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# Proceedings of the Standing Committee on Public Accounts

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Department of Health and Community Services
Eastern Regional Health Authority

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Public Accounts Committee

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Chair: Jim Bennett, MHA

Vice-Chair: Kevin Parsons, MHA

Members:

Keith Russell, MHA
Eli Cross, MHA
George Murphy, MHA
Tom Osborne, MHA
Calvin Peach, MHA

Clerk of the Committee: Elizabeth Murphy

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Appearing:

**Office of the Auditor General**
Terry Paddon, Auditor General
Sandra Russell, Deputy Auditor General
Brad Sullivan, Audit Senior

**Department of Health and Community Services**
Don Keats, Interim President and CEO
Reece Bearnes, Director of Medical Services
George Butt, VP, Corporate Services
Sharon Lehr, Chief Performance Officer
Debbie Molloy, Interim VP, Human Resources
Carmel Turpin, VP, Communications

**Also Present**
Tom Hedderson, MHA

Pursuant to Standing Order 68, Tom Hedderson, MHA for Harbour Main, substitutes for Eli Cross, MHA for Bonavista North.

The Committee met at 9:00 a.m. in the Assembly Chamber.

**CHAIR (Bennett):** Good morning, everyone.

This is a meeting or hearing of the Public Accounts Committee of the Province of Newfoundland and Labrador, and I am the Chair. My name is Jim Bennett.

I am going to ask individuals to introduce themselves momentarily. The procedure that we follow is when we begin questioning, members each use approximately ten-minute allocations back and forth, and it is maybe a lot less low key than a person might think it is. We are really interested in looking for answers, explanations, information, and so on.

Some people appearing who are with the AG's office have already been sworn. It is not necessary for them to be re-sworn, because they have been sworn before the Committee in this session. The other individuals who are witnesses can be sworn or affirmed as they see fit. Ms Murphy is our Clerk, and I am going to ask the individual members to introduce themselves first starting with…

**MR. OSBORNE:** Tom Osborne, Member of the House of Assembly.

**MR. K. PARSONS:** Kevin Parsons, Member for the District of Cape St. Francis.

**MR. PEACH:** Calvin Peach, Member for the Bellevue district.

**MR. HEDDERSON:** Tom Hedderson, Harbour Main.

**MR. MURPHY:** George Murphy, MHA for St. John's East.

**MR. PADDON:** Terry Paddon, Auditor General.

**MR. SULLIVAN:** Brad Sullivan, Audit Senior.

**MR. KEATS:** Don Keats, Interim CEO

**MS LEHR:** Sharon Lehr, Chief Performance Officer, Eastern Health.

**MR. BUTT:** George Butt, Vice-President, Eastern Health.

**MS MOLLOY:** Debbie Molloy, Interim Vice-President, Eastern Health.

**MR. BEARNES:** Reece Bearnes, Director of Medical Services, Eastern Health.

**MS RUSSELL:** Sandra Russell, Deputy Auditor General.

**MS TURPIN:** Carmel Turpin, Vice-President, Eastern Health.

**CHAIR:** Thank you.

Ms Murphy will administer the oath to those who have not been sworn.

**Swearing of Witnesses**

Don Keats
Sharon Lehr
George Butt
Debbie Molloy
Reece Bearnes
Carmel Turpin

**CHAIR:** Did anybody have any questions before we begin?

First of all, the heading that we are looking at today is from the Auditor General of the Province of Newfoundland and Labrador, the annual report, Part 3.1.

I will begin with Mr. Osborne.

**MR. OSBORNE:** Thank you.

**MR. KEATS:** (Inaudible) opening statement?

**CHAIR:** For sure.

**MR. KEATS:** Good morning, Mr. Chair, and members of the Public Accounts Committee, Mr. Paddon, and representatives of the Office of the Auditor General.

I thank you for the opportunity for Eastern Health to appear before the Public Accounts Committee. As you know, Eastern Health receives a significant portion of the annual budget of the Government of Newfoundland and Labrador on an annual basis and we certainly welcome the interest of the Public Accounts Committee into how we manage that budget.

I do want to take a moment to provide you with a brief description of Eastern Health. Formed in 2005 as a result of the amalgamation of seven health boards, Eastern Health is the largest regional health authority in Newfoundland and Labrador and one of the largest in Atlantic Canada.

Eastern Health has a budget of approximately $1.3 billion, nearly 13,000 employees, and over 700 members on the medical staff. From a regional perspective, it serves a population of just over 306,000 and provides a full continuum of health and community services including public health, long-term care, hospital care, community-based services, and medical clinics.

In addition to its regional responsibilities, Eastern Health is responsible for provincial tertiary levels of health services through its academic health science facilities and provincial programs such as the Neonatal Transport Team and genetics.

Geographically, Eastern Health includes the Island portion of the Province east of and including Port Blandford. The area encompasses the entire Burin, Bonavista and Avalon Peninsulas, as well as Bell Island.

In March of this year, Eastern Health received Accreditation Canada's designation of Accreditation with Commendation. In its letter, Accreditation Canada stated: This achievement demonstrates your organization's determination and commitment to ongoing quality improvement. We applaud your leadership, staff, and accreditation team members for their efforts and dedication to the provision of safe, quality health services.

At Eastern Health we are very proud of this designation, and it is truly a reflection of the commitment and dedication of all our employees and physicians.

On July 2, 2014, Eastern Health publicly released its strategic plan for the years 2014-2017. This builds on our strategic plan of 2011-2014, and carries forward the focus on our four strategic priorities of quality and safety, access, sustainability, and population health. Over the next three years we have set new goals, objectives, and indicators to work towards, with a number of performance measures which will be used to monitor our progress, and on which we will publicly report on an annual basis through our annual performance reports.

