress me every day. I started in this role on December 11, and that was a time, as many people probably know, when we were seeing heavy patient volumes as a consequence of respiratory virus. Hospitals and health care systems are built for variability in patient flow, and we have developed some excellent predictive capacity that allows us to bring on the space we need for increased patient volumes when circumstances dictate. Even during these times the dedication of our staff is undiminished.

AHS is a busy and complex health care system. On any given day there are 13,700 ambulatory visits, more than 2,000 incoming clinical Health Link calls, nearly 5,500 emergency department visits, more than 7,700 people in hospital, 800 surgeries, nearly 4,800 X-rays, more than 2,000 CT and MRI exams, we do 227,000 lab tests every day – although sometimes those are multiples for one patient – 2,000 cancer care visits, and more than 1,800 EMS events. That's just a partial picture, and of that immense daily activity, I'm pleased to report that during '22-23 there were 11,000 fewer patients waiting for surgery outside of clinically recommended time frames. That was accomplished through the work on the Alberta surgical initiative.

Paramedics were spending less time in hospital, handing over patient care to emergency department staff, through the return to service initiative. We are also improving ambulance availability in communities through EMS' 811 shared response line. This transfers non-urgent 911 callers to Health Link registered nurses for further assessment and has helped to avoid unnecessary ambulance dispatches. We also continue to launch connect care. By the end of '22-23, 75,000 staff physicians and health care providers had shifted to the system, and at this point the number is now over 112,000.

To reduce acute care length of stay and enable timely admissions from emergency departments, we implemented team targets to monitor patient flow and urban acute care length of stay improvement bundles. Significant efforts were also made, and continue to be made, to address workforce recruitment and retention through national and international recruitment campaigns, employer-based health care aide programs for rural areas, and creation of the rural capacity investment fund, which was done in partnership with unions.

Good progress is being made, but we have more work ahead. Of our 31 performance indicators, 18 were improved, reached target, or remained stable. A number showed deterioration, however, and they continue to be a focus for our work.

Turning to the Auditor General recommendations. At December 31, 2023, we had 10 outstanding: two are related to improving processes to deliver CT and MRI services and reduce wait times; four relating to responding to future pandemics in the continuing

care system; one is related to identifying and mitigating risks related to the provision of adequate staffing in continuing care facilities; and three are related to chronic disease management. For all of those, work is under way, and for some of them we are nearing completion of the OAG's assessment of implementation. Like Andre, I'd like to thank the Auditor General for this work.

I started my remarks by sharing some of the immense volumes of clinical activities that we provide every day. Delivering these services requires complex planning processes, careful management, and vigorous oversight to ensure we are learning and striving for continuous improvement. The vast majority of our resources are clinical. Other elements of our work are not as visible to the public, but they do form a critical component of our ability to deliver front-line care.

Thank you.

**The Acting Chair:** Thank you very much for your remarks.

I'll now turn it over to the Auditor General for his comments. Mr. Wylie, you have five minutes.

**Mr. Wylie:** Thank you very much. I'll just pick up where the others left off, and that's dealing with our recommendations. Just to give you an update on the status from our perspective, the CDM, chronic disease management: we're in the final phases of reporting that, so we've done the follow-up work. Primary care networks: we are at the planning phase of doing that follow-up work. With respect to the remaining recommendations – and that's publicly funded CT and MRI services – we're, I believe, still waiting for an implementation plan on our recommendations related to that piece of work, and on COVID-19 and continuing care facilities we are having meetings with management, I believe, again in the near future. We've provided some comments on their implementation plan, and we look forward to working with management on those.

Regarding the publicly funded CT and MRI services, just to give you a little context, a little bit more information on the recommendation, in that piece of work we concluded that the government does not have effective and efficient intake and scheduling processes for publicly funded outpatient and diagnostic CT and MRI services. As we all know, Albertans need assurance that these services are being delivered within a reasonable time no matter where one lives within the province. As well, we would all recognize that waiting for medically necessary care can have consequences for patients and those who care for them.

Just to give you a little bit more information on this particular piece of context, some of the findings that we had were that intake and scheduling processes were highly manual and decentralized – you'll see that on page 12 of our report – that prioritization guidelines were not applied consistently across the province, and that AHS had not developed province-wide protocol and guidelines. That was on page 13. Wait time targets were continually exceeded, and wait times vary across the zones, and wait-lists were growing at the time of our report. Also, notice that AHS does not use wait times or demand as a primary factor when allocating exam budgets to the zones. Finally, at the time of our audit there was more machine capacity available to perform more exams. That was on page 21 of our report.

Relating to our COVID-19 continuing care facilities, we had a number of areas for improvement that are relevant not only in a pandemic scenario but also in general operations. We made recommendations in the areas of pandemic preparedness, staffing, infrastructure, lab testing, and monitoring. I'll just highlight two of those. We made one recommendation to develop a continuing care staffing strategy to increase staffing system resilience, and the other one: evaluate all existing infrastructure and set a strategy for improving facility infrastructure.

We noted that having enough staff to provide care was a persistent and systemic weakness within the system. We also noted that 85 per cent of the staff at the facilities were part-time and casual workers.

The area of facility infrastructure was cited as a common problem in major outbreaks. Some of the common features included large facilities; use of shared rooms; small, congested communal areas; HVAC systems with poor circulation; no air conditioning; old buildings with significant maintenance issues. Building layouts were an issue, and some of the facility entrances were also an issue. We also noted that one-third of the facilities did not meet the current requirements at the time.

We also followed up on recommendations from our report on seniors care and long-term facilities, and that report dates back to 2005. We found that all three recommendations that we followed up were implemented. However, we made two new recommendations directed at improving performance reporting and mitigating the risk of insufficient staffing. Albertans spend more than $2 billion a year on continuing care services and entrust the system with the care of some of our society's most vulnerable people in these long-term care facilities. Therefore, services to those individuals are often those with the greatest needs in our province. Our work focused on having clear goals, adequate staffing, regular measurement, and accountability for results and continuous improvement was at its core.

Chair, that concludes my opening remarks, and we'd be pleased to answer any questions that the committee may have as we go through today's session. Thank you.

**The Acting Chair:** Thank you very much, Mr. Wylie and everyone who provided opening comments.

We'll now proceed to questions from committee members, and we begin with the Official Opposition. You have 15 minutes.

**Mr. Schmidt:** Thank you very much. I'm going to start by asking a number of questions around physician recruitment and retention. Page 39 of the Alberta Health annual report talks about the AMA agreement. In particular, it mentions that $20 million annually will be provided in the business-cost program. That works out to approximately $2,300 per clinic going forward. I'm just curious. You know, this number appears with no measurement or indicators of success. Presumably, keeping clinics open would be a primary indicator of success. How many clinics were open at the beginning of the fiscal year 2022-2023, and how many were open at the end?

***10:20***

**Mr. Tremblay:** We don't assess specific clinic openings. We assess the number of family physicians that exist in the system and their attachment rates. There are a number of different clinics that exist across the province. Some of them are a single proprietorship. Some have seven or eight doctors in them. Some have a smaller roster of physicians. But from a family medicine point of view what we're looking at is attachment rate, and we're looking at the number of family physicians in the system.

**Mr. Schmidt:** Do I understand you correctly? You sign an agreement that gives $2,300 per clinic, but you have no idea how many clinics there are?

**Mr. Tremblay:** We do from that perspective.

**Mr. Schmidt:** What perspective?

**Mr. Tremblay:** From the perspective of paying to those specific clinics. But are you . . .

**Mr. Schmidt:** Okay. So then you're making payments to specific clinics. Is that correct?

**Mr. Tremblay:** Yeah. Absolutely.

**Mr. Schmidt:** So then how many clinics were open at the beginning of the year?

**Mr. Tremblay:** We'd have to look at it.

**Mr. Schmidt:** Okay. And how many clinics were open at the end of the year? I'm just trying to get a sense. We have a number of $2,300. It's touted here in your annual report. It's said to be keeping clinics open. I want to know whether or not it was successful in actually keeping clinics open.

**Mr. Tremblay:** Yeah. Good question. Thank you.

**Mr. Schmidt:** Okay. Thank you.
How is that number, $2,300, determined? The business-cost program discussion says that it was related to inflation and keeping practices open. How did that number, $2,300, get developed?

**Mr. Tremblay:** Within the context of the AMA agreement those programs are codeveloped between the AMA and the government of Alberta. When programs are developed, there are a number of different programs that are established in that agreement. Through the negotiation process there is analysis undertaken of patient requirements, of physician requirements, and those programs are developed collaboratively through that negotiating process.

**Mr. Schmidt:** What were the indicators that the government and the AMA looked at to come up with that $2,300 number just for this particular program?

**Mr. Tremblay:** I'd have to go back and look at all of the analysis that was undertaken to develop that level in conjunction with the AMA through the negotiating teams.

**Mr. Schmidt:** Okay. Would you be able to provide that in writing to the committee?

**Mr. Tremblay:** I'd have to assess whether that's doable or not, so I'll consider it.

**Mr. Schmidt:** Okay. Thank you very much.

**Mr. Tremblay:** You're welcome.

**Mr. Schmidt:** I want to continue on with the issue of physician recruitment. Page 51 and page 52 of the annual report talk about a couple of different initiatives related to physician recruitment. In total it looks like the government has spent $15 million to attract physicians into rural communities, and it says that this resulted in seven new physicians, an interesting number that's completely without context. What was the goal? How many physicians did Alberta Health intend to attract with this investment?

