April 24, 2020

The Ministry of Health's Written Responses to Outstanding Questions from the February 11, 2020 Public Accounts Meeting

Question/Request:
Could AHS provide the Committee with a list of all AHS locations in 2018-19 that provided services of limited clinical value and how many procedures were done at each of those facilities in terms of breast reductions and tubal ligation? (PA-117)

Response:
- Procedures of a limited clinical value are defined as "procedures where the evidence of clinical effectiveness is deemed to be weak or absent". Many times, alternate therapeutic approaches exist that reduce the risk of patient harm and promote more efficient use of operating room capacity.
- Attachment 1 provides the data requested for those procedures referenced in the question; but, without further review, AHS is unable to confirm whether they were of low value. AHS would need to understand the specific indications for the procedure to determine if clinical benefit would have been anticipated.
- AHS and its clinicians are constantly evaluating the appropriateness of treatments and testing in order to ensure that patients get the most appropriate care to address their health issues.
- Ultimately, the decision regarding whether a particular procedure or course of treatment is the right choice for a patient is between a patient and their healthcare provider.

Question/Request:
Could officials provide a list of the 83 hospitals in rural Alberta identified by the Ernst and Young report and provide the Committee with some data on the activity levels in each of those emergency departments? In particular, I'm curious about how many patient visits there were on average per day, per month, and for the 2018-19 fiscal year. (PA-117)

Response:
- Please view Attachment 2 for the summary of Small Community Hospital Visits for 2018/19 fiscal year.

Question/Request:
Could officials from AHS provide a list of all of the long-term care beds that are currently operated by Carewest and Capital Care during the fiscal year 2018/19, including the location and the number of those beds? (PA-117)

Response:
- The list requested on all long-term care beds currently operated by Carewest and Capital Care is below.

CAREWEST - BEDS BY FACILITY

BEDS STAFFED & IN OPERATION SUMMARY as of March 31, 2019

Alberta Health Services

					LONG TERM CARE (LTC)			DESIGNATED SUPPORTIVE LIVING (DSL)				
Zone #	Facility Name	Location	Designated Sub-Acute in Long Term Care	Community Palliative & End of Life Care	Auxiliary Hospital	Nursing Home	Long Term Care (LTC) Total	DSL4-Dementia	DSL4	DSL3	Designated Supportive Living (DSL) Total	Total Beds
	CAREWEST											
2	Carewest Colonel Belcher	Calgary	-		175		175		30		30	205
2	Carewest Dr. Vernon Fanning Centre	Calgary	98		191		191				-	289
2	Carewest Garrison Green	Calgary	-			200	200				-	200
2	Carewest George Boyack	Calgary	-			221	221				-	221
2	Carewest Glenmore Park	Calgary	147				-				-	147
2	Carewest Nickle House	Calgary	-				-		10		10	10
2	Carewest Rouleau Manor	Calgary	-			77	77				-	77
2	Carewest Royal Park	Calgary	-			50	50				-	50
2	Carewest Sarcee	Calgary	35	15	46	39	85				-	135
2	Carewest Signal Pointe	Calgary	-			54	54				-	54
	Carewest Total		280	15	412	641	1,053	-	40	-	40	1,388

Prepared by Strategy, Accountability & Performance
February 26, 2020

CAPITALCARE - BEDS BY FACILITY

BEDS STAFFED & IN OPERATION SUMMARY as of March 31, 2019

Alberta Health Services

					LONG TERM CARE (LTC)			DESIGNATED SUPPORTIVE LIVING (DSL)				
Zone #	Facility Name	Location	Designated Sub-Acute in Long Term Care	Community Palliative & End of Life Care	Auxiliary Hospital	Nursing Home	Long Term Care (LTC) Total	DSL4-Dementia	DSL4	DSL3	Designated Supportive Living (DSL) Total	Total Beds
	CAREWEST											
2	Carewest Colonel Belcher	Calgary	-		175		175		30		30	205
2	Carewest Dr. Vernon Fanning Centre	Calgary	98		191		191				-	289
	CAPITALCARE											
4	CapitalCare Dickinsfield	Edmonton	-		175	100	275				-	275
4	CapitalCare Adult Duplexes (Dickinsfield)	Edmonton	-				-			14	14	14
4	CapitalCare Grandview *	Edmonton	34		147		147				-	181
4	CapitalCare Laurier House Lynnwood	Edmonton	-				-		80		80	80
4	CapitalCare Lynnwood	Edmonton	-		248	28	276				-	276
4	CapitalCare McConnell Place North	Edmonton	-				-	36			36	36
4	CapitalCare McConnell Place West	Edmonton	-				-	36			36	36
4	CapitalCare Norwood **	Edmonton	114	23	68		68				-	205
4	The Dianne and Irving Kipnes Centre for Veterans	Edmonton	-		120		120				-	120
4	CapitalCare Laurier House Strathcona	Sherwood Park	-				-		42		42	42
4	CapitalCare Strathcona	Sherwood Park	-			111	111				-	111
	CapitalCare Total		148	23	758	239	997	72	122	14	208	1,376

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* Grandview - LTC Auxiliary Hospital numbers include 11 Restorative Care spaces
** Norwood - Designated Sub-Acute LTC numbers include 29 Sub-Acute spaces, 45 Restorative Care spaces, 40 Transition Unit spaces.
** Norwood - LTC Auxiliary Hospital numbers include16 Restorative Care spaces

Question/Request:
Could officials provide a list of all of the long-term care facilities, the number of beds in each facility, and an estimate of the costs at each facility for the use of nonprescription medications for the fiscal year 2018-19? (PA-117)

Response:
- Please view Attachment 3 for table of long-term care facilities, number of spaces and non-prescription drug spending for 2018/19.