Each and every day within our organization, our employees remain focused on providing safe and quality care to our residents, patients, and clients. As the series of experience of care surveys that we have completed indicated, the people we serve express high satisfaction with the care they have received.

Yet we do face challenges, not the least of which has been our financial performance. While in 2007-2008 Eastern Health recorded a balanced budget, we have experienced significant deficits in subsequent years that required stabilization funding from the provincial government. Based on that experience, Eastern Health realized that they have to take action to find a way to meet its accountability to achieve balanced budgets.

We embarked on a benchmarking process and hired an expert in the field, Health Care Management Group. Through that process, we compared our operations to those of similar organizations across the country. What we discovered is that we were not operating efficiently. In fact, we were among the worst performers in the country.

Working diligently with all of our front-line managers, we developed a series of initiatives to improve our performance with two very important guidelines: no permanent employee would be laid off; and no program or service would be reduced.

As you know, in May of 2012 we publicly released our operational improvement initiatives that would assist the organization achieve savings of $43 million and reduce the number of full-time equivalents by 550. In terms of our progress to date, we have achieved nearly $30 million in savings and have reduced the number

of full-time equivalent positions by 350, without any layoffs. This was achieved through attrition and various other initiatives such as reduced work hours for overtime and constant care. Our efforts will continue throughout this fiscal year to achieve the remainder of the savings.

Through our focus on our spending, we were able to reduce our deficit from a high of $27.6 million to $8.3 million in 2012-2013. Yet we again see our deficits increasing. Eastern Health, similar to other boards across the country, is challenged to meet escalating costs in the provision of services. There are a variety of factors that contribute to the financial position of any health authority such as increased utilization of services, inflation, negotiated labour costs, and the introduction of new technologies and services.

In addition to our operational improvement initiatives, Eastern Health is also reducing the number of management positions through attrition. In an effort to save $6.8 million, Eastern Health is working to reduce about seventy positions. To this end, by the end of June, we have been able to eliminate forty manager positions, resulting in a savings of $4.1 million.

We are building lean capacity at all levels of the organization through coaching, mentoring, and team building to enable change management and the creation of an organizational culture of continuous quality improvement. Although the general perception of lean is that it is focused on improving efficiency, successful implementation of lean-based process improvements inevitably result in improvements in other domains of quality including patient safety, timeliness, patient-centeredness, equity, and clinical effectiveness and efficiency.

Compared to other systems that have spent enormous amounts of money on external lean consultants, Eastern Health has adopted the long-term plan of developing capacity and self-renewal. To date, approximately 450 employees of Eastern Health have received a three-day lean training and hundreds more have received short-focused training.

Lean initiatives are currently ongoing in the following areas: in-patient nursing units, laboratories, pharmacy, physiotherapy, occupational therapy, emergency departments, ambulatory clinics, rehabilitation medicine, community services, and long-term care. These initiatives have directly improved patient flow, patient safety, and cost efficiency.

Earlier this year, Eastern Health completed a clinical utilization review to ensure we use its resources appropriately, effectively, and efficiently to meet the health needs of the people we serve. Complementing the operational improvement process, the clinical utilization review compared Eastern Health's clinical utilization to organizations across the country. The review focused on six key acute care areas: emergency, cardiac and critical care, medicine, surgery, women's and children's health, and mental health.

With initiatives targeting a number of patients admitted, the length of time a patient stays in hospital and reducing the number of procedures we perform while continuing to offer a high level of care, we have the potential to reduce operating costs by $4.6 million and reduce by the equivalent of fifty-eight full-time positions through attrition. We have developed tools and increased the flow of information for our front-line managers to assist in them meeting their budgets.

It is a constant and continuous effort on the part of many throughout our organization. We acknowledge how important it is for us to be good stewards of the taxpayers' money, we take this responsibility quite seriously, and we do not leave any stone unturned in our efforts to reduce our costs and operate efficiently. Considering that about 75 per cent of our budget is spent on direct care and about 66 per cent of the budget is compensation, it is not easily accomplished; however, we will remain every vigilant.

We welcome the findings and the recommendations of the Auditor General to assist us in doing a better job of fiscal management. We have been working to resolve the issues identified and look forward to discussing with you over the next two days the progress we have made.

Thank you very much, Mr. Chair.

**CHAIR:** Thank you, Mr. Keats.

I am going to ask you if you could table that so it could become a part of our official record. If you do not have an extra copy, we can have one made, whatever is easier.

**MR. KEATS:** Yes.

**CHAIR:** I will begin with Mr. Osborne.

**MR. OSBORNE:** Thank you, Mr. Chair.

Thank you, Mr. Keats, for your presentation. I know that some of the questions that we will have today will overlap on some of the information but to help facilitate some discussion.

I know you are acting CEO right now, so some of these questions may be more difficult. You may put them off to staff or whatever. Can you outline some of the measures that Eastern Health is taking to address the deficit issues that you experience?

**MR. KEATS:** I guess Eastern Health started the process back four or five years ago looking at its deficit position and for the last several years, it has been running the deficit of $20 million, $26 million. Two years ago, it was down to $8.3 million. It is a lot of money, but you have to look at it in relative terms; $8.3 million is about point six of 1 per cent of our budget.

The deficit over the last five years is about 1.5 per cent of our budget – over the past five years, it has been about $5.57 billion. It is a tremendous amount of money. We will not be happy at Eastern Health until we have no deficit on an ongoing basis and that we live within our funding envelope.