**Mr. Tremblay:** Again, what we look at is demand for family physicians across the province, right? We have a growing population, complex population needs from a health perspective, different requirements in different target populations and in different community characteristics, so what we look at in conjunction with AHS and the Alberta Medical Association is: what sort of demand do we need for family physicians across the province? Then we invest through those programs with the AMA to place as many physicians in those areas of persistent need as possible, and that's done in conjunction with the AMA. AHS has a very strong relationship with family physicians in rural settings, and we deliver those programs to ensure that we are meeting demand for clinical services.

**Mr. Schmidt:** I'm hoping that the deputy minister will eventually come up with a number. It sounds like you're doing a rigorous demand analysis. Now, typically when people do a demand analysis, that actually results in a number of family physicians that are required to meet the needs. What is the number?

**Mr. Tremblay:** That depends on specific community needs, specific regional needs . . .

**Mr. Schmidt:** No, no, no. Overall. The annual report talks about overall physician recruitment. It says that there were seven physicians recruited. Like I said, that number is completely without context. You must have had a goal for recruiting physicians. What was it?

**Mr. Tremblay:** Again, I appreciate the question. The demand for family physicians is fluid across the province. We know that.

**Mr. Schmidt:** Yes, but what was it in fiscal 2022-23? Come on, Andre. I know you have a number. Just share it with the committee.

**Mr. Tremblay:** I don't have a number for that right now because those numbers are fluid. As you know, MLA Schmidt, things change regionally and on a community basis. We know we have persistent shortages for physicians across the province, and you know we're recruiting as many international graduates as possible and locally . . .

**Mr. Schmidt:** Thank you, Deputy Minister.
Then how do we know that Albertans are getting value for the $15 million that you spent? If you won't share with Albertans what your goal is in attracting physicians and you're throwing out a number of $15 million and you're saying that we recruited seven physicians, is that a good outcome? Is that a bad outcome? Did we get value for money or did we not?

**Mr. Tremblay:** At the end of the day, as you know, it's a persistent issue. The investment that was made is targeted at improving and increasing capacity across the province, and we're seeing evidence of that both with international graduates and locally trained physicians in multiple communities across the province.

**Mr. Schmidt:** Okay. What evidence, then? Is seven new physicians the evidence, or is there something else that wasn't included in that number?

**Mr. Tremblay:** We do know that we need more than seven, obviously.

**Mr. Schmidt:** Oh, so you do have a number, then. It's frustrating that you won't share that with the committee. We're trying to get at an understanding of what the goals and targets are and whether or not Alberta Health achieved them with $15 million. How are we supposed to know how much more needs to be invested? Or maybe we're investing too much. Did we attract too many doctors? Is seven physicians in rural Alberta too many? Are they just spending their time golfing and waiting for patients to come along? Like, give

us a sense of how well we are meeting the demand for physicians in rural areas.

**Mr. Tremblay:** I don't believe family physicians are golfing across the province.

**Mr. Schmidt:** I don't either, but . . .

**Mr. Tremblay:** I think family physicians and the supply of family physicians is a persistent problem across Canada and internationally. We sit down with the AMA and AHS and other partners and identify where specifically we're having chronic shortages, and we invest accordingly in those programs.

**Mr. Schmidt:** The Health minister is frequently on record claiming that we've recruited more physicians. You know, she, I suspect, has numbers that may or may not reflect the reality of the situation. So again I'm going to ask: how many physicians did you intend to recruit with the $15 million that was invested in the program?

**Mr. Tremblay:** Before this session is over, we'll provide you some information on how many physicians have been added to the system.

**Mr. Schmidt:** Okay. Thank you.

I want to move on now to page 52 of the annual report. It mentions that "in May 2022, the Minister accepted . . . seven recommendations that address broader systemic aspects of rural health service challenges," but it appears that no further work has been done on that report in this fiscal year. What did the ministry do with those recommendations in the following 10 months?

**Mr. Tremblay:** What report are you referring to?

**Mr. Schmidt:** Page 52 of the annual report.

**Mr. Tremblay:** Are you talking about the palliative care report? Are you talking about the MAPS report regarding primary care? Our labour and workforce plan? I just want to make sure I'm answering . . .

**Mr. Schmidt:** Yeah. "The Provincial Primary Care Network Committee provided the Minister with a recommendations report on supporting recruitment and retention of primary care physicians."

**Mr. Tremblay:** That report fed into our overall MAPS initiative, so our primary care initiative, that was announced in the fall. There are a number of different elements of that report around workforce mobilization, stronger community engagement, improving physician and allied health professional capacity, stronger linkages to Indigenous communities with regard to primary care, and some advice on different governance elements of the primary care system around primary care networks. That strategy has set out, in our view, probably the most aggressive primary care strategy in Canada as it currently stands. It was just announced before Christmas. There were a number of different reports that came into place to help inform that strategy. We're in the process right now of engaging health care providers in communities across the province on how to best implement that strategy from a primary care perspective. There are a number of different elements. There are workforce elements. There are also community engagement elements.

***10:30***

**Mr. Schmidt:** Yeah. Thank you, Deputy Minister.

**Mr. Tremblay:** Yeah. You're welcome.

**Mr. Schmidt:** This question: I'm not sure if it's for the deputy minister or for the CEO of AHS. Can somebody at the table tell us how much was spent in 2022-23 on overtime and agency staff costs?

**Mr. Tremblay:** We're pulling that information. Can we have just a few moments?

**Mr. Schmidt:** Yeah.

**Mr. Tremblay:** Thank you very much.

**Ms Mentzelopoulos:** In '22-23 we spent $383 million for overtime and $88 million for agency nurses.

**Mr. Schmidt:** Okay. Can AHS give the committee a sense of what the salaries for agency staff are compared to nurses directly employed by AHS?

**Ms Mentzelopoulos:** I think that I have that. I'll just, as a preface, say that I believe that the total number of agency nurses, at least at the present time, is about 500; that is compared to, I believe, 47,000 nurses that we have employed at AHS. So I just provide that for context. While I look for your answer, which is – you're asking for the relative cost of an agency nurse compared to an employed nurse?

**Mr. Schmidt:** Yes.

**Ms Mentzelopoulos:** I don't have the exact numbers, but I believe that it is about double.

**Mr. Schmidt:** Double. Okay.

Okay. Then, as a follow-up to that, you said that approximately 500 nurses that are working or providing AHS services right now are contracted through agencies, and then the other 47,000 are directly employed by AHS. Did I understand that correctly?

**Ms Mentzelopoulos:** That's correct. Yeah.

**Mr. Schmidt:** Okay. How does this number compare to previous years? How many agency nurses were there working in, say, 2018-2019, for example?

**Ms Mentzelopoulos:** To be clear, the number I cited, 500: that is at the present time approximately 500. In '22-23 there were 219, and prior to that, it would have been quite a bit smaller, I understand.

**Mr. Schmidt:** Oh, okay. Why do we continue to hire nurses at twice the rate of an employee, then? That number has now doubled in the last year. Why does that make good fiscal sense for the operation of Alberta Health Services?

**Ms Mentzelopoulos:** I would rather not hire agency nurses. We do have a very high vacancy rate at the present time, and we are doing a lot of work to recruit nurses. We do have some challenges that are worth reflecting on. First of all, our vacancy rate needs to be looked at in the context of the fact that we continue to grow. We have more and more employees every year, so with each step of that incremental growth . . .

**The Acting Chair:** Thank you. That concludes the first block for the Official Opposition.

We'll now turn to the government for 15 minutes.

**Mr. Lunty:** Thank you, Madam Chair. First of all, I'd like to thank the officials present for all their hard work and their commitment to

this very important file, including those joining us in the gallery. It's encouraging to see such an interest for this important work.

I'm going to start with a topic that is very important to the constituents in my riding, just from talking to them and some of their concerns, and that's on reducing wait times. Digging right into the report, under outcome 1 on page 22, key objective 1.1 of the report focuses on increasing health system capacity and reducing wait times for Albertans, particularly for publicly funded surgical procedures, diagnostic MRI and CT scans, emergency medical services, and intensive care units.

In the last few years this government has been committed to increasing surgical capacity to reduce the amount of time Albertans are waiting for scheduled surgeries. One of the major initiatives listed to support this outcome is the Alberta surgical initiative, that was discussed on pages 22 and 23. Could the ministry please provide more details on what progress has been made on the Alberta surgical initiative in 2022-23?

**Mr. Hedley:** Thank you for the question. AHS had started streamlining orthopaedic surgery referrals through the FAST, or facilitated access to specialized treatment, program, that launched in August 2022. Family doctors and other providers across Alberta can send their referrals to the FAST central team and then assign the referrals to a specialist with the shortest wait-list.

Approximately 292,500 surgeries were completed in the 2022-23 fiscal year, up from just over 278,000 in the '21-22 fiscal year. Alberta ramped up the number of hip and knee replacements. According to AHS about 3,385 more knee and hip replacements combined were performed in 2022-23 compared to the prior year. During the '22-23 fiscal year approximately 51,700 surgeries were completed in acute-care facilities in rural Alberta. This represents a 5.9 per cent increase above the volume completed across the same sites in the prior fiscal year, which was about 48,800.