Question/Request:
What is the total sum that was spent during the fiscal year 2018-19 on capital purchases related to diagnostic imaging and can we get a list of all the equipment that was purchased and which AHS sites that equipment went to? (PA-117)

Response:
- $21,741,295 is the total sum spent during the fiscal year 2018/19 on capital purchases related to diagnostic imaging.
- Please view Attachment 4 for the list of the equipment that was purchased and to which sites the equipment went.

Question/Request:
About 30 percent of the (diagnostic imaging) equipment that was nearing the end of its useful life and quite a few others were needing replacement. Were we able to make progress on that during the 2018-19 fiscal year? (PA-117)

Response:
- Please view Attachment 4 for the list of diagnostic imaging equipment that was purchased in 2018/19 to replace equipment near their end of useful life.

Question/Request:
In relation to unavoidable growth pressures: what was the Ministry's assumption in 2018-19 in terms of what the costs would be for unavoidable growth pressures in total? What was your estimate on the combination of population increase, demographic changes, and inflation in percentage terms as it applies to the Ministry of Health budget and the AHS budget, assuming roughly flat levels of service, both as a summary and broken down as separate amounts? (PA-117)

Response:
- The Ministry of Health considers a number of unavoidable growth pressures when preparing its budget. These include population growth, demographic trends (e.g., an aging population, changes to the unemployment rate) and general inflation. The Ministry also incorporates other factors, such as cost drivers related to technology shifts (e.g., the addition of new, high-cost drugs to the public formulary) and/or changes in service utilization patterns (e.g., trends in the number of physician visits per person) into the budget; however, these are projected at the individual program level, not Department-wide.

- For Budget 2018, population was projected to grow by 1.4 per cent, inflation (Alberta Consumer Price Index) by 2.1 per cent (Source: Economic Outlook Chapter of the Fiscal Plan) and seniors population by 4.4 per cent (Source: Alberta Population Projections [2017-2041, Medium Scenario], Alberta Treasury Board and Finance). The Ministry of Health's consolidated 2018 budget was $22.1 billion, an increase of $634 million or 3 per cent over the 2017/18 third quarter (Q3) forecast, and AHS' budget was $15.2 billion, an increase of $396 million or 2.7 per cent over the 2017/18 third quarter forecast. A combination of Operational and Clinical Best Practice initiatives at AHS, a new funding arrangement between the province and the Alberta Pharmacists' Association, and a pan-Canadian Agreement on generic drug prices helped to keep the Ministry and AHS' budget growth below population plus inflation.

- It is not possible to provide the precise contribution of each unavoidable growth pressure to the Ministry's overall budget, since the budget is prepared by combining individual program estimates that weight the various pressures differently. For example, the main contributor to expense growth for the Seniors Drug Program is the number of Albertans that are seniors, whereas the Department's low-income benefit programs are linked to the unemployment rate and overall population growth. This is further complicated by the fact that the final budget also incorporated cost avoidance measures, which are also calculated at the individual program level.

- The Canadian Institutes for Health Information (CIHI) has examined the relative share of average annual growth in Canadian public-sector health spending. For 2018, CIHI estimated that 39.5 per cent of growth was due to general inflation, 32.6 per cent to population growth, 18.6 per cent to aging and 9.3 per cent to other factors (National Health Expenditure Trends, 1975 to 2019).

Question/Request:
What information would you have on the differences in costs in the 2018-19 year on similar or identical (laboratory) tests performed between the private provider and the public providers within Alberta? (PA-118)

Response:
- The comparison between the public laboratory services provider and the private laboratory services provider is complex. The current laboratory services contract with the private provider is structured as a "basket of services" contract that increases three percent each year. Costing of the private services contract is very high level, arriving at an average cost per test calculated by dividing the overall contract cost by the number of tests performed. With these limitations in mind, the following is an attempt to compare the average cost per test of the private and public laboratory services providers prior to the formation of Alberta Precision Laboratories.

Basket of Services	DynaLIFE	CLS
Patient Service Centers	√	√
Transportation/Courier	√	√
Hub Lab	√	√
Hospital/Urgent Care Lab	n/a	excluded
Specialized and Complex Testing	n/a	excluded
Referral Testing (Rural)	√	√
Pathologists	√	√
Administration	√	√
Lease	√	√
Amortization	√	√
Profit	√	n/a

- Information from 2014-15 is the most recent data AHS has available. The difference in pricing could be attributed to the testing performed at each site. Calgary Lab Services (CLS) testing includes tests coming from acute care settings which often have a higher percentage of abnormal results that precipitate the need to do further testing. DynaLIFE's percentage of acute care patient testing is lower than CLS'.

Year	DynaLIFE		CLS	
	Cost/Test	**No. Tests**	**Cost/Test**	**No. Tests**
2014/15	$7.25	16.0M	$7.62	17.8M
2013/14	$6.76	15.8M	$7.73	16.4M
2012/13	$6.81	15.1M	$7.59	15.7M

Question/Request:
What is the cost-effectiveness for a typical patient in an ALC bed versus what it would be for a complex care patient in these two new facilities (Bridgeland and Norwood)? (PA-121)

Response:
- Alternate Level of Care (ALC) patients may reside in a number of locations. AHS tries to avoid having ALC patients in acute medicine or surgery units. These units are staffed for acute care patients at the rate of about $800 - $1,000 per day.
- AHS has Transition or ALC units in some hospitals which are staffed for individuals who are awaiting admission to community based care options. These units are staffed at the rate of about $450 per day.
- Complex Care units in the proposed Bridgeland or Norwood sites could serve a variety of needs for clients who are presently waiting in acute care on ALC status. These units are staffed at the rate of about $250 - $550 per day, depending on the level of complexity of the individuals needing care and service.