In 2010 thereabouts, Eastern Health started on the operational improvement initiatives, looking at all areas of the organization. There were meetings with all managers throughout the organization. A number of initiatives were put in place. Anything that was of the discretionary nature starting in 2011, education, any of those sorts of things that had no direct impact on patient care, those things were eliminated, reduced or primarily eliminated.

We also, at the time, said there is a potential for us to eliminate or save about $43 million and to achieve savings equivalent to 550 full-time equivalents. To date, $30 million has been achieved and there are about 350 equivalent full-time positions that have been eliminated.

Now, it is important that you understand that it is not people. I will give you an example. There has been a significant reduction in the overtime usage in the organization in the last four years, and each year it has gone down. Through the major savings in overtime in the last four years, we have saved the equivalent of forty-two full-time equivalent positions. Forty-two full-time people were not laid off, but you saved that.

Through efficiencies in the provision of constant care services, there have been a number of equivalent full-time positions eliminated. So, measures bring you up to the 350 range. We have had changes in the numbers of managers at Eastern Health. There has been a reduction of forty so far; their target is seventy. That has resulted in about a $4 million savings.

There have been efficiency efforts looked at through all usage areas, such as vehicle travel, callback, any of those relief areas. Through the lean process, we have had some really good success with improving patient flow or operational efficiencies throughout the organization.

The benefit of the lean process is that it is the front-line employees and staff who participate, come up with the recommendations, and follow through with the implementation of the recommendations. In many areas like laboratory – if any of you have gone to Major's Path, I would hope that you have noticed a significant reduction in the wait times and the service times at Major's Path.

Through a lean process, the staff made recommendations and made changes to staffing schedules. When people come to work, staffing schedules are co-ordinated with when people are there for the services obviously. That has led to improvements in patient flow and cost and so on.

I am going to ask Sharon Lehr, our VP of Performance, to give you some more examples

of some of the things that we have done in the lean areas and other initiatives that we have undertaken to save money.

**MS LEHR:** Thank you.

The initiatives in particular for the lean is we are putting a lot of effort into ensuring that we are pulling patients from the emergency department to the in-patient units. So there is a lot of work being done on discharge planning, on improving processes to eliminate – the steps in processes that we currently undertake, we look at what the ideal state would like and then we coach with the front line and they become the problem solvers.

So that is the work we are doing in lean. We are working in ambulatory clinics to reduce wait times. We are working in pharmacy to improve chemotherapy wait times for patients who are accessing that care.

The benefit for the patient clearly is that they are waiting less, but it is also a benefit for the organization because it allows us to staff more appropriately. It puts the staff in at the right time so that we are not using overtime and extra workload to address the demand for service.

So that is a lot of initiative that we are doing at Eastern Health right now, primarily focused at the Health Sciences Centre, putting a tremendous amount of effort in improving service delivery there.

From the operational improvement process, we identified every manager of every functional centre, every department, went through their own data compared to their peers in the country to see if they were as efficient as they could be. If we were not at median or one of the top performers, we looked at were there things that we could reasonably do.

So, if it was an in-patient unit, as an example, and we were delivering our hours of care to deliver service to an in-patient medicine department was eight or nine work hours per patient day, but our peers in the country could do it for seven, then we looked to see if we could reasonably compete or compare with that as well. Where we could, the managers put initiatives on the table and they are implementing those. We did the same for housekeeping, dietary, all the different areas of the organization, and each manager has a list of initiatives that they are implementing, and we are working our way through that.

To date, $30 million, as Mr. Keats indicated, has been achieved; so we have $13 million left that we are working very hard this year to implement, without service reduction and without laying off any staff.

**MR. OSBORNE:** Okay.

I know Eastern Health is a big, big, big machine, and so many wheels, let alone cogs on the wheels, and it is difficult to focus on that. Just out of curiosity, is there a position within Eastern Health specifically dedicated to finding efficiencies, or is that task added on to somebody else's responsibilities?

**MR. KEATS:** We do have a number of positions throughout the organization that is focused on – for example, we have people who work in clinical efficiency. All of our managers and directors and staff will endeavour to make sure they provide the most efficient, effective, safe, quality level of services that they can provide. So, it is spread throughout the organization.

**MR. OSBORNE:** Okay.

The position control number system: Can you give some greater detail, explain how that is implemented, the benefits of that system?

**MR. KEATS:** Yes, I will just start by telling you that we are implementing another position control system. We anticipate that it will be in place by April of next year, by the end of this fiscal year. I will ask our VP of HR to provide some comments on how that system will work.

**MS MOLLOY:** The position control system will allow us to track budgeted positions within the organization and the people that hold those positions. That is it at its most basic level. What it will also do, though, is allow us to know – because we do have internal movement within our system, and it will allow us to track people as they move throughout the system and knowing that when we do add a position to

complete work, that we have the budget that is necessary to fund that position.

Right now because we focus on full-time equivalents, we do not always equate that to people, and this is an addition to our system to allow us to take that system and translate it back in to people.

**MR. OSBORNE:** Okay.

As part of that system, I know the Auditor General found that there were 130 individuals double dipping and two individuals triple dipping; will that help identify, through that process, the individuals who are receiving multiple incomes from either government or Eastern Health?

**MR. KEATS:** There are a number of processes that are in place for that, and maybe I can speak about some of these. In pensions, for example, currently I think we have 119 people who work at Eastern Health who also receive a pension. We have four people who receive survivor pensions and some who receive medical pensions, and one who receives a deceased spouse pension and so on. I think we even have one who receives a teacher's pension.