AHS entered into a contract with the Institute of Healthcare Optimization to implement their surgical smoothing process to increase the volume of surgeries that can be performed in AHS facilities. Alberta's total adult surgical wait-list as of March 2023 was 67,186, down 10 per cent from March 2022. Approximately 52 per cent of patients were waiting within clinically recommended timelines, up from 41.6 per cent in March 2022.

AHS entered into agreements in November 2022 and January 2023 for approximately 6,000 more orthopaedic surgeries annually in chartered surgical facilities, including 2,275 hip, knee, and shoulder replacement surgeries. Two additional requests for proposal were released in the fall of 2022 in the central and south zones for general surgery, plastics, and orthopaedics, which will increase surgeries performed in these zones by a total of 2,600.

**Mr. Lunty:** All right. Thank you for providing that information.

If I can maybe follow up on a specific performance indicator in the report, performance indicator 1(a) is the percentage of surgical procedures that met national wait time benchmarks. I see on page 23 of the annual report that the '22-23 results for hip, knee, and cataract surgical procedures showed a decline, meaning that fewer Albertans received these surgical procedures within national benchmark wait times when compared to '21-22 results. Can you explain: what were some of the reasons for this decline?

**Mr. Hedley:** Well, thank you for the question. These surgeries typically had the longest wait-lists and were impacted by surgical postponements in 2020 and '21 due to multiple waves of COVID-19. As a result, surgeries that were urgent and emergent such as cardiac procedures, neurosurgeries, and major trauma were prioritized and completed within clinically recommended targets. Additionally, workforce constraints such as the ongoing anaesthesiologist shortage impacted the number of surgeries performed. Following the appointment of the official administrator and the health care action plan in late 2022, wait times for hip, knee, and cataract surgeries began to improve.

***10:40***

**Mr. Lunty:** All right. Thank you.

I think that's – well, that was my follow-up question. After the appointment of the official administrator and the health care action plan, we saw some improvement in the last quarter on some of these wait times. That's correct?

**Mr. Hedley:** That's correct.

**Mr. Lunty:** Do you have any comment on specifically some of the changes or the rationale that saw that improvement after those changes were made?

**Mr. Hedley:** AHS can speak to specific operational details implemented. However, orthopaedic surgery referrals were streamlined through, again, the facilitated access to specialized treatment, or FAST, program that launched, and family doctors and other providers across Alberta could send referrals to the FAST central team, which then assigns the referral to a specialist with the shortest wait-list. Also, AHS entered into a contract with the Institute of Healthcare Optimization to implement their surgical smoothing process to increase the volume of surgeries that can be performed in AHS facilities. Moreover, there was an ongoing focus on leveraging capacity within hospitals and chartered surgical facilities to perform surgeries. We saw success with this approach based on the positive upturn in final surgery volumes across the province, where about 3,385 additional knee and hip replacements were performed in 2022-23 compared to the prior fiscal year.

**Mr. Lunty:** Thank you.

I'll just turn my attention to MRI and CT diagnostics. Many Albertans, of course, require MRI and CT diagnostic imaging in order to ensure they get an accurate diagnosis and the appropriate care that they need. Can you please provide some specific initiatives that were introduced to help reduce wait times for diagnostic imaging?

**Mr. Hedley:** I'll start off the question, but then I'll hand it over to my colleagues at AHS. For context, in 2022-23 access to MRI scans was negatively impacted by both staffing issues and machine malfunctions while access to CT scans was impacted by a global shortage of contrast dye. Despite these challenges, through an additional investment of about $33 million AHS was able to perform approximately 90,000 additional CT and 40,000 additional MRI scans.

In 2022-23 AHS also finalized implementation across all zones of a clinical appropriateness project aimed at decreasing unnecessary MRI scans so that patients who most require an MRI scan can access one. The specific project is intended to decrease the use of unnecessary MRIs in knee osteoarthritis.

For the budget increase, the primary metric was the number of scans performed. For the clinical appropriateness project, the metric used is the percentage of osteoarthritis knee MRI scans relative to the other MRIs. The metric dropped from a baseline of 2.37 per cent to 2.03 per cent at the end of 2022-23 although the full benefits will not be realized until the end of 2023-24.

Maybe I can hand it over to AHS, to Athana, for additional details.

**Ms Mentzelopoulos:** I guess I would just add two things. I think part of this reflects what I would call very, very granular management. We're looking at metrics that look at the number of exams conducted per hour, per shift; looking at workload units per exam, workload units per shift, operational days, budget activity, budget efficiency variances, staff vacancy, and sick rates; and just making sure that, for all those metrics, they're closely tracked to make sure we're getting the maximum efficiency of the resources we have. The only thing that I would add as well is that some of the delay, although I wouldn't want to underplay the improvement, is associated with the ongoing implementation of connect care, so with the completion of that we would see even more effective tools.

**Mr. Lunty:** Thank you.

You know, this was a topic – we heard briefly from the Auditor General on a recommendation. One of the outstanding recommendations for AHS from 2021 is regarding improvement for outpatient CT and MRI intake and the scheduling process. I see here that AHS has a plan in place to implement these recommendations by 2025. Can the department please share with us how this timeline is determined, and what are the processes for evaluating the urgency of this Auditor General's recommendation?

**Mr. Hedley:** So I'll start off, but Athana may want to add on this one. The OAG recommendations as they relate to standardizing and scheduling protocol and integrating decision support tools in the AHS ordering process could not be completely undertaken until a crucial step in the connect care rollout in diagnostic imaging. Connect care was rolled out in November 2023, with a final implementation schedule for late 2024. Adopting a standard system with shared data elements is fundamental for standardization and crucial for measuring and assessing the standardized elements. This is why these particular OAG recommendations are slated for completion in 2025. Diagnostics and imaging reports to the OAG and meets with them on a regular basis to discuss urgencies and necessary reprioritization.

**Ms Mentzelopoulos:** There's nothing more that I would add to that. Thanks, Darren.

**Mr. Lunty:** All right. Thank you for that.

I'll turn my attention to something, you know, on page 25. Alberta Health initiated several actions to address some recommendations from the Alberta Emergency Medical Services Provincial Advisory Committee report and dispatch review recommendations and strengthen the EMS system across the province. I see that in '22-23 a total of $590 million was spent on EMS. Can you speak to the work that was undertaken to strengthen the EMS system across the province, specifically in rural areas, and how these funds helped improve the system?

**Mr. Hedley:** Thank you again for the question. Specific measures implemented in 2022-23 that improved the EMS system were the following.

The cities of Edmonton and Calgary saw the addition of new EMS resources. A total of 19 staffed ambulances were added between January and December of 2022. This addition resulted in the hiring of 341 new paramedics.

New EMS resources were added to the communities of Okotoks and Chestermere, doubling the total ambulance hours delivered in the communities, which contributed to a decrease in response times.

Implementing guidelines for the timely and safe hand-off of EMS patients to emergency department waiting rooms. This allowed paramedics to return to service earlier and thereby respond to emergency calls sooner, decreasing overall response times.

Implementation of the AHS EMS return-to-service initiative, a procedure intended to support EMS units returning back to the community for coverage within a 45-minute target by safely transitioning care of EMS patients in emergency departments.

An exemption under the emergency health services legislation to allow greater use of emergency medical responders, a recognized EMS practitioner in Alberta, to work on emergency ambulances with a paramedic when required to maintain coverage.

**Mr. Lunty:** All right. Thanks for those updates.

You know, the good news is that it certainly appears to be having an impact. From November 2022 to March 2023 EMS response times for the most urgent calls had significantly decreased; for example, in metro and urban communities from 21.8 minutes to 15 minutes and in communities over 3,000 residents from 21 and a half minutes to 16.4 minutes and in rural communities under 3,000 residents from 36 to 33.3 minutes. Again, this is great news, and thank you, everyone, for your hard work.

My question is: how do these response times compare to previous years?

**Mr. Hedley:** Alberta measures response times from the time that the EMS resource received the call to the time that it arrives on scene. This data is captured in minutes and is reported at the 90th percentile. Put differently, 9 times out of 10 the response times will be equal to or less than the indicated value in minutes. Across Alberta response times for emergency calls were relatively stable at about 18 minutes, so the 90th percentile.

**The Acting Chair:** Thank you. That concludes the government block.

We will return to the Official Opposition for 10 minutes.

***10:50***

**Mr. Haji:** Thank you very much for the introductory part of the report. My first question will be a follow-up with the EMS. The $590 million investment is what you've reported. I'm just wondering: how much is that compared to the previous year? Do you have the data, the amount?

**Mr. Tremblay:** Would you be able to give us just a minute, please?

**Mr. Haji:** Sure.

**Mr. Tremblay:** I'm going to ask Chris Nickerson to come up, our ADM that looks after EMS. He'll be able to provide you some context on that question.

**Mr. Haji:** I just need the amount for comparative purposes.

**Mr. Tremblay:** I understand. Yeah.

**Mr. Nickerson:** Good morning.

**The Acting Chair:** I will just ask you to introduce yourself before you begin your comments. Thank you.

**Mr. Nickerson:** Thank you. Chris Nickerson, assistant deputy minister, acute-care division in Alberta Health. The number that I have from the 2022 annual report would be $533 million.