Question/Request:
In relation to overdose prevention, or harm reduction initiatives around opioids, how many lives were saved during the 2018-19 fiscal year and how many referrals were made as well? (PA-121)

Response:
- Between April 1, 2018 and March 31, 2019:
  - 3,037 overdose events were managed by staff at Alberta's seven supervised consumption services sites;
  - 344 overdose events were managed by staff at the Red Deer overdose prevention site; and
  - 2,210 naloxone kit overdose reversals were self-reported province wide.
- Alberta's seven supervised consumption services sites also facilitated over 21,000 referrals, which include, but are not limited to, referrals to detox, opioid dependency treatment, shelter programming/housing, social work and urgent care.

Question/Request:
Can you expand on what was done in terms of breast cancer surgeries, hip fracture repair surgeries, and some of the others where there was a particular emphasis to ensure that wait times were reduced? What were some of the strategies, and how did those benefit patients? (PA-121) Also please provide information regarding funding spent on improving the quality improvement initiatives and to expand on the NSQIP program, the expansion from five sites to 16 sites. (PA-121, 122)

Response:
In 2018/19, Alberta Health Services (AHS) used a combination of strategies to decrease wait times for surgeries. These strategies included increasing volumes of certain surgical and cancer care procedures or treatments, expanding quality improvement programs and streamlining breast cancer care with standard pathways.

- Increased volumes and treatments. In 2018/19, AHS targeted approximately $40 million in investments from within their global budget to address wait times by funding additional surgeries for cancer, cardiac, cataract, and orthopedics. The funding was also used to hire additional staff and expand treatment hours to reduce wait times for post-operative cancer care and non-surgical cancer treatment and follow up. At the end of 2018/19, the number of patients receiving care increased by:
  - 10 per cent for follow-up cancer care;
  - Seven per cent for radiation treatment; and,
  - Six per cent for systemic treatment.

- Quality Improvement. A portion of the $40 million investment also went to expanding quality improvement in surgery. To reduce variation in surgical practice, decrease length of stay and increase quality surgical care, the National Surgery Quality Improvement Program (NSQIP) was expanded from five sites to all 16 major surgical sites (the 14 largest hospitals and two pediatric hospitals).

- A 2015 NSQIP pilot program at five AHS sites improved surgical efficiency and patient outcomes achieving cost savings of approximately $4.30 for every $1 invested.
- NSQIP reduces readmissions and lengths of stay, which frees up bed capacity for other patients.

- The allocation of the $40 million investment is detailed in the table below.

Procedure/Initiative	Zone(s)	Investment (Million)	Target additional surgeries	Notes
Cancer surgeries	Provincial	$12.5	1,284	Completed 1,946 by May 2019
Cardiac open heart surgeries	Calgary	$6.6	221	Completed 221 by June 2019
Orthopedic – Hip and knee arthroplasty	South, Central	$2.2	194	Completed 204 by March 2019
Orthopedic – spine / foot / knee surgeries	Edmonton	$1.6	113	Completed 150 by October 2018
Cataract surgeries	North	$0.02	30	Completed 299 by October 2018
Post-operative cancer care	Provincial	$11.3	Not applicable	Increased capacity
Cancer care – non-surgery follow up and treatment	Provincial	$2.3	Not applicable	Increased capacity
Quality improvement initiatives	Provincial	$4.4	Not applicable	National Surgery Quality Improvement Program (NSQIP) expanded to all 16 major surgical sites.

- Breast cancer standard pathways. AHS has made a number of improvements to care and wait times across the breast cancer patient journey since 2016 with the End-to-End Breast Cancer Pathway.
  - The pathway added a new focus on improving processes for genetic testing, multidisciplinary case conference reviews of complex subpopulations and a provincial measurement framework for the pathway.
  - Patient navigation within the Comprehensive Breast Cancer Program was improved with patient-designed processes and navigation services.
  - The proportion of same-day mastectomies was 49 per cent for the first three quarters in 2018/19. This represents an eight per cent increase over the same period in 2017/18 (41 per cent) and a 22 per cent increase over 2016/17 (27 per cent).

Question/Request:
Can you provide information on how much higher perinatal mortality rates are for Indigenous and First Nations people is that non-indigenous people? (PA-122)

Response:

Performance Measure		2014–15	2015–16	2016–17	2017–18	2018–19	2017–18 Target	2018–19 Target	2019–20 Target
Perinatal Mortality rate among First Nations (number of stillbirths and deaths in the first week of life per 1,000 total births)	First Nations	10.5	10.7	9.7	8.4	8.66	Reduce gap between First Nations and Non First Nations populations		
	Non First Nations	5.7	5.3	4.7	5.5	5.41			
	Gap	4.8	5.4	5.0	2.9	3.3			

Source: Alberta Health Services, 2017-2020 Health Plan and Business Plan (page 16)

Question/Request:
It was indicated that there was about $3.7 million spent each year in audit recoveries: how much was spent on the audit function? (PA-123)

Response:
- Between fiscal years 2013/14 to 2018/19, Alberta Health recovered an average of $3.7 million annually after overpayments to physicians were identified during physician billing audits and compliance reviews. The cost to Alberta Health to employ staff to support the audit process is approximately $2.2 million annually. There were no non-salary expenses associated with audits and compliance reviews in 2018/19.