Out of that 119, there is 105 who receive pensions but they work only on a casual or a temporary basis. By the way, I am one of them; I receive a pension. I am back on a temporary basis while Eastern Health pursues another president and CEO. That is a short-term process. We are following government guidelines on that. We are getting whatever approvals we need from that.

Out of the 105, about 55 per cent of them are nurses. None of them are in full-time permanent or part-time permanent positions. It is basically casual, on-call relief, or it is a temporary position that they are in.

We do have a mechanism now whereby because it was tough in the past to find out – unless people self-declared that they were receiving some kind of a pension, we would not know that they might be. Right now, you have to self-declare before you go into the organization.

Also, anybody who is hired, who is on a pension, it requires the approval of two of our vice-presidents. They also have to demonstrate before they are hired that there has been a search or a search is underway and that this is a short-term solution for the organization.

Health care is a very complex environment. So, I will you an example of one of the individuals who worked two jobs while on a pension. The individual was actually a plumber. The plumber was employed on an hourly rate to provide services in two organizations, two facilities. One was St. Pat's. St. Pat's is part of the faith-based homes. They manage some of their own affairs, so that was a different control number. The other was employed at St. Clare's hospital.

That was the two jobs this individual had. They were an hourly rate job that this individual was employed. As you can appreciate, we cannot just go and take a private plumber off the street and say we want you to go in and fix the problems at St. Clare's. That is a very complex organization. From a plumbing perspective, you have to know what is going on in there. So, if somebody is off on leave, sick leave, annual leave or whatever type of leave and you need somebody to do some work in there, sometimes the very best, most effective, efficient way to do that is to get somebody who understands the building and the system and can come back and provide that relief on an hourly basis.

The same thing with nursing; nurses are very difficult to get in certain areas and in certain rural areas of the Province. We have retired nurses who are available to provide relief services, cover off on sick leave, annual leave relief or whatever, we do that. The objective overall, Mr. Osborne, is to make sure that we do not have people who are pensioned and are working in full-time jobs and part-time jobs; that does not take place.

**MR. OSBORNE:** Okay.

Delays in classification resulted in 123 employees being paid overtime. Have you addressed or how are you addressing the delay in classifications?

**MR. KEATS:** Admittedly, it took us a longer time at Eastern Health to have the classifications

done than we would have liked. Usually with some of those things, when the organization starts – I have been involved with organizations that have reduced the number of boards. In the first two of the three years, you are inundated with all kinds of transitional issues and union issues and personnel issues. Classifications take a little bit of time.

We had that issue at Eastern Health and then, shortly afterwards, some things like ER-PR kind of delayed some of those things, but we do admit that it took quite some time. Usually what happens with these classifications in a regional health authority – over the years I have been involved with them, for example – the regional health authority will set a number of benchmarks and then they will internally classify people and put them in what they think is the rational or realistic number within the classification system. Then those things are sent off to government who will make a final decision on those.

What we now have at Eastern Health is a validation committee. The validation committee meets twice a year. The VPs are responsible for ensuring that anybody who requires a classification goes through that validation committee. There should be nobody who requires a classification that does not get that performed and sent off to be done through the appropriate government department within a six-month time frame.

Out of the people who were classified lower than the actual classification, the expectation, when they were done, was that that was an appropriate level. When your classifications came back lower – they could have easily have come back higher, so Eastern Health did not think that many people would come back out of classification.

I would also tell you that out of the people who have been classified on the management pay scales, there is about 252 of them who are now seeking appeals for that classification. We do not know what level of them will be successful in doing that. We do acknowledge that it is an incredibly long time to get some classifications worked through the system. Hopefully the new validation process will ensure that the classifications are done in a timely manner in the future.

**CHAIR:** Mr. Parsons.

**MR. K. PARSONS:** Good morning.

Thank you guys for coming here today. I am first going to start off with a little statement that I would like to make. I really do appreciate the work that Eastern Health does. Over the last couple of years, I had a couple of parents who had to avail of your services. I have to say that I was more than pleased with the level of care and also with the amount of concern from nurses, from the cleaning staff right on through. They showed professionalism in what they do. I was really pleased with what happened with my family and I really want to say to you guys that there is a great staff over there and there is a lot of good people who work in your organization.

I am sure that you hear it every day, but there are a lot of times when you deal with organizations like yourselves it is the negative things that get reported and not the positive things that get reported. I just wanted to let you know that the majority of people who deal with your organization, I am sure, come out on the positive. While there are probably a couple of negative things that get reported most times, I can assure you that most of the dealings I have had with Eastern Health have been very, very positive. I wanted to let you know that right off the bat.

I understand that Eastern Health is so large. All you have to do is walk into one of your hospitals and just see the flow of people. The Health Sciences is absolutely crazy over there sometimes. If you are going for an appointment, trying to get a parking spot over in the thing, driving around for about ten minutes or whatever. In saying that, we still are dealing with a $1.3 billion budget. I think, going through the Auditor General's report, that there are a lot of areas where we can improve things. I think a lot of it has to do with the proper controls in place. I think that we should be looking at making sure that these controls are in place.

I have a general question first. I know Mr. Osborne asked the same basic question. What controls are you putting in place? We are looking at monies that are getting spent; for example, overtime is 22 per cent higher. I

understand that the health care system is generally over anyway, but there has to be some controls put in place to control this stuff.

**MR. KEATS:** Thank you very much.

I would just like to address your first comment and the compliment to the staff. As you say, Eastern Health is a big organization. There are 13,000 employees. On a daily basis, employees throughout our organization provide tens of thousands of services every day of the year around the region. By and large, the vast majority of those are extremely good, quality, safe services that our clients and residents receive. We are very proud of the fact that our staff does that.