**Mr. Haji:** Five hundred and thirty-three million dollars; $590 million this year.

**Mr. Nickerson:** Last year, '22-23.

**Mr. Haji:** But I'm asking for the previous year. You reported in your annual report $590 million. For comparative purposes, for the prior year how much was that? I just want to determine if there was an increased investment or not.

**Mr. Nickerson:** So the prior year would be '21-22, and that was $533 million.

**Mr. Haji:** Thank you.

**Mr. Nickerson:** Thank you.

**Mr. Haji:** So EMS delays in ED were a primary target for improvement. How was this metric defined?

**Mr. Tremblay:** Could you repeat the question? Sorry. I just want to make sure we hear it.

**Mr. Haji:** EMS delays in ED, emergency departments, were a primary target for improvement. What metric are you using, and how was this defined?

**Ms Mentzelopoulos:** I believe that you are talking about the target for how long an ambulance should stay in a hospital?

**Mr. Haji:** Yeah.

**Ms Mentzelopoulos:** Chris Nickerson may want to add to this because he was very involved in the work as well. But at the time we really took a practical approach. There was some comparative analysis, but largely it was from a practical point of view of: what's the time that's required for an appropriate and safe hand-off of a patient?

I don't know if Chris wants to add anything.

**Mr. Nickerson:** Thank you. Chris Nickerson, ADM, acute care. Thank you for the question. As far as the EMS off-load delay, one of the key things that was raised at the EMS Provincial Advisory Committee was a recognition we heard from front-line staff and from a variety of stakeholders. It was raised at a variety of the subcommittees from paramedics and stakeholders alike. Part of the work was to review other jurisdictions as part of the committee work, and the committee came up with one of the recommendations – I don't have the exact number – around the 45-minute off-load target based on a jurisdictional scan that the committee conducted.

**Mr. Haji:** When does the 45 minutes start?

**Mr. Nickerson:** There are two recognized metrics. One is from the time that the ambulance arrives at the hospital until the time that the ambulance is available for the next call. There's also a time from when the patient is triaged to the time that the hand-off to the actual facility-based care takes place.

**Mr. Haji:** The U of A hospital has built a new infrastructure in the ambulance bay for EMS to wait. Why is that? If that metric is what has been defined, within 45 minutes, why does there have to be additional infrastructure for them to wait longer there, so they cannot get back to the community?

**Mr. Nickerson:** I might defer that to AHS.

**Ms Mentzelopoulos:** Yeah. I would have to check on when decisions were made about standing up that new capacity at U of A. The work that was done to bring a lot more rigour into turnaround times for ambulances: that implementation really began in earnest at the very end of the last fiscal year, '22-23. It was, as Chris noted, a consequence of the input that we had from the AEPAC group and also, I think, a recognition amongst AHS that those resources needed to be freed up. So it may have been that some of the decision-making didn't necessarily correspond. That said, there are still times when that capacity is required.

**Mr. Haji:** Can you provide that contextual information to the committee so that we understand why?

**Ms Mentzelopoulos:** The contextual information in terms of some of the decision-making?

**Mr. Haji:** Yeah.

**Ms Mentzelopoulos:** I would be speculating, so it would be, I think, more appropriate for me to go back and take a look at some of the decisions that would have driven the capital decision behind the capacity referenced.

**Mr. Haji:** Thank you.

The November '22 goal looked to improve EMS response time, and some of the comments that we've heard now are that it has reduced from 21 to 15 minutes as a significant improvement. Do you think there was a significant improvement?

**Ms Mentzelopoulos:** Yeah. I can start, but there are lots of folks who have lots of information about this. I think that we did see, as a consequence of EMS return to service, very significant improvement. We saw it in every size of community and for every type of call. Some of that performance subsequently eroded, for all the reasons that we saw not just in Alberta but around the country, but the initiative, I believe – and Chris can correct me if I'm wrong – helped us to restore our response times to pre-2019 levels. So, yes, I would say that it did have a significant effect, and we continue to put a lot of emphasis on that timely turnaround.

**Mr. Haji:** Just a follow-up question on that, then. What is the acceptable wait time? Is 15 minutes an acceptable benchmark that we can say that that's what we need to maintain? Is it 10 minutes? Is it 20 minutes? Like, what is the benchmark that we will say is the conventional benchmark for a population? I understand that density, population complexity, the infrastructure that we have all play a factor, but what is the acceptable benchmark for metro areas in Edmonton and Calgary?

**Ms Mentzelopoulos:** Do you mean the acceptable response time if someone calls an ambulance?

**Mr. Haji:** Yeah.

**Ms Mentzelopoulos:** Well, that will vary on the severity. Chris may have those numbers at his fingertips, but when a call comes in, immediately there is an assessment that's undertaken of the severity of the call, and depending on the severity, the rig is dispatched. So if you call and say, "I'm having a heart attack . . ."

**Mr. Haji:** Yeah. I do understand that it depends on the severity of a call. It depends on the location. Like, there are many factors. But should we celebrate 10 minutes or 15 minutes? Like, what is the standard that AHS has in place saying, "We need to get to that target"?

**Ms Mentzelopoulos:** Well, some of those standards are comparative, and, again, I'd be reluctant to say one number because they do vary somewhat. In a rural area you will not expect the same response time for . . .

**Mr. Haji:** I'm asking for metro areas, Edmonton and Calgary.

**Ms Mentzelopoulos:** Just let me see. I may have the grid of our target response times. For delta and echo in metro areas our response time target is 14.5 minutes.

**Mr. Haji:** So we're still not at a 10.5 target. We're not 21 – I understand – but we are still not, then, at 14.

**Ms Mentzelopoulos:** Correct.

**Mr. Haji:** But in 2017 we had 10 minutes. In 2017 we had 10 minutes' wait time.

**Ms Mentzelopoulos:** I'm not sure if that's a question.

**Mr. Haji:** Okay. Well, yeah. It's because we're saying that we have a target of 14, but are we saying that we were doing much better than the target in 2017?

***11:00***

**The Acting Chair:** Thank you very much, everyone. That concludes the second block for the Official Opposition.

We now move to the government for 10 minutes. MLA Lovely.

**Ms Lovely:** Thank you so much, Madam Chair. You know, I am from the Camrose constituency, where we have almost double the number of seniors in our community, and I'm very proud of that. Seniors' care is very important to me, so I have a few questions based on that. Thousands of Albertans rely on Alberta's continuing care system. Our government is committed to providing Albertans with the best continuing care possible and has undertaken transformative changes in order to address gaps that may exist. "In 2022-23," I'm pleased to read on page 29, "871 new continuing care [spaces] were created at AHS-operated or contracted facilities." Could you please share with this committee how many of these new spaces have helped address the needs of Albertans?

**Mr. Tremblay:** Sure. Developing additional continuing care capacity is obviously important, and thanks for the question. There are a number of different strategies that we're enlisting: reducing wait times to access the continuing care system, which supports Albertans in receiving timely access to care they need in the most appropriate settings; reducing the number of people in acute-care facilities waiting for continuing care spaces, thereby increasing capacity in the acute-care system; increased choice for Albertans by providing more continuing care homes in their communities, close to friends and family; and meeting the government's commitment to transforming the continuing care system based on recommendations from the facility-based continuing care review such as eliminating shared rooms.

**Ms Lovely:** Okay. On page 29 of the report it shares that Alberta Health has acted on several recommendations from the facility-based continuing care review final report, which was released on May 31, 2021. Some of these recommendations include "the introduction of self-managed care as a way to provide greater choice regarding locations, types and providers of services" and "supporting more continuing care clients in the community rather than at FBCC sites" in order to enhance client choice. Can you please discuss in further detail how these and the other recommendations that have been implemented are allowing Albertans to choose the right type of care for their unique situations?

**Mr. Tremblay:** Thanks so much for this question. It's a very important one. Self-managed care continues to be a province-wide option available to Albertans, actually since the 1990s. It offers increased flexibility and choice in care providers. It can entail a lot of administration to act as an employer of staff, so an additional model has been introduced, the client-directed home care model, which is currently fully implemented in the Calgary and Edmonton zones and is being expanded to rural areas in 2024. In CDHC, Alberta Blue Cross manages the administration, budgeting, invoicing, reimbursement, and management costs directly with the provider on behalf of the client, alleviating administrative burden.

In June 2022 Alberta Health worked with AHS to initiate a request for expression of interest in a qualification procurement process to explore opportunities to optimize the provision of home-care services in Alberta as well as identify innovative service delivery solutions to support specialized needs and populations. Albertans will begin to see the outcomes and impacts of this process as the successful proposals are implemented across the province.

**Ms Lovely:** Thank you so much for the answer and also to your team for the hard work that it takes to accomplish this. Much appreciated.

On page 29 it also details Health's work in conjunction with AHS and Alberta Blue Cross to implement the client-directed home care invoicing model.

> This model was [first] implemented in the Edmonton Zone in April 2022, and in the Calgary Zone in the fall of 2022. Expansion to rural [Alberta was scheduled to] move forward over 2023.

Can you please provide an update on the rural expansion of client-directed home care invoicing and some of the key takeaways from the earlier implementation in Edmonton and Calgary that were used to guide and inform the rural expansion?