Question/Request:
In the event that there was an audit discovery of an overbilling, what monetary penalties were imposed in those cases? (PA-123)

Response:
- Practitioners are required to repay the estimated overpayment, plus an annual rate of eight per cent simple interest. Interest is calculated monthly based on the outstanding amount owing. No other monetary penalties were imposed.

Question/Request:
Would you be able to provide the Committee with comparators in terms of looking at physician compensation growth versus population growth? (PA-123)

Response:
- Physician compensation grew from $5,164 million in 2017/18 to $5,406 million in 2018/19 for an annual growth rate of 4.7 per cent. From 2017 to 2018, actual population growth was 1.5 per cent (Source: Statistics Canada and Alberta Treasury Board and Finance). For the past five years, the average annual growth rate in Physician Compensation and Development spending was 4.9 per cent while growth in the Alberta population averaged 1.3 per cent per year.

Question/Request:
Was there an increase in funding put into programming to ensure that First Nations people had appropriate access to medical care directed toward their particular needs in 2018-19? (PA-124)

Response:
Below is a list of the projects AHS commenced in 2018/19 to help improve appropriate health care access for First Nations people.

- Urban Opioid Emergency project – To support efforts and programming with specific attention to the Indigenous Urban Opioid community. (March 2018 to March 2020 - $250,000 annually for two years).
- Honoring Life Program (formerly Aboriginal Youth and Communities Empowerment Strategy) – To focus on higher priority communities to support First Nation and Metis communities in suicide prevention, mental wellness and healthy lifestyle promotion. (October 2018 – $5,000,000 annually for three years).
- The First Nations Prevention and Screening Practices project has implemented a First Nations Support Team to increase skills and capacity in First Nations communities. (2018/19 - $767,252)
- Alberta Screening and Prevention (ASaP) in High Needs Settings – Adapt ASaP to the needs of primary care settings that primarily serve Indigenous patients and work with the AHS Indigenous Health Program to scale it up to through the Indigenous Alternative Relationship Plan. (2018/19 - $70,443).
- Three grants have been awarded to AHS from the Canadian Partnership Against Cancer. The primary goal of these initiatives is to develop an Alberta Indigenous Cancer Strategy.
- SCN Indigenous Health and Safe Healthy Environments partnered with the Maskwacis Health Services to attract a grant of $50,000 for a radon housing project, identifying dangerous levels of radon and the remediation of homes on Louis Bull and Samson First Nation Lands.
- Community Helpers Program (CHP) - Safe Healthy Environments received a term-limited grant to expand the CHP to three additional sites. Funded for three years, each site must focus on specific populations such has high risk youth. Indigenous youth are represented in all of the target populations.
- Wabasca Nurse Practitioner Discovery Project - To improve service delivery and to address gaps and barriers with access to timely service for Indigenous peoples. The four priority areas for the members of Bigstone Cree Nation were:
    1. Addictions and Mental Health,
    2. Diabetes,
    3. Decrease the number of communicable disease in the community,
    4. Develop a comprehensive injury prevention program.

  (May 2018 to March 2020 - $300,000 annually for two years.)
- STBBI (Sexually Transmitted Blood Borne Infections) Outreach - To enhance STI outreach in the provincial STI program to support increased access to testing, treatment and linkage to care for vulnerable populations who are most at risk for STBBI. Targeted population includes Indigenous people. (October 2018 to December 2019 - $1,000,000 total).

Question/Request:
In 2018-19, are there any other demographics that have been identified as a higher risk of smoking addiction outside of the youth component? (PA-125)

Response:
- Since reporting at the Public Accounts Meeting that Alberta's teen vaping rate (used in past 30 days) rose from eight per cent in 2014/15 to 22 per cent in 2016/17 among students in grades 10 to 12, new data from the Canadian Student Tobacco, Alcohol and Drugs Survey show that Alberta's teen vaping rate increased to 30 per cent in 2018/19.
  - Vaping products containing nicotine can result in nicotine addiction, particularly in youth.
  - As well, vaping can model and renormalize smoking behaviour among youth. Some studies have found an association between vaping and smoking, suggesting that youth who vape have an increased risk of subsequent smoking.
- Addiction to tobacco is the leading cause of preventable illness, disability and death in Alberta, and the prevalence of smoking in Alberta is second highest in Canada.
  - In 2018/19, 15.6 per cent of Albertans aged 18 years or older indicated they smoked cigarettes daily or occasionally.
- Vulnerable populations are disproportionately more likely to use tobacco.
  - The prevalence of smoking among Indigenous peoples is two to five times higher than among non-Indigenous people.
  - Smoking is prevalent in the lowest income groups and a leading cause of health inequalities. In 2017, among households within the lowest income quintile, over one in five were smokers (21.7 per cent), compared to households in the highest quintile where just over one in ten were smokers (11.9 per cent).