In terms of controls, we agree that we need to make sure we have the proper controls in place. One of the things we have done through the finance committee of the board is approved – we have retained the services of Ernst & Young who are external auditors to do a review of our control areas, many of the control areas that have been identified by the Auditor General's staff, to make sure we have the proper control procedures in place and that we follow best practices around the country.

That study or that report with that information should be completed for us by the end of September of this year. That is one of the major general things that we have done as a result of the AG's report. We have also taken internal actions to make sure, where possible, we do the monitoring and the auditing that need to be done and that we comply with provincial legislation, regulations, or whatever is necessary.

**MR. K. PARSONS:** Okay.

I just want to go to the piece where the Auditor General has major concerns about compensation and recruitment in your department, like with recruiting people and compensating. In compliance with government, it seemed like Eastern Health was on their own and did it the way they do it rather than follow the rules that should be put in place. What changes have you made there with any of the compensation programs that you have done there?

**MR. KEATS:** Generally the compensation obviously is made through a government classification process. People get paid on the appropriate scales. Earlier this year, effective April 1 of this year, the educational differentials, the overtime in lieu of, and the management supervisory benefits that people got if they were not a nurse, supervising nurses, those were all eliminated effective April 1 of this year.

**MR. K. PARSONS:** Okay.

I think a lot of the Auditor General's concern was with the lack of documentation. What improvements have you done to improve your documentation, for employees, anything that was done with compensation? It here seemed there was no documentation in place. What document controls have you put in place?

**MR. KEATS:** There has been a reiteration to our staff and our managers and so on of the importance of making sure there is documentation either before or after the fact. Let us face it; if you work in a health care environment, it is not always easy to get prior approval for overtime. That happens on a Saturday night somewhere when somebody needs to get called in somewhere. Reaching your supervisor to get approval for overtime is not always easy, nor do they say when they have some emergency situations I have to take the time to get somebody in for overtime.

Afterwards though, the prior approval needs to be made sure that it is given. There are general parameters around which people will be available or through which overtime is being used wherever possible. Again, every day at Eastern Health there are tens of thousands of transactions that take place. Things that are documented, overseen, and so on. Occasionally, some of those are missed. We want to make sure that we have the best system we can put in place so we do not miss those. There are some misses but, by and large, the vast majority of what we do receives documentation.

**MR. K. PARSONS:** The Auditor General found that there were areas where there was recruitment and said there was missing screening documents and lack of documents to show how you recruited certain people and

individuals. Have you done anything to improve these circumstances?

**MS MOLLOY:** We did feel that we had fairly good documentation in most cases; however, we took it in the spirit that it was given, that we did not always have the same documentation or the process that the Public Service Commission has.

We have undertaken a review within the Human Resources department and that is just coming to a conclusion. We plan on piloting a new program which does mirror a lot more closely that of the Public Service Commission. We will be starting that in September or October of this year.

**MR. K. PARSONS:** Okay.

I want to go to the leave and overtime bit. I am not saying it is an abuse or anything like that, but I understand in an organization, especially in health care, it is not like you can say that fellow is not coming in tonight, that is okay, we will get by without him; because you are dealing obviously with people's health and stuff like that.

Again, it seems like there is a lack of oversight and people being prepared. It seems like it is done on a whim type thing. What processes do you have in place for overtime, for example, for people being called in? You know it is going to happen but it seems like – I know you talk a lot to different people in the health care system and the one thing they will always say is we do not have enough staff; so-and-so is sick, blah, blah, blah; and that is the reason why it is slow here tonight or we are not getting this done or that done.

I am just wondering what the process is. Obviously it is a very important part; it is something that you have to be ready for because it is not like a job where if there is no one there, then it is okay. I just want to know the whole procedure of what you do with your overtime.

**MR. KEATS:** I will make a general comment. Eastern Health has worked over the last couple of years to reduce its overtime and have made significant reductions in the number of worked hours for overtime. As I indicated earlier, it is the equivalent of forty-two full-time people on a yearly basis. We basically have freed up, in overtime, forty-two full-time equivalent positions.

We have a policy that generally says overtime is to be pre-approved. As you have indicated, this is not possible in all circumstances, but there are general guidelines. For example, if somebody calls in sick, you do not necessarily say right away we are going to replace that person on sick leave. You make a determination: Can you work the area without the person being replaced?

There are many areas throughout the organization where we have minimum staffing requirements; for example, in neonatology, if we have six babies then we are required to have six nurses there. If somebody calls in sick or if somebody gets sick and has to leave and so on, you make whatever arrangements you can to get the relief staff in. The same thing with people who go on paid leave or annual leave, you try to replace them.

Sometimes you cannot give people – for example, you will hear a lot of times people say I cannot get a day off. Wherever possible, we endeavour to give our staff time off. It is important that they get the time off. Through the collective agreements and so on, there are certain times that they are supposed to be off and certain amounts of leave you can carry forward.

It is not always possible. I talked to a nurse the other day, for example, who could not get a day off. She could not get a day off because there were four other people in her area who were off that day. Sometimes when people are off we have incidents where one sick leave call can create five paydays for an individual, which may be in overtime. It does not take long for the overtime in those areas to build up.

We monitor those and we try to make sure that people are required for the shifts or for the weeks or whatever that they come in. We have a couple of hundred nurses every summer who are hired to provide relief, where we can get them. We have situations now in our organizations where relief staff is not available, so if somebody calls in sick or if somebody is off for whatever reason, it generally will incur

overtime. We are kind of in a situation where we have to go with the overtime in those areas.