**Mr. Tremblay:** Thanks for the question. Alberta Health worked with Blue Cross and AHS to implement the client-directed home care invoicing model, beginning in April 2022 in the Edmonton zone and October 2022 in the Calgary zone. As of January 2023 both zones have fully implemented the model. The client-directed home care invoicing rollout to the rural zones, as I mentioned in the previous question, will begin in early 2024. Planning includes identification of communities, staff education, business process alignment, and investigation into vendor presence within the communities. Following client enrolments in initial communities in January 2024, we will evaluate scale and spread to other communities within the area.

Some of the key takeaways from earlier implementation that helped guide and inform rural expansion include leveraging provincial resources, so staff education, training, info packages, self-guiding tools for rural zone implementation so that practitioners and clients have access to the same information across the province; understanding the types of clients and families who are most likely to benefit from and embrace this new service model as it currently is designed, so being a bit predictive in that; and learnings about mechanisms for effectively sharing information about the program to increase uptake in the new model across the province.

**Ms Lovely:** Thank you.

Several of the sites in the Camrose constituency indicate there is apprehension to move into continuing care facilities following COVID-19. I see on page 44 of the report that a total of $286 million was provided in 2022-23 for additional staffing costs and cleaning supplies, PPE, and screening of visitors to protect the health and safety of residents. I'm wondering how this investment has been used to ensure the sanitation and overall safety of our continuing care facilities. I see that both AHS and Alberta Health

have four outstanding recommendations from the Auditor General in regard to this response from continuing care facilities to COVID-19. I want to ask what steps, if any, you've taken to meet some of these recommendations.

**Mr. Tremblay:** Thanks for that. All of the Auditor General's recommendations in this area were accepted, and corresponding actions were submitted to the OAG in November of last year. Final feedback from the OAG on these plans is pending. Obviously, they need time to evaluate the work, action plans, and projects. Teams have begun advancing all of the work in these strategic areas. They're working right now. I appreciate the opportunity to highlight for you some of the initial steps that have been taken to address two of the key recommendations, that relate to continuing care staffing and infrastructure.

With respect to recommendation 3, which is developing a continuing care staffing strategy to increase staffing system resilience, the following has been allocated as part of budget '23-24: investments into staffing as part of the continuing care transformation that will positively impact resilience, including $84 million to make wage increases for health care aides in home care and continuing care homes permanent and to align the home-care wages with facility-based continuing care; over $100 million towards incremental increases in hours of care in facility-based continuing care, which will help reduce staff workloads across the system; $2.5 million to support staff-led mental health projects.

Alberta Health will also develop and make public a continuing care workforce action plan. The action plan will align with the five pillars from the Alberta Health workforce strategy, that was actually released in March 2023. The actions will aim to ensure there is an appropriate number and mix of continuing care workers with the skills and training to deliver high-quality care as well as ensure continuing care workers have safe, inclusive, and supportive work environments.

The continuing care workforce working group, comprised of key stakeholders, has been meeting since September 2023 to develop recommendations, including addressing the OAG's recommendations related to this. The work is on track to culminate in a continuing care workforce action plan in the '24-25 fiscal year.

With respect to recommendation 6, to evaluate all existing infrastructure and set strategy for improving facility infrastructure, some of the initial progress includes a review and update to the continuing care design standards and best practices in Alberta. That's under way. Alberta Health developed a continuing care capital program to modernize older buildings, including addressing learnings from the pandemic. In the fall of 2023 the evaluations were completed to conditionally select the first 10 projects to be funded under a continuing care modernized capital stream with new requirements.

**Ms Lovely:** What is the status of the Auditor General's outstanding recommendations to the department to improve public reporting outcomes for seniors in long-term care?

**Mr. Tremblay:** The minister . . .

***11:10***

**The Acting Chair:** Thank you very much.

We now move to the Official Opposition for a 10-minute block, and we'll begin with MLA Renaud.

**Ms Renaud:** Great. Thank you, Madam Chair. On page 29 item 1.2 talks about modernizing Alberta's continuing care system. Of course, that includes Albertans living with a disability. My question is: what is the difference between the client-directed home care invoicing model that you talked about in Calgary and Edmonton, going to rural next, and self-managed care under home care?

**Mr. Tremblay:** Thank you very much for the question. I'm actually going to ask Corinne Schalm, our ADM accountable for continuing care.

**Ms Renaud:** Okay. Actually, maybe I'll add another question for the ADM on top of that.

**Mr. Tremblay:** No problem.

**Ms Renaud:** Can you tell me how many individuals use the current program that you talked about in this report, the client-directed home care invoicing model, and how many use self-directed care or self-managed care?

**Ms Schalm:** Yeah. I'll maybe ask AHS if they have those numbers handy. If not, we can get back to you on the actual numbers.

The difference: both the self-managed care program and client-directed care are opportunities for clients who don't want to use the standard way of accessing home care, and there are two different options. The self-managed care, as was mentioned earlier, has been around since the 1990s, and I know you'll be very familiar with it from persons with disabilities. In that program, in the self-managed care program, a person is still assessed for their needs by somebody from Alberta Health Services, a health professional, and once that assessment arrives at what their needs are, the hours of care, et cetera, the person may choose to manage their own care. That means that the funding comes to them rather than an agency coming in, and they have the option to hire their own caregiver.

**Ms Renaud:** Sorry. So are you saying that the primary difference is that the care is directed by the person with the disability as opposed to an agency? Is that the main difference?

**Ms Schalm:** The care is always directed by the care plan. The care plan is developed, but . . .

**Ms Renaud:** Yeah. Sorry. I don't have much time. I want to pass it on to my colleague.

**Ms Schalm:** Sure.

**Ms Renaud:** I just want to know the main difference between self-managed care and this new program that you're piloting.

**Ms Schalm:** The main difference is that in the newer program, which is the client-directed care program, that we are starting to roll out, all of the administration goes through Alberta Blue Cross, just as you would go to your dentist, and if you have an insurance program, the payments go through that.

**Ms Renaud:** If I could ask for some clarity: is a person with a disability, let's say, given the option that you can choose A or B, or are they sort of encouraged to use one? Is there any sort of active encouragement involved?

**Ms Schalm:** Clients are presented with the various options, and that is that it's going to be client specific as to what works best for them. The self-managed care program is a lot of administration for the person. They act as an employer. They have to submit employer . . .

**Ms Renaud:** But they could choose that if they choose?

**Ms Schalm:** Absolutely.

**Ms Renaud:** Okay. Thank you very much. I'm going to pass the rest of my time to my colleague.

**Mr. Haji:** Thank you. I understand that the annual report states that Alberta's and other provinces' wait times for three common surgical procedures – hip replacement, knee replacement, and cataract surgeries – continue to be impacted by delays due to workforce shortages. What do you think the reasons are?

**Ms Mentzelopoulos:** My colleague Sean Chilton may add to this. But could I just note for the record, because I managed to look up some data, that I determined that in 2017 at the 90th percentile our average response time for echo delta was 12.7 minutes. I just wanted to put that on the record.

I would say that probably fundamentally the issue, to your question, is around the availability of anaesthesiologists. That's probably the key issue in terms of what we're dealing with for shortages in the workforce.

I don't know if Sean . . .

**Mr. Haji:** Why is that? Why is the recruitment an issue? Do people not want to work in Alberta?

**Ms Mentzelopoulos:** No. People want to work in Alberta. In fact, if I looked up the number of incremental physicians, I think it's 2 to 4 per cent overall. There is a challenge with anaesthesiologists certainly across Canada – I think this is something CBC reported on recently – and I think that even beyond Canada there's an ongoing challenge with resourcing for anesthesiologists. I'm not an expert on what all of the factors may be. I only know that we don't have enough.

**Mr. Haji:** Not only anaesthesiologists, but when you look at your report, it shows that it's taking longer to recruit positions that you post. In your report you also report that the vacancy rates are higher than they used to be before just compared to the previous year. So don't you think this is a general problem, that we are unable to attract and retain the health care workforce?

**Ms Mentzelopoulos:** Andre might want to add, but the point I was trying to make earlier, that I think is very, very fundamental to understanding our vacancies, is also the extent to which we have incremental growth in our system. We continue to grow. The government has provided us with increased resources year on year, and we use that funding primarily to hire people. There are shortages in key areas, and we also have really complex issues that affect things like overtime. They're related, for example, to provisions in the collective bargaining agreement. So we look at this, I think, from a four-dimensional point of view. We look at all the resources that we have available. We undertake very focused . . .

**Mr. Haji:** Would you say, then, that we have a workforce strategy problem here?

**Ms Mentzelopoulos:** No. I would say that we have a workforce supply problem.

**Mr. Haji:** Okay.

**Mr. Tremblay:** Maybe I'll add something. Thanks for the question. We do have a workforce strategy that was announced in March 2023. Physician shortages are persistent globally – right? – and I think that's worth noting. From an Alberta perspective, we're the highest paying jurisdiction for physician compensation in Canada, and we have one of the lowest cost operating models.

**Mr. Haji:** Sorry to . . .

**Mr. Tremblay:** I just want to add one thing because I think it helps with MLA Schmidt's question as well. From the previous year to what we're talking about in terms of this year, we actually increased the number of physicians from 10,965 to 11,132. Even though we have persistent physician shortages, we are still increasing numbers, and we still have a compensation rate that is competitive, from a Canadian perspective, in terms of highest compensator. So I just want to say that I think Athana is right; there's definitely a supply issue. But in this jurisdiction we're undertaking any and all strategies to address that persistent shortage.