Question/Request:
In relation to the $65 million project to build a new emergency department at the Misericordia Hospital, would you give a bit of context to define the need? How many visits per day was the existing emergency department designed to serve? (PA-126)

Response:
- Due to the population increasing and changing demographics in the surrounding communities and the Edmonton Zone, the Misericordia Community Hospital (MCH) has experienced an increase in emergency room visits. Originally designed for 25,000 visits annually, it now sees double that number averaging 50,000 visits per year, with 50,600 visits in 2017/2018 and 48,527 visits in 2018/2019.
- The current aging infrastructure, size and design of the emergency department (ED) presents challenges to meeting increasing patient volumes and modern care requirements. Over the past several years, the MCH has implemented several initiatives focused on reducing overcrowding, improving overcapacity management, supporting vulnerable patient populations, and improving throughput and transition of patients.
- The new ED offers the opportunity to develop innovative approaches integrated with community care to improve access and service, and to make the best use of hospital

and community-based resources. It will be based on best practice with current architectural standards to design a patient-centred department with enhanced privacy, safety, and efficiency. The expanded ED will be 5,000 square meters (up from 1,700 square meters), have six ambulance bays (up from four), two radiology rooms and increased capacity up to 60,000 annual visits.

Question/Request:
Can you say how much money has been invested so far in the planning for the emergency department construction at the Misericordia Hospital? (PA-126)

Response:
- The spending on the Misericordia Community Hospital emergency department expansion project to date is $3,130,376.

Question/Request:
In relation to labour and delivery events, particularly outside the major cities, what is the demand around the province and whether that is increasing or not? What are the types of delivery? (PA-127)

Response:
- Please view Attachment 5 for a list of the labour and delivery events from 2014/15 to 2018/19 by hospital, local geography area and delivery mode.

Question/Request:
How many physicians were indeed using complex modifiers in 2018-19, what the ancillary costs are from that, and any numbers that were involved in that regard? (PA-129)

Response:

Complex Modifier	**# of Physicians That Used Complex Modifiers**	**# of Times Complex Modifiers Were Used**	**Billing Costs associated with Complex Modifiers**	**Business Cost Program Costs *(Est.)****	**Total Costs *(Est.)***
CMGP-01	4,557 *97% of eligible*	7,100,739 *54% of eligible claims*	$196,991,692	$31,655,081	$228,646,773
CMXC30	7,256 *91% of eligible*	2,257,694 *50% of eligible claims*	$70,750,484	$6,660,197	$77,410,681
CMXV	4,743 *68% of eligible*	947,573 *34% of eligible claims*	$21,431,124	$2,795,340	$24,226,464
Total	**7,690 *(Distinct Count)***	**10,306,006**	**$289,173,300**	**$41,110,618**	**$330,283,918**

*Business Cost Program payment of $2.92 was paid on each complex modifier call on top of the modifier rate in the Schedule of Medical Benefits.
Source: Alberta Health Physician Claims Dataset

Question/Request:
Could you identify the number of physicians that were indeed part of the $3.7 million recovery and any numbers you would have in regard to how many physicians are in fact overbilling and the related dollar amounts? (PA-129)

Response:
- Audits completed between 2013 and 2018 identified an average $3.7 million in recoveries annually. The average number of reviews per year during this time period is 33.5, and the number of physicians reviewed annually varied from 27 to 42.

Question/Request:
In regard to compensation versus population growth, in 2018-19, what demographic shift would there also have been amongst the population that might have also driven those factors? (PA-129)

Response:
- Aging is one of the factors that correlates with increased health needs.
  - In Alberta, the elder population (aged 65 and above) grew from 525,317 in 2017 to 551,682 in 2018 at an annual growth rate of five per cent (Source: Statistics Canada and Alberta Treasury Board and Finance). This growth rate exceeds the growth of the general population resulting in an increasing proportion of Alberta's population being aged 65 and above.
- The average Fee for Service utilization per capita for seniors was $1,881 compared to that for the younger population (age below 65), $842, in 2017/18.
- Alberta still has the youngest population among all the provinces in Canada with the median age of 37.1, compared to 40.8 for Canada (Source: Statistics Canada, Population estimates on July 1, 2019).

Question/Request:
In terms of diagnostic imaging for 2018-19, how was the additional funding provided for diagnostic imaging applied, and what was the effect on the wait-list numbers for 2018-19? Were there any efforts made or consideration given to physician costs for radiography and how those might be addressed in 2018-19? (PA-129)

Response:
An additional $10.3 million was provided to diagnostic imaging in 2018/19 to decrease the wait times for urgent CT and MRI.
- There was a total of 441,938 CT scans performed in 2018/19, which included scans completed with supplemental funding.
  - An additional $6.4 million was allocated to urgent CT scans with the target of adding 24,800 CT scans by March 31, 2019. AHS completed an additional 34,111 CT scans in 2018/19 with this funding.
    - 83 per cent of Priority 1 patients received their CT scan within the 7 day guideline. This increased from 69 per cent in the previous year.
    - 61 per cent of Priority 2 patients received their CT scan within the 30 day guideline. This increased from 46 per cent in the previous year.

    - The average urgent CT wait time for 90 per cent of patients dropped from 14 days to 9 days (March 31, 2018 to March 31, 2019, respectively).
    - There was a total of 35,491 Albertans waiting for a CT scan March 31, 2018 and 34,627 waiting March 31, 2019.
- There was a total of 204,744 MRI scans performed in 2018/19, which included scans completed with supplemental funding.
  - $3.9 million was allocated to urgent MRI scans with the target of 12,600 MRI scans by March 31, 2019. An additional 2,981 scans were completed. The discrepancy was due to late receipt of funding (August 2018) and the inability to hire and scale up AHS operations for MRI scans.
    - 64 per cent of Priority 1 patients received their MRI scan within the 7 day guideline. This increased from 50 per cent in the previous year.
    - 41 per cent of Priority 2 patients received their MRI scan within the 30 day guideline. This increased from 34 per cent in the previous year.
    - The average urgent MRI wait time for 90 per cent of patients dropped from 40 days to 14 days (March 31, 2018 to March 31, 2019, respectively).
    - There was a total of 56,278 Albertans waiting for an MRI scan March 31, 2018 and 60,189 waiting March 31, 2019.
- In 2018/19, efforts were underway to decrease radiologists' fees through contract negotiations. In most sites in Edmonton and Calgary, this negotiation led to an 11.64 per cent decrease in fees, to be implemented over two years.
  - In collaboration with Alberta Health Services, Alberta Health has created a Diagnostic Imaging Action Plan, which aims to manage costs, wait times, and the demand for CT and MRI scans. Two of the actions, Action 1: Alberta Health Services reduce radiologists' fees to align with those of peers in comparator provinces and Action 3: reinvest savings in diagnostic imaging to support sustainability, will drive down the costs of CT and MRI scans and improve health system sustainability.