There are certain things as well, a section in the report that talks about unworked overtime. As you may know, through collective agreements in an area like lab and X-ray, there is an agreement that says somebody goes on callback and it is not feasible in all programs or in all areas of the region to have an area staffed around the clock. In a smaller rural area, St. Lawrence or Grand Bank, for example, we may have a lab and X-ray person who works an 8:00 o'clock to 4:00 o'clock shift. If the doctor decides there is an X-ray needed or a blood test needed at 6:00 o'clock, the person on call comes back in, performs the test, it may take five minutes, gets paid three hours. Compensation is in lieu of scheduling somebody or giving notice to somebody that they are going to get called in.

You can get pyramiding based on that. If that individual leaves their place of work – and by the way, there was an arbitration case several case that I was involved with that determines place of work. Your place of work under that circumstance would be where you sit in this House. If you got up and walked to the floor there, you are determined to be a way from your normal place of work, even if you are still in the lab or in the diagnostic (inaudible) part.

If you get another call and the doctor determines who is going to get called, you go back to work, you get another three hours pay. If that happens again in the first hour, you get another three hours pay. You can accumulate nine hours pay for three calls that may take place in an hour or two hours.

There are circumstances where people get paid overtime or callback at the end of a shift or just before the beginning of a shift. Better management is required to make sure those things do not happen. Sometimes it is not always possible because if a physician says I need this test done, I need it done, stat, we are really not in a position to argue with them about that at the time; but we will have discussions with them about making sure they understand the consequences of their actions on the cost for the organization and what it might mean for the individual who is on callback.

Those are some areas we have to work on. We think we are doing a satisfactory job with our overtime and our callback and so on. Are we happy with that? No, we are not. We know we need to make improvements, and we will continually try to make improvements in those areas.

**MR. K. PARSONS:** Okay

An example you just gave that time, I have heard the example before that a person was in the parking lot, just got called in, and then in the parking lot gets called back in again, and again another three hours within a half hour period of time, another six hours overtime given for it.

I only have one more question here. The Auditor General found that there was 712 employees had taken paid annual leave, but they were not entitled to it. That number seems to be a lot for me. What are you doing to address that? I know when people take leave often then we are into the same thing you are doing with calling in for overtime and stuff like this, but when you have 712 that are taking beyond what they were supposed to take, there must be some way to be monitoring this and seeing that this does not happen.

**MR. KEATS:** The leave generally might be taken on an anticipated basis, so somebody might overrun their leave bank. There are no large amounts of time. If you look at the financial amount and the numbers of people who have done that, it is usually a day or so that people will overtake their leave. It is done on an anticipated basis; this is what you are entitled to.

It is picked up again immediately the very next year. If you have gone over – and I have always found this a little bit strange. The first time I started work in health care, they told me I am entitled to twenty-four days and I can take them in advance. If I am entitled to ten days leave, I have ten leaves on the books and I take eleven days, then I pick it up, the organization picks it up the very next year.

Instead of having X number of days the next year, you get X minus the time you picked up. The only problem with it you might say from a cash flow perspective – it created a major

problem, which it does from that – is it incurred in one year versus the other year.

**MR. K. PARSONS:** It also must encourage for overtime because if that person is not there, someone there has to replace them. It is a cost not only for the leave cost, it is a cost for someone to come in and replace that employee. If they have ten days off and they take eleven, obviously on the eleventh day there is someone either going to be called in on overtime or someone has to fill that position for that day. I can see it as a major concern when I see numbers like that.

**MS MOLLOY:** Part of anticipation though is – so if I take a holiday in April, by the end of the year in December I would have earned back that time. It is not taking over what you are entitled to having, it is just taking it earlier than – you earn it every pay period.

There is, though, a small amount. When you take an audit at any time, we may have people who are on an unpaid leave, for example, a maternity leave. That person may have anticipated and had their holiday in April and then they had a child in June or July. They show that they are in deficit when you actually run them, but as soon as they come back from their maternity leave then that gets reconciled.

It is not really a case of people are taking more than they earn, they are just taking it before they have earned it. That is something within the collective agreements and policies that are mandated for us.

**MR. K. PARSONS:** Okay.

**CHAIR:** Mr. Murphy.

**MR. MURPHY:** Thank you very much, Mr. Chair.

Thank you very much for coming in today and making yourselves available for a few questions. Mr. Keats, I just have a couple of questions.

In your opening statement, if I can come back to that before I get on with regular questions, you said a line that kind of rang with me. You said that you had to live within your funding envelope. I have a father who is also in the system and I see pressures that are there within the system. He is now in long-term care down at the DVA. He has been transferred, but for two months he was at the Health Sciences and I got exposed to a lot of things there.

I saw that the staff were working hand over fist to get the job done and, in some cases, there were not enough resources there. I learned an awful lot and heard an awful lot too from the loved ones of loved ones who are within the system. I am a bit curious about the line that you said when you said you were living within our funding envelope. Do you have enough money?

**MR. KEATS:** Mr. Murphy, I am sure if we ask individuals who receive care through Eastern Health or are concerned about maybe some of the staffing levels or whatever they may see, that they might say we do not have enough money and we do not have enough staff. From an overall perspective, I think Eastern Health has enough money. We need to make sure we spend that money better.

If you look at Newfoundland and Labrador versus other provinces, we spend more per capita than any other province on health care. We spend $1,000 more per capita than, say, Nova Scotia, and $1,200 more than Quebec. There is absolutely no evidence that says we are healthier. In fact, it is the reverse. If you look at our general population, we have the worst hypertension rates. We have the worst cancer rates. We have the worst diabetic rates. We have the lowest level of physical activity. We have the lowest consumption of fruits and vegetables and healthy foods. We have the highest smoking rates. We have the second highest drinking rates and so on. We are spending the most money and we still have all of these major problems.