**Mr. Haji:** Yeah. According to CIHI other provinces share the same backlogs, whether it is pandemic or other general issues that you have indicated as a general supply when it comes to the health care workforce, but it seems that they're catching up compared to Alberta. Why is that?

**Mr. Tremblay:** Are there any specific indicators you want to illuminate?

**Mr. Haji:** Yeah. Hip replacement, knee replacement: Albertans wait longer than other provinces.

**Ms Mentzelopoulos:** I think that in terms of some of the CIHI indicators there are areas where we lag other provinces. There are also areas where we lead other provinces. So I'm hoping – and we are tracking very closely – to see some improvement, for example in some of those specific surgical procedures, for the 2023 data set, and we will also see as a consequence of that data set how we continue to compare with other jurisdictions. But I know, in terms of just comparing to ourselves, we have increased volumes.

**Mr. Tremblay:** I'd also like to ask Kim Simmonds to come up and talk about some inconsistencies in measurement that sometimes create issues with reporting.

**The Acting Chair:** If you could just begin with introducing yourself. Thank you.

**Ms Simmonds:** Thanks. My name is Kim Simmonds, ADM of strategic planning and performance. I'm pleased to talk about CIHI, one of my favourite topics. New numbers will be coming out for CIHI. We do expect to see an improvement for arthroplasty. One of the things I'd like to point out with regard to CIHI is that Alberta performs extremely well when we look at high-acuity procedures. When we look at those who have a hip fracture, the need to get that repaired within the clinical guideline is really important, and we always perform better than most of our counterparts. This is something where we consistently triage to: those who need it most get it first.

With CIHI, because they have to report across all of the provinces, they have to tailor to the lowest common denominator to some extent. What that means is that they roll it all up, and we lose that acuity measure. One of the things that we're working on is actually reporting the CIHI number, so how many weeks people are meeting for the benchmark, but then unrolling that by acuity so Albertans will actually be able to see how well we are achieving those for those who most seriously need the surgeries.

***11:20***

**Mr. Haji:** Yeah. But the most comparative indicators that are used by CIHI on surgeries and wait times are those three.

**Ms Simmonds:** Yes.

**Mr. Haji:** And it seems that with all the resources that we have, we are behind on those.

**The Acting Chair:** Unfortunately, that ends that 10-minute block.

We'll return to the government for a 10-minute rotation. MLA de Jonge.

**Ms de Jonge:** Thanks, Madam Chair. My colleague MLA Jackie Armstrong-Homeniuk, who's a member of the committee and, unfortunately, not able to be here today, is also the parliamentary secretary for settlement services and Ukrainian evacuees, so I'm pleased to ask this question on her behalf. In the last fiscal year our government established the Alberta Ukrainian evacuee health benefit program, and this program is essential to our government's efforts to support Ukrainian evacuees as they settle into their new communities in Canada. Ensuring that they have access to world-class health care is a critical part of that. The program provides supplemental coverage for prescription and nonprescription drugs, nutritional products, diabetic supplies, and dental, optical, and emergency ambulance services. Would the department please outline how these services were delivered to evacuees?

**Mr. Hedley:** Thank you for the question. Upon approval of the Ukrainian evacuee Alberta health benefit application Ukrainian evacuees are provided a health benefit card. Ukrainian evacuees present their health benefit card at the point of service – pharmacy, dentist, optometrist – to receive coverage for eligible benefits under the Ukrainian evacuee Alberta health benefit program.

**Ms de Jonge:** Thank you very much.

As shown on page 48 of the report, $9.5 million was allocated by our government to support the Alberta Ukrainian evacuee health benefit program. While the report states that a majority of the funds were used towards physician services, would the department please highlight some other areas the funds went toward?

**Mr. Hedley:** Sure. Thank you. In the 2022-23 fiscal year Alberta Health invested $5.81 million to provide supplementary health benefits to Ukrainian evacuees, which included prescription and nonprescription drugs, nutritional products, diabetic supplies, and dental, optical, and emergency ambulance services.

**Ms de Jonge:** Thank you very much.

Improving health outcomes of newly arrived Ukrainians is of high importance for our government, which is why programs like this are incredibly encouraging. Ensuring that Ukrainian newcomers have access to the medical care they need is a fundamental aspect of our commitment to promoting the well-being of all residents. Would the department please outline any measurements of improved health outcomes for Ukrainians accessing the services provided by the Alberta Ukrainian evacuee health benefit program?

**Mr. Hedley:** Sure. In 2022-23, 4,156 Ukrainian evacuees accessed drug benefits, 2,367 Ukrainian evacuees accessed optical benefits, 59 accessed emergency ambulance services benefits, and 4,979 evacuees accessed dental benefits.

**Ms de Jonge:** Thank you very much.

I'd like to now turn the discussion towards regulatory efficiency. Page 20 of the report states that "the Ministry of Health remains committed to regulatory approaches and program delivery that reduce unnecessary government oversight and emphasize outcomes." To this end, I'm pleased to read that as of March 31, 2023, AHS achieved a combined reduction of regulatory requirements of 36.6 per cent while the Ministry of Health, including AHS, achieved a net reduction of 36.1 per cent, surpassing the government's target of 33 per cent. This goes a long way to ensuring that Albertans can access the health care they need without the burden of endless red tape.

There are a couple of specific red tape reduction initiatives listed on page 20 that I'd like to inquire further about. Page 20 talks about the shift from paper based to digital, with the number of Albertans registered on MyHealth Records having grown from 1.25 million users in March 2022 to just under 1.5 million users at the end of March 2023. This has and will continue to ease access to records for many Albertans. With that said, can you please outline some of the processes and mechanisms that have been put in place to ensure that Albertan seniors and others who have difficulty with digital records are not being left behind in this transition?

**Mr. Hedley:** You bet. MyHealth Records is an optional service that provides Albertans 14 years of age and older with online access to their personal health information. Albertans who choose not to sign up for MyHealth Records may alternatively access their health information by making direct requests to custodians using the process established under the Health Information Act. Custodians may charge an initial $25 fee to cover the cost of performing one or more of the steps required to produce a copy of the requested health information, including locating the record, preparing it for release, and photocopying. MyHealth Records also allows Albertans to share their record electronically with whomever they choose. Albertan seniors and others who have difficulty with digital records may wish to take advantage of the sharing feature to enable caregivers and trusted individuals access to their digital records.

**Ms de Jonge:** Thank you very much.

Page 20 also discusses red tape reduction initiatives introduced through amendments to the Pharmacy and Drug Act, the pharmacy and drug regulation, and the Health Professions Act. Can you please outline some of the changes introduced through these amendments and the intent behind these changes?

**Mr. Hedley:** You bet. In March 2023 changes to the Health Professions Act strengthened and streamlined the governance framework for regulated health professionals. Changes included streamlining the language in the Health Professions Act to remove duplication and making the related regulations more consistent between health care professions. One of the changes to the Health Professions Act will also help ensure regulated health professionals maintain competency in an ongoing way. The government also created a new regulation under the Health Professions Act, the health professions restricted activity regulation, which sets out the procedures different health care workers are qualified to perform in a single place. Previously these procedures were defined across many different regulations. These changes to the Health Professions Act make the legislation governing health care workers' professions easier to understand and more transparent for Albertans, who have a right to know that they are receiving care from qualified, accountable professionals.

The Red Tape Reduction Statutes Amendment Act, 2022, also made changes to the Pharmacy and Drug Act to enable more flexible oversight of Alberta pharmacies by moving requirements to the Alberta College of Pharmacy standards of practice rather than with the college regulation.

**Ms de Jonge:** Thank you.

What feedback have you received from the public and from health care professionals regarding these red tape reduction changes?

**Mr. Hedley:** Department officials have confirmed that there has been no feedback from the public on these changes but that the regulatory colleges have been supportive.

**Ms de Jonge:** Thank you.

On the same note, regarding regulatory efficiencies, I see on page 41 of the annual report that

> amendments to the Pharmacy and Drug Act and the Pharmacy and Drug Regulation came into effect June 1, 2022. These amendments allow the Alberta College of Pharmacy and pharmacies to better respond to changes in the provision of pharmacy services . . . and [help to] reduce . . . red tape faced by pharmacy operators.

How have these amendments expanded pharmacists' scope of practice and worked to ease the burden that may have otherwise been placed on emergency and health care services in Alberta?

**Mr. Hedley:** The amendments to the Pharmacy and Drug Act and regulation enabled the Alberta College of Pharmacists to establish standards of practice related to unexpected changes to pharmacy service requirements such as the pandemic, thereby enabling a rapid response to patients' primary care needs. Previously this would have been required to be done through amendment to the act or regulations, a very time-consuming process.

**Ms de Jonge:** Thank you very much.

Now switching to home care, which is incredibly important to my constituents in Chestermere-Strathmore, page 62 of the report indicates that 3 per cent of the Ministry of Health's consolidated expenses for that fiscal year went towards home care. Can you please expand on how these investments in home-care services have helped to take some of the burden off continuing care and long-term care facilities in Alberta?