Question/Request:
Could the Committee get any numbers on changes in ratios or staffing in acute care, long-term care, all other forms of hospital care? (PA-129)

Response:
- Staffing ratios are a measure of the number of patients cared for per staff member. A comparison of staffing ratios for 2016/17 to 2017/18 for Alberta, using available CIHI data, shows the overall ratios have changed from 3.86 patients to staff member to 3.89 patients to staff member. In comparison, British Columbia's staffing ratios for 2016/17 and 2017/18 are 4.42 patients to staff member and 4.40 patients to staff member respectively (see below). The 2018/19 data has been submitted to CIHI and will be available in Summer 2020.
- Please view Attachment 6 for the 2018/19 data which indicates the staffing ratios.

Question/Request:
What amounts were invested in improving community care in rural areas? (PA-129)

Response:
- Compared to 2017/18, the budget for rural community based care increased by $68 million (seven per cent) in 2018/19. The budget in 2017/18 was $948 million and in 2018/19 was $1,016 million. Included in this are the changes in Community Based Care, Home Care, and Continuing Care financial statement budget categories.

Question/Request:
What is the number of Albertans under 65 years' of age who have developmental disabilities who may be in long-term care? (PA-129)

Response:
- Approximately 320 in 2018/19.

Question/Request:
In relation to the Ernst and Young report: when do you anticipate that you will be able to come up with the implementation of this plan within the next hundred days? (PA-129)

Response:
- As announced by the Minister of Health, the original plan was for AHS to provide its implementation plan to the Minister on May 13; however, due to the COVID-19 pandemic, this date has been extended by three months, to August 13, 2020.

Question/Request:
For fiscal year 2018-19, how many full-time equivalents (FTE) does Alberta Health Services have allocated for rural mental health? (PA-129)

Response:
- 2018/19 AMH Rural Zone Budgeted Positions

Zone	Total FTE
Central	1,059.19
North	535.12
South	458.06

Question/Request:
Can you please provide data showing the number of agricultural producer suicides in Alberta over the last five years? (PA-129)

Response:

- Alberta Health does not have data at the requested level of specificity. Broader data categories are reported by next of kin, if reported at all, and therefore not reliable.

Question/Request:
Can you shed light on how much it costs for the distribution of more than 137,000 naloxone kits and if these kits and their costs have proven beneficial in addressing opioid-related overdoses? (PA-129)

Response:
- From January 1, 2016 to March 31, 2019, the provincial naloxone program dispensed 146,892 naloxone kits in Alberta, with 9,386 overdose reversals self-reported.
- Alberta's provincial naloxone program has been supported through grant funding since 2015.
- In 2018/2019, over 90,000 injectable naloxone kits were distributed under two grants valued at $4,505,966 (includes cost of purchasing the kits):
  - Alberta Health Services: $3,455,966
  - Alberta Community Council on HIV: $1,050,000
- In 2018/2019, there were 22,781 claims from pharmacies for distribution of naloxone kits with an associated cost for dispensing fees (not purchasing) of $276,785.
  - Pharmacies receive the kits from AHS via their distribution grant above.

Question/Request:
If your largest cost driver lacked appropriate internal controls, unaddressed for five years, what steps could you take specifically to accelerate the timetable to put in the internal controls requested by the Auditor General for physician compensation? (PA-129)

Response:
- The Office of the Auditor General (OAG) finding determined Alberta Health audits physician billings it believes to be of higher risk but does not have a process to ensure payments to the remaining part of the physician population were billed correctly.
- The OAG recommendation directed Alberta Health to enhance processes to check whether patients received medical services for which physicians billed the department.
- In response, the department has developed a plan to conduct a pilot project in which 10 physicians will be randomly sampled. Data analysis will be performed on 100 per cent of the claims those physicians submitted over a one-year period, and a sample of patient charts will be reviewed for compliance.
- The department is taking this approach as consulting with patients to determine if they received services has been attempted by Health in past with poor results.

Question/Request:
In relation to First Nations life expectancy, being based on small samples: given how unreliable the data is, how effective is this performance measure and what is the ministry doing to make sure that it better understands First Nations life expectancy so that we are in a better position to improve it? (PA-129)

Response:
- Life expectancy is the most commonly used measure of overall health status in the world because it is a measure of the general health of all people in the population, rather than just a specific subset (such as infant mortality or child mortality).

Furthermore, it is a broad outcome measure that is influenced by not just the health system, but economic, social, genetic, and environmental factors as well.