I think we have enough money in health care. Are we spending it the most effective way possible? I do not think so. We have to find different models of care, other than the models we now have. I heard a phrase a while back that says in Newfoundland, we are acutely addicted to the provision of acute care. That happens a lot. We have tremendous resources that are tied up in our hospitals and in our institutions. We

do not have near enough resources that we need to provide other services in the community.

If you were to ask me in my short time back at Eastern Health what would I say is one of the greatest priorities, it would be a shift in the way services are provided from an institutional setting. Granted, there are a lot of people who have these problems and they are going to require the acute care in the institutional setting, but we have to do a better job in other models of care.

If we have an elderly person who is in one of our acute care beds that is not available to somebody who has an acute care problem, is the best way for taking care of that patient in the short term in that acute care bed? Or is it better to have some system that allows that individual to stay at home with the appropriate supports until the appropriate long-term care becomes available?

I think we do have enough money. I do not think we spend the money as effectively as we need to do. That is why at Eastern Health we are looking at and talking and working with the government about other models of care, improving our primary health care programs and services and other such things.

**MR. MURPHY:** Okay. Thank you very much for that. I just had to ask the question because I hear an awful lot. I had to come back to it.

I will get into the questions that the Auditor General was asking. I am interested in Eastern Regional Health Authority's relationship with the Department of Health and Community Services. I think it is kind of important. I was wondering if the authority is getting the support it needs from the department, which is part of the reason why I am asking the question. I am looking forward to getting more details on some of these issues that we will be talking about in the next couple of days.

I want to come to the monitoring of the financial position that you are in. Under your budget deficit the April 30 response to a question posed by the Committee on March 25 noted that Eastern Health will have a balanced financial position at the end of March 31, 2014 as a result of one-time stabilization funding. Can I ask what the prognosis is for this fiscal year? Will Eastern Health be on budget this year?

**MR. KEATS:** This fiscal year we are projecting a deficit of about $16 million on $1.3 billion. To put that into perspective, that is a little over 1 per cent and it is about three days operation. A change in operation for just three days could impact on that. We are projecting a deficit of $16 million. Part of that is because it has taken a bit longer to do some of the operational improvement initiatives we thought that we would have in place by now. Because we are doing things through attritions and so on, that takes a little bit longer. The $16 million deficit is what we are projecting for this year.

**MR. MURPHY:** Okay. I presume now at the same time you would have an operational plan in place, of course, that would be covering off most of the things that the Auditor General would be addressing?

**MR. KEATS:** Yes, we do.

**MR. MURPHY:** Okay.

The authority has been running deficits despite the budgeting process with the department. As the minister noted in a letter dated May 13, 2011, hiring people without formally approved funding is a significant decision for a regional health authority to make. The AG recommended that this no longer happen and Eastern Health has replied that they are working to stop the process. Have you been successful in stopping that process?

**MR. KEATS:** Through the position control system and through other monitoring, I think we may not have stopped the process fully. I do not think we are hiring people now in unfunded positions. There were 630 unfunded positions at one time; we are now down to seventy-five unfunded positions throughout the organization. Moving into the future with the monitoring system we put in place, unless there is funding for a position, then there will not be a competition for that position.

**MR. MURPHY:** Okay. I know that there are probably reasons why you would have to hire somebody without having the funding in place. That is probably understandable on some

scenarios. Would you be able to give us an example where somebody would have been hired to do a particular job before the funding was in place?

**MS MOLLOY:** An example might be – I think people knew in 2010 we had a lot of difficulty attracting nurses to the Province and we had a nursing shortage. In some cases, we did hire nurses on a full-time permanent basis to work in what we called float positions. Those were funded through our relief budgets, not through a formal position.

That would be an example of where we did know we were doing that. We certainly hoped that we would be able to use those people although they were in permanent positions on a relief basis. That would have contributed in some way to the budget.

If that decision were to happen today, it would have to go to the executive level. That is part of what the position control number will help us to identify is when someone is asking for a position that we have not secured funding for. That will go then to the executive level. As we are in the process of putting that in and we have not put it in place yet, we did put in a process where human resources, if they do recognize that there is not funding, they do check with budgeting now on a manual basis. We are trying to do that more automatic with the position control system.

**MR. MURPHY:** Okay. Thank you very much for that. I think it is a valid explanation.

Can we get some details on the implementation of the Position Control Number system that you put in place? Why have they not implemented that system before now?

**MS MOLLOY:** What we are trying to do is embed the system within our human resources information system. In order to do that we are working with the vendor to determine – it is a little bit technical, but there are a number of screens that need to be linked.

To maintain a system outside the human resources information system would require additional resourcing that we feel we can do that within the system itself, it will just take a little bit more time. The first thing we are doing is having to do an inventory of all of our positions, and then compare that to budgeting and the FTs within budgeting.

Once we match those up then we can assign positions. That is about 75 per cent complete. The second piece of that though is because we do have temporary positions as well that are in place. We then need to match the temporary positions or the temporary replacement to permanent positions.

We are on track to start actually implementing it on a small scale in the fall and then we will be implementing it full scale throughout Eastern Health. We are still on track to do that by the end of the year.

**MR. MURPHY:** You anticipate some savings from that?

**MS MOLLOY:** We anticipate being able to do it within the current resourcing that we have. What it will do is then provide us with the information to ensure that if there is a position that is being requested which is outside of those that have been funded, that we know that and it is an informed decision that is happening.