***11:30***

**Mr. Hedley:** Thanks again for the question. Investments in home care support the shift to care in the community, helping to alleviate some of the burden on continuing care and acute-care facilities, funding caregiver supports, increasing access to nonmedical community supports for community-based clients and their caregivers, expanding client direct care models to provide choice and flexibility to clients and caregivers, and creating more flexibility by funding innovative approaches to providing home . . .

**The Acting Chair:** Thank you, everyone.

We are now entering the fourth rotation. The Official Opposition. MLA Haji.

**Mr. Haji:** Yeah. Thank you, Madam Chair. Just to follow up on the wait time again, on November 23, 2021, the department reported to this committee that the estimated cost to reduce the 30,000 backlog as of March 2021 is $258 million. At the time the department said that to eliminate the COVID-accumulated backlog and address those patients that were delayed, we must go above 100 per cent of the average activity baseline for several months. Additionally, this will require additional overtime. Regardless, your current report captures that the government of Canada transferred additional and budgeted $232 million to address the surgery backlog. How will this resource assist reducing the backlog, and where are we on the 30,000 backlog, that requires this amount of money?

**Ms Mentzelopoulos:** I believe that we have addressed the COVID surgical backlog.

**Mr. Haji:** So the 30,000 have been cleared?

**Ms Mentzelopoulos:** Correct.

**Mr. Haji:** On page 25 of the AHS annual report '22-23 the wait time to see a doctor in an emergency department deteriorated by 37 per cent. Why this deterioration of wait time?

**Mr. Tremblay:** Can you identify the specific indicator, if you wouldn't mind, please?

**Mr. Haji:** It says that the wait time to see a doctor in emergency department is 6.3 hours, and the report says that it "deteriorated by 37 per cent," which means that it used to be 4.6 hours in a prior year. My question is: why is it worsening?

**Ms Mentzelopoulos:** I can speak to a couple of general factors in the absence of having the specific data indicator in front of me, but at the highest level I can tell you that we have more traffic. We have seen an increase in traffic into EDs, but more importantly what we see is an increase in severity or acuity of the individuals who are coming to our emergency departments. There may be others who would like to expand on that, but at the highest level that's what would drive that.

**Mr. Haji:** Okay. Do you think this is, again, back to the workforce, that that's why we have this deteriorating number of wait times?

**Mr. Tremblay:** We're just pulling some numbers here. But, you know, just to support what Athana is talking about, increased volume: certainly, we know that there was an increase in population in the last year of about 200,000 people, give or take. We know that there's persistent workforce shortages across the country. We know that with nursing staff and physicians.

**Mr. Haji:** But I assume that in your workforce strategy you factor in growth of population.

**Mr. Tremblay:** Absolutely. Absolutely. Again, we are increasing seats in our nursing colleges and our med schools as well. We've increased international graduate pathways into Alberta. As I mentioned, there is a workforce strategy that was released in March 2023, so we're pushing as hard as we can.

**Mr. Haji:** Yeah. I hear that, but the committee looks into the annual report. The numbers in the annual report are not supportive of that. They are not showing that in the numbers that you have reported in the annual report. We are seeing that lagging behind when it comes to hip replacement, knee replacement compared to the other provinces. We are seeing that that wait time is deteriorating. We're seeing that those numbers are not supportive, and it shows that you're not recruiting, I mean, in a timely manner. It's taking longer to recruit. It's becoming difficult to retain. Those are some of the factors that we see reflected in the indicators from a health care perspective.

**Mr. Tremblay:** Well, I really appreciate that, and I think we should note what ADM Simmonds said about some of those indicators. As ADM Simmonds just mentioned, higher acuity or more severe hip and knee replacement circumstances: we're actually ahead of most other jurisdictions. I think the challenges with federal standardized indicators is that they don't always tell the full story, so I just want to reiterate that.

In terms of workforce challenges I'm just going to turn it over to Athana. I really appreciate the question, but we're pushing hard. We're adding additional seats, additional placements, additional . . .

**Mr. Haji:** But, Mr. Tremblay, I assume that these are indicators that are discussed interprovincially with the federal government and that come up as standard indicators that we have to use for performance.

**Mr. Tremblay:** Yeah, but it's only part of the picture, right? When you have something nationally standardized, it's good for interjurisdictional comparatives, but it doesn't always tell the full story around how an individual health care system triages and prioritizes. So I just think it's important to understand that.

**Mr. Haji:** Okay.

I'll move on to other mechanics that you have used to address the problem, which is increasing the CSFs. According to the report there were 38 CSFs, or chartered surgical facilities, and three new CSF contracts were implemented. Why can't we see the impact of these additionally contracted private facilities to wait time benchmarks for surgical procedures?

**Mr. Tremblay:** Do you want to hit that one?

**Ms Mentzelopoulos:** Sure. I could say a few things. The number of surgeries that we are doing has gone up. It has gone up this year compared to last year, and last year it went up as well. We continue to see people come on to the surgical wait-list. As we deal with folks who have been waiting, more people are assessed and more people come on to that.

**Mr. Haji:** But that would be what you would expect. That's why you have facilities, because once you have a population that will be coming through the pipeline, you expect that, you project to that, and then you address that with the workforce that you have in place.

**Ms Mentzelopoulos:** Yeah. If you look at the utilization rate of rural ORs, for example, I think it went up by about 6 per cent. We're using the capacity that we have available to us for public procedures. In the CSFs we're using all of the OR space that we have across the province as effectively as possible with the additional resources, obviously, that are required. The thing I think that is sometimes overlooked is the number of surgical procedures that are done on an emergency basis. Those are not predictable, but they typically – the U of A hospital, as an example: about 50 per cent of their procedures in any given year are done on an emergency basis. So there are a lot of dynamic factors there.

**Mr. Haji:** Yeah. The struggle that I have, as I was reading the report, is that if you know – and you have alluded already that there is a workforce supply problem. How will the additional CFSs support? Like, additional contracts: how will they support if there is no pool of workforce that you can draw from? Don't you think that is why AHS is having retention – don't you think that is why AHS isn't having recruitment in a timely manner?

**Ms Mentzelopoulos:** I think your question might be premised on the idea that our workforce has been static, and it hasn't. It grows every year.

**Mr. Haji:** Relative to the population is it the same kind of growth?

But you are indicating in your report – I'm just reading the report. You're indicating in your report that just compared to last year, it's taking longer for you to recruit. You have higher vacancy rates, meaning that you are not retaining and you are not recruiting compared to the previous year.

So back to the question of CSFs. How will the CSFs reduce the problem if you have a supply problem of workforce?

**Ms Mentzelopoulos:** Again, I think your question might be premised on the idea that our workforce does not continue to grow, and it does continue to grow. We have, I would say, an acceptable vacancy rate related to factors that aren't necessarily within anyone's control, but we hire more people as well.

***11:40***

**Mr. Haji:** Don't get me wrong. I'm not saying that it's not growing. What I'm saying is that 10 per cent is growth. If your population is growing at 40 per cent and your workforce is growing at 10 per cent, you're not catching up.

**Mr. Tremblay:** Again – and we're just pulling those numbers – we've increased the health workforce each year since in perpetuity to pace as much as we can with population growth. I just want to go back to . . .

**Mr. Haji:** I'm running out of time. Can you provide that information, growth of workforce versus growth of population?

**Mr. Tremblay:** We'll absolutely consider that. Yeah.

**Mr. Haji:** Thank you.

**The Acting Chair:** Thank you.

We return to the government for a final 10-minute block. MLA McDougall.

**Mr. McDougall:** Thank you very much. Page 21 of the report details the results of the government of Alberta's COVID-19 recovery plan. As you're aware, this government has remained committed to supporting the health of all Albertans through the transition from a pandemic to endemic state. It's mentioned in the 2022-23 fiscal year that $1.2 billion was spent by Health on Alberta's COVID response. That's a lot of money. I'm just wondering, you know, if you could break that down, at least the top three or four elements, the relative size of how that money has been allocated. What are we spending that money on?

**Mr. Tremblay:** I just want to – we do have a number for you, actually, if that's okay. In 2023 we had 324,400 health care workers. That's a 14 per cent increase from 2019, so it's a significant increase in health care workers across multiple occupations. Just out of respect to the question.

Thank you.

**Mr. Haji:** Thank you.

**Mr. Hedley:** Then I'll move to answering the member's question as well. Alberta's laboratories maintain baseline testing capacity of 5,000 tests a day with an ability to surge quickly to around 8,000 per day. This includes rapid point of care testing, public health outbreak response, integrated diagnostic and surveillance testing for COVID-19 and other viruses. The Alberta government provided enhanced personal protective equipment and masking supplies to AHS staff as well as third parties, and distribution to third parties ended on April 1, 2023.

The Ministry of Health added three permanent public health subject matter experts to continually assess risk, monitor, and develop policy related to emerging communicable diseases. Operational resources were also added to support public health information technology systems, including one permanent FTE and five temporary FTEs. Two FTEs were added to the provincial vaccine depot to support vaccine logistics and distribution. The AHS public health workforce capacity was expanded to support

ongoing response to respiratory virus cases and outbreaks, and AHS communicable disease control added over 100 temporary FTEs.

The AHS immunization program maintained capacity to provide 6,000 immunization clinic appointments per week and support oversight and outreach activities of the immunization programs, about 105 and a half FTEs. AHS increased their capacity to provide a catch-up program in school and for routine infant preschool childhood immunizations.