- Although the First Nations population is small relative to the non-First Nations population, these estimates are accurate for comparisons. While some data limitations exist when compiling life expectancy of First Nations people, Alberta Health is confident that life expectancy estimates provide a reasonable indication of population health for First Nations people in Alberta.
- The First Nation population in Alberta is large, with more than 165,000 Indigenous citizens. In 2018, the life expectancy gap between First Nation and non-First Nation populations was over twelve years, which is a statistically significant difference.
- While the Department is currently unable to identify First Nations people who moved to the province since 2009, we are confident that historic identifiers derived from the Alberta Health Care Insurance Plan and postal code information, continue to capture the majority of First Nations people living in the province.
- We are working with First Nations partners, and Indigenous Services Canada to ascertain effective ways to identify First Nations people within health databases. We are also working with our partners to explore the key drivers contributing to gaps in life expectancy between First Nations and non-First Nations people in Alberta, with the aim of identifying targeted approaches to addressing inequities.
- Alberta Health has developed a partnership and provides funding to the Alberta First Nations Information and Governance Centre, to support capacity development of First Nations data collection and reporting.
  - This partnership has resulted in publication of regular the First Nations data reports called 'Health Trends', which are publicly available and examine the incidence and prevalence of chronic disease, injury, morbidity and mortality rates.
  - 'Opioids and Substances of Misuse among First Nations People in Alberta' (2017) includes information on opioid use, and opioid-related deaths.
  - Work is currently underway to produce a report assessing Alberta First Nations' health status.

Question/Request:
What are you doing to ensure that practitioners such as optometrists, pharmacists, PCNs, including the use of the 811 line, reduce emergency room visits? (PA-130)

Response:

- AHS Emergency Departments do not currently utilize the services of optometrists, however pharmacists are important members of the health care team providing advice to clinicians and patients about the right drug at the right time via the right route, including the most cost effective therapy.

PCN after hours:

- In September 2018, the Alberta Medical Association conducted a survey of PCNs related to extended hours and after-hours programs and supports. Based on the definitions of extended and after-hours services at the time:
  - 24.4 per cent of PCNs had after-hours programs
  - 38.5 per cent of PCNs had extended hours programs
  - 40.2 per cent of clinics independently offered extended hours

    - Both urban and rural models offered on-call programs and some extended hours in individual clinics (only in larger rural locations)
    - Rural models implemented locums and ER coverage/utilization
- Definitions of extended and after-hours access that take a provincial direction were developed by the Access and Continuity Task Group, and endorsed in February 2020. There are not yet any statistics of PCN extended or after-hour services based on the renewed definitions.
  - After-hour access: "Provision of coordinated 24/7 management of access to appropriate primary health care services when the practice is closed or when the Albertan's primary care provider, or a provider who is part of their functional group, is unavailable. After-hour access involves, at a minimum, triaging needs to ensure access to urgent care that would normally be performed by a primary care provider. This includes provisions for informational continuity."
  - Extended hour access: "Additional hours of regular, day-to-day, primary care services provided outside of regular business hours (8:00am to 5:00pm, Monday to Friday), including weekends and holidays, by the Albertan's regular primary care provider, or a provider who is a member of their functional group. Extended hour services are intended to reflect the needs of the community, inclusive of the patient panel. This does not include 24/7 management of access after-hours."
- In addition, evidence suggests that the benefits of relational continuity, where Albertans have a continuous, trusting relationship with a family physician or nurse practitioner and team, include increased access to appropriate care when it is needed. A provincial continuity of care communication campaign is underway, and includes an example of a PCN initiative supported by AHS and the AMA. The Find a Doctor initiative provides Albertans who do not have a primary care provider with information on available family physicians (soon to include nurse practitioners). Patients visiting an acute care facility or ED are provided with the Find a Doctor website so they can connect with available providers, which enhances their access to primary care services, and may reduce visits to acute care for primary-care-sensitive conditions.

<u>Health Link (811)</u>:

- Health Link is a province-wide service which operates 24/7 out of two contact centers (Edmonton and Calgary) and is a service available to all Albertans by calling 811.
- Health Link provides the following:
  - Symptoms assessment and management for Albertans and guides them to the most appropriate care provider, in the right time frame, at the right location; thereby enabling safe care and encouraging appropriate use of Alberta's health care resources, such as Emergency Department and primary health care resources
  - Assistance in locating health services and health providers (such as a family doctor, community care – Aids to Daily Living or Home Care, immunization information and records, addictions mental health information and referral, influenza clinic information, wayfinding help re: laboratory services, diagnostic services, medical assistance in dying etc.).
  - Health Link works in partnership with AHS and community services to develop referral processes for follow up for callers when needed (i.e. public health, environmental health, emergency departments, AHS dietitians, Mental Health Access Teams and community support groups). In addition, Health Link works with

Primary Care Networks to refer patients to primary care services such as on-call physicians and after hour clinics.
  - Immediate response to emerging local and provincial health issues ensuring Albertans have accurate and timely access to information by phone or online. Some examples of recent emerging issues are: communicable disease outbreaks (such as COVID 19), wildfire evacuations, and health related breeches. Health Link works closely with Emergency Disaster Management to provide real-time support during emerging events. Health Link also acts as a Single Point of Contact to industry to respond to any industrial incidents which could have health impacts to the community. Having this service available 24/7 through Health Link helps avoid Albertans from making unnecessary visits to their local Emergency Department.
- In 2018/19 Health Link had 911,958 contacts. The average wait time for callers was approximately 2:00 minutes. Of those contacts, approximately 600,000 were symptom-based calls. The disposition of those calls are as follows:
  - 21 per cent advised to seek care in an Emergency Department (ED) or urgent care centre
  - 33 per cent advised to see physician or other health care provider (ex: Dentist, Pharmacist, Home Care etc.)
  - 46 per cent advised self-care with teaching to manage symptoms at home.
- Some of the referrals to ED are made due to a lack of other urgent care options available for callers. In the past year, Health Link referrals to the ED accounted for 3.9 per cent of all ED visits in Alberta.
- Health Link recently acquired the ability to link its data to ED visit data and has started to examine whether callers who are advised to go to the ED actually present to the ED. Of the Health Link patients who presented to the ED, 68 per cent were CTAS 1, 2 or 3 (high acuity). (CTAS – Canadian Triage Acuity Scale).

<u>SCN (Strategic Clinical Networks)</u>:

- <u>Improving Acute Care for Long Term Care Residents</u>:
  - The Emergency Strategic Clinical Network has partnered with Long Term Care (LTC) Facilities, Mobile Integrated Healthcare (MIH), the AHS provincial Seniors Health team, and additional stakeholders to propose a solution to improve acute care for LTC residents. Our proposed solution is a centralized and standardized LTC-ED care and referral pathway through RAAPID (Referral, Access, Advice, Placement, Information & Destination) for LTC facilities seeking transfer to ED. Assisted by INTERACT® (Interventions to Reduce Acute Care Transfers) and informed by the LTC residents Goals of Care Designation, RAAPID will identify cases suitable to be treated by the MIH program within LTC. This will help to better optimize use of both the ED and the MIH program, in a way that is patient-centered. Expected impacts include a reduction in LTC transfers to the ED per 1000 resident days, a reduction in inpatient admissions, a reduction in instances of hospital acquired infections, delirium, and cognitive and functional decline, and an annual efficiency savings of $7.44 million if implemented on a provincial scale.
- <u>Initiation of Suboxone in ED/UCC (Urgent Care Center) Referral to Community</u>:
  - Dependence on opioids is a major public health issue with increased number of Albertans impacted by addiction resulting in increased number of overdoses and death. Data shows that there are approximately 500 opioid related events occurring monthly to EDs in Alberta. Currently, there is no coordinated treatment

options for patients presenting to EDs with opioid dependency. Opioid agonist therapy (Suboxone and its generics), in combination with ongoing inpatient/outpatient therapy, is one of the most effective treatments for patients resulting in longer continuation in treatment and decreased reported usage of opioids.

- In Fall 2017, the Emergency Strategic Clinical Network launched the Suboxone Initiation program in EDs with a next day referral in the community. This program gives the health care provider a unique opportunity to provide treatment (Suboxone) to patients in EDs after screening for opioid use or a recent overdose of opioids. In conjunction with primary care, third party providers and Addiction and Mental Health outpatient clinics, the patient accepting this treatment is given an initial dose of Suboxone in the ED with instructions to follow up at one of these outpatient clinic options. Ongoing care and addiction counselling will occur and be coordinated appropriately in the community while improving repeat visits to the ED/UCC.

Pharmacists:

- Pharmacists have the ability to prescribe a restricted number of pharmaceuticals without a patient visiting a physician, which can result in a reduced number of visits to acute care or ED for these prescriptions.

Question/Request:

In relation to performance measures for clients placed in continuing care within 30 days. The results steadily declined year over year from 2014-15. What did this decline occur and what is the department doing to rectify this situation for Alberta's seniors? (PA-130)

Response:

- The proportion of clients placed in continuing care within 30 days declined yearly from 2014/15 (60 per cent) to 2017/18 (52 per cent). The results improved by six per cent to 58 per cent in 2018/19, which is a reflection of the impact of increasing facility-based continuing care spaces and enhancing home care.
- Timely access to care soon after being assessed supports the health and well-being of both the client and their family.
- To ensure timely access to facility-based continuing care, the appropriate addition of capacity in targeted communities is required each year.
- As of March 31, 2019, there were 26,914 facility-based continuing care spaces.
- The number of facility-based continuing care spaces added each year are:
  - 2014/15- 875 spaces
  - 2015/16- 962 spaces
  - 2016/17- 376 spaces
  - 2017/18- 572 spaces
  - 2018/19- 1,261 spaces

Question/Request:
How did performance decline for continue care while, according to page 49 the annual report, the continuing care budget was overspent by $18 million? (PA-130)

Response:
- Most continuing care performance areas improved in 2018/19, including:
  - Proportion of clients placed in continuing care within 30 days;
  - ALC inpatient days waiting for admission to continuing care; and,
  - Number of clients waiting for continuing care.
- AHS appears to have overspent in continuing care because there was budget allocated to community-based care that should have been allocated to continuing care.
  - To clarify, actual expenses for new spaces opened during the year were attributed to continuing care expenses, while the budget associated for those spaces remained in community-based care. Community-based care actual numbers are lower than budgeted.
  - There is explanation on page 57 of the AHS 2018-19 Annual Report.
- Actual spending for continuing care can vary from budget for several reasons, including new facilities being opened and opening dates can be earlier or later than planned.

Question/Request:
On page 49 of the annual report, administration was $12 million over budget for 2018/19 and support services over budget by $51 million. Can the department explain these specifically and comment on the examples of overspending for the most recently reported fiscal year?

Response:
- Administration was higher than the budget mainly due to higher than budgeted costs of liability insurance.
- Support services were higher than the budget mainly due to the reclassification of bad debt expense from Acute Care to Support Services to align with Canadian Institute of Health Information's Management Information System standards. Increased activity, direct and indirect costs related to the carbon levy also contributed to the variance.