**Mr. McDougall:** So if somebody is to ask me, "MLA McDougall, where's the money going, this $1.2 billion?" and I say, "Okay; give me the top three things in relative size of the allocations for that," is it possible to break that out?

**Mr. Hedley:** To break it out? If you give us a moment, we can break out the three.

**Mr. McDougall:** Okay. While you're looking at that, I'll follow up. The report specifically indicates that several initiatives were implemented to ensure a more resilient health system that can respond to future waves of COVID-19 or other public health emergencies. Can you please share some of the specific resiliency initiatives that were introduced?

**Mr. Hedley:** Give me a moment as I look that up.

**Mr. McDougall:** Okay. Perhaps while you're looking that up, I'll just move on to some other questions here. My time is running out.

**Mr. Hedley:** Yes. Sorry. We'll get that back to you.

**Mr. McDougall:** In the fall of 2022 the government of Alberta introduced the modernization of Alberta's primary health care system, MAPS, strategy, outlining plans to support the current health care workforce and develop future workforce with the establishment of three advisory panels among other initiatives. Since then $125 million has been invested into the program to help carry out its objectives. Could you please inform the committee exactly how these funds were being used and the progress that has been made in achieving the objective set up by the strategy?

**Mr. Hedley:** In the fall of 2022 three advisory panels were established as part of the MAPS program to identify primary health care improvements in the short term and over the next five to 10 years. In February 2023 the MAPS strategic and Indigenous advisory panels presented interim reports to the Minister of Health, who accepted all of their recommendations in principle. This included recommendations on initiatives that could be implemented more quickly and resulted in meaningful changes while broader system design is being considered. The final report was provided to Alberta Health on March 31, 2023.

Budget 2023 provides $125 million over the next three years to start implementing some of the MAPS recommendations while doing more consultations and engagement in other areas addressed by the report, including the allocation of $57 million over three years to provide family doctors and nurse practitioners with support to help manage their increasing numbers of patients, creating a $20 million fund for Indigenous communities to design and deliver innovative primary care health care services and projects and other early investment opportunities. As this funding is specific to Budget 2023, additional details would be provided in future reporting.

If I can go back to your other question on COVID-19, in terms of the top three areas what I can provide is that personal protective equipment, rapid test kits, and other testing kit supplies were the top spend, and that was $368 million. A lot of that, I believe, came through the federal donations as well. Continuing care, $286 million; and the acute-care system about $230 million.

**Mr. McDougall:** Thank you.

The modernization of Alberta's health care sector is one of the most important goals of this government, and we firmly believe that integrating technology into the sector can allow for greater efficiency and reduce regulatory hurdles. Key objective 1.3, which can be found on page 32 of the report, calls for the use of digital technology to enable such models of care and reduce manual and paper-based processes. Can the department please outline some of the ways the uptake of digital technologies has contributed to streamlining health care?

**Mr. Hedley:** Thank you. Digital technology allows health care professionals to gain clinical insights more efficiently from other providers, reduce and avoid duplicative work, automate repetitive tasks, and communicate and collaborate more efficiently with colleagues across the health system. It can also allow patients and providers to interact more effectively and co-ordinate care. This allows care providers to operate more efficiently and effectively and ultimately streamline health care in Alberta.

Alberta Netcare is the provincial electronic health record that allows health care providers access to a consolidated view of key patient health information to support care delivery. MyHealth Records is the primary patient portal for Albertans over 14 years of age to access their personal health information. The breadth and depth of information and services of Alberta Netcare and MyHealth Records continue to be enhanced to enable streamlined health care.

**Mr. McDougall:** Okay. Thank you.

As a way to encourage the integration of technology in the province's health care system, Alberta Health established Alberta's virtual care action plan, which identified four objectives in modernizing digital health care. The objectives include the establishment of an e-health strategy and includes a strategy for virtual care and the expansion of MyHealth Records, the development of secure messaging services between community electronic medical records, EMRs, in Alberta Netcare, and the development of a privacy and security framework for virtual care. Will the department please outline what successes have been made in achieving these objectives?

***11:50***

**Mr. Hedley:** You bet. In terms of the virtual care action plan successes include the Alberta e-health strategy, that has been developed and aligns with the e-health ecosystem under a common vision and sets the direction for e-health in the province. Significant . . .

**The Acting Chair:** Thank you.

We now have a three-minute block for the Official Opposition, followed by the government to read questions into the record. I'll turn it over to MLA Renaud to begin.

**Ms Renaud:** Thank you, Madam Chair. My first question is about home care. Would you please list for the committee program differences and eligibility differences between self-managed care and client-directed home care, the invoicing model that we spoke about earlier, the total spending for each program in the fiscal that we're covering in this meeting, and the total number of people served in each of those programs?

My second question is: would the deputy minister or any ADM please list for us any consultation that the Ministry of Health has

engaged in around accessibility with either the Ministry of Seniors, Community and Social Services or the disability advocate?

My third question is about unbudgeted expenses noted by the ministry. These are support services. The annual report notes that the $223 million spent over budget under support services is largely due to high utility costs due to inflation, carbon tax, delays in outsourcing initiatives, increased cost in infrastructure, maintenance projects, unbudgeted costs for biomedical waste. So first question: what is the breakdown of the proportion of each of those categories in the overexpenditure? How much did utility usage and cost increase from this fiscal and the 2021-22 year?

The report states that the carbon tax was one aspect of unexpectedly high utility costs. What proportion of the expense was specifically due to the carbon tax, and why was this tax an unexpected expense? Please explain.

Could the ministry also describe the reasons for the unexpected costs resulting from the Swan Hills Treatment Centre and what actions are in place to mitigate those expenses?

Thank you.

**The Acting Chair:** I see no other comments from the Official Opposition.

I will turn it over to government for three minutes. Thank you.

**Ms de Jonge:** Thank you. Page 17 of the annual report talks about improving health care access for underserved populations and initiatives undertaken to attract physicians. Can you outline the programs in place during 2022-23 to attract international medical graduates to Alberta? Can you please provide a detailed explanation of AHS policies and processes regarding sponsorship of IMGs for practice-readiness assessments in order to be registered on the provisional register? And can you specifically expand on how AHS decides to sponsor IMGs for both urban and rural family medicine positions requiring RPAPs?

**Mr. Rowswell:** Thank you. I'll continue on from there. Pages 51-52 highlight the work the ministry in AHS has done to improve health care access and outcomes for rural Albertans and communities. It is a priority for this government to better attract and retain health care professionals in rural areas. Two of the programs outlined on pages 51 and 52 include rural education supplement and integrated doctor experience reside programs as well as the rural health professionals action plan. Can the ministry please explain the difference between these two programs and how they interact as part of the comprehensive strategy to help attract and retain health care professionals in rural Alberta? How successful have these and other programs been in retaining health care professionals in rural Alberta and what metrics have been used to track this success?

A key responsibility of the ministry is to strengthen Alberta's health care system by implementing programs and policies which support public health and improve the general health and well-being of all Albertans. Page 46 of the annual report states that "in 2022-23, $646 million was [spent] to support population and public health initiatives." I'd like to discuss a couple of these in more detail. Can the ministry provide more detail on what was done in 2022-23 to prevent injuries and chronic disease, referenced on pages 46 and 47? Page 47 of the report discusses the expansion of the insulin pump therapy program to include newer pumps and supplies. Can the ministry please detail some of the benefits of this program as well as feedback they have received from Albertans since the program's implementation?

Last fall saw one of the highest rates of influenza in the province's history. What steps did the department take to ensure the efficient delivery of flu shots last season, and how successful were these efforts?

I think I'll stop there. Thank you very much.

**The Acting Chair:** Thank you very much, everyone.

I will simply ask if there are any closing remarks from the department officials or any final follow-up that you might want to get on to the record before we close this meeting.

**Mr. Tremblay:** I just really appreciate the opportunity to talk about issues that are of common interest to the entire collection of people in the room and really appreciate the respectful conversation today.

Thank you very much.

**The Acting Chair:** Great. Thank you very much, Deputy Minister, and thank you to all of the officials from the Ministry of Health, AHS, the office of the Auditor General for their participation, responding to the committee members' questions, and thank you in advance for written responses. I've had the opportunity to review written responses that have been submitted by the Ministry of Health in the past, and I know they are done with great diligence, so we appreciate that. We do ask that any outstanding questions be responded to in writing within 30 days and forwarded to the committee clerk.

That concludes the first business meeting portion of our 31st Legislature. Thank you, committee members. As per the agenda I will just ask if there are any other items for discussion under other business.

Seeing none, I will just remind committee members that the next business meeting of the committee will be with the Ministry of Energy and Minerals and the Alberta Energy Regulator after the budget estimates debate has concluded. The end of estimates: we don't know that date just yet, so this will all come once we have a better sense of that schedule.

I would also remind committee members that we do have a final orientation session with the Canadian Audit and Accountability Foundation that we are planning to have in February. The chair will call the date shortly on that.

At this point I will call for a motion to adjourn. Would a member move that the meeting be adjourned?

**Mr. McDougall:** So moved.

**The Acting Chair:** MLA McDougall. Thank you very much.

All those in favour? Opposed? We are adjourned.

Thank you, everyone.

[The committee adjourned at 11:57 a.m.]

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