**MR. MURPHY:** Okay. We will look for that in early fall.

**MS MOLLOY:** Yes.

**MR. MURPHY:** All right.

I want to come over to compensation and recruitment under job competitions. The Auditor General found a number of problems with the authority's human resources client services division recruitment files not being in line with provincial government policy and procedures. From my reading of this, it appears the managers and other HR people were cutting corners. It sounds like it to me. Maybe you can explain that.

Was this in effect of not having enough people to do the job? Is this a problem with training managers? Maybe somebody can answer that one.

**MS MOLLOY:** The system that we had in place for recruitment we did feel was an

adequate system, but it did not match the system that is used in the Public Service Commission. What we have done since we have received the comments from the Auditor General is that we did take a very close look at what is happening within the Public Service Commission. We have a plan in place to implement a system which is similar to that.

What we also were not doing was auditing our recruitment files, which the Auditor General did. Part of our new system will include regular auditing to make sure that the documentation is on file.

We do think that people and our managers all did get the correct approvals; it was not always documented. We recognize that we do need to improve that. That will happen within the new system.

**MR. MURPHY:** Okay, so while we are on the topic of auditing on page 9 of the Auditor General's report, number 28, he says that, "There was no functioning Internal Audit Department during the period of our review." I take it that was for the internal controls that he was talking about. "An effective internal audit function can help ensure that preventative and detective controls are implemented and functioning properly."

I am just wondering about the auditing system that Eastern Health would have in place now. In general, for example, how many auditors do you have within the system now and how many audits in the run of a year?

**MR. BUTT:** We do not have an internal audit function within Eastern Health. When the six legacy boards came together, none of them had that function. It is a function we agree with. We think it is valuable.

It is difficult sometimes in health care to garner resources for things that are not direct client care, but it is something that we would support and it is something that we have to look into. Our board is, I think, looking at a process to look at risk to the organization. I think they are looking at the internal audit function as a part of that process. It is certainly something that is lacking and it is something that we would support and we need.

**MR. MURPHY:** It surprises me actually with a budget of $1.3 billion. It begs the question how many other audits within say, for example, Western Regional Health and everything – you are probably going to need funding to do something like this, but you are talking $1.3 billion of taxpayers' money that is not being audited here. I think that is probably a pretty important point here.

While the Auditor General looked in this report, do you just depend on the Auditor General to look at that? There are no internal control mechanisms like an audit or anything that Eastern Health carries out?

**MR. BUTT:** I am sorry; I might respond.

We also have our own external auditors.

**MR. MURPHY:** Okay.

**MR. BUTT:** Every year our financial statements are audited by a chartered accounting firm. The current incumbent is Ernst & Young. So we go through the whole process of that external audit and all the testing and procedures that go with that. We do not have a robust internal audit function, and I think that is where we are lacking.

**MR. MURPHY:** Okay. So, do you anticipate putting one in place?

**MR. BUTT:** I would think so.

**MR. KEATS:** As Mr. Butt has indicated, there has been discussion with the board – right now, we have a finance committee of the board. We are looking at changing the committee structure of the board and expanding some of the duties. So the finance committee will essentially become a finance, audit, risk-management committee; and the internal audit will become a function that will report through the appropriate VP to the board.

There are risk in an organization in a lot of areas, and the board's intent was not to say we are going to have a risk-management process for operational and a risk-management process for financial, because you get silos, but to have something that is called an enterprise risk-management system in place that makes sure

through one area, going into the board, all of our risks are assessed and controlled and there is some synergy in that process.

So, we are looking at that, and that is one of the priorities of the finance committee of the board, to make sure we have these risk procedures in place.

**MR. MURPHY:** How often does Ernst & Young come in, or an outside auditor come in?

**WITNESS:** (Inaudible).

**MR. MURPHY:** Every year?

**WITNESS:** (Inaudible).

**MR. MURPHY:** Okay. Is there any particular aspect, for example, that they looked at the last time where they actually picked up some of these things that the Auditor General reported on?

**MR. BUTT:** They come in January and meet with our finance committee with an audit plan, and at that time they would ask is there any particular areas of emphasis that we would like for them to look at, and we might say payroll processing or payments processing, these kinds of things. So, they bring an audit plan, we approve the audit plan, and they carry out the audit in accordance with the plan. It is not the same function as an internal audit function, not at all –

**MR. MURPHY:** No.

**MR. BUTT:** – and I would not want to make you believe that it was, because it is not. An internal audit function is much more internal, much more process-oriented. I, for five years, managed the Province's internal audit function, so I am well familiar with it. The strength, I think, of a proper internal audit function is the reporting relationship within the organization so that we have the autonomy within the organization to do these audits and report up to the board. It is a function that is lacking and it is a function that we will pursue.

**MR. MURPHY:** Okay.

**CHAIR:** We should move on to Mr. Peach now.

**MR. MURPHY:** Sure.

**MR. PEACH:** Thank you, Mr. Chair.

Before I get into questions – I have a couples of questions and a couple of clarifications I want to ask – I do want to comment on Eastern Health and to let you know that I echo Mr. Parsons' comments earlier with regard to Eastern Health and the great work that they do.

We hear a lot of negativity out there, but it is until somebody is directly involved with the care that they are given that you realize the type of care that we have. I say that through my own family. My brothers and sisters in the past couple of months have gone through some ordeals with regard to the care at the hospitals, especially the Health Sciences.

I have had several e-mails from the hospital in Clarenville where some constituents had been there and they sent e-mails to me. I forwarded some of these on to Vickie Kaminski when she was there and also to the minister. There is a lot of praise out there for health, but then again there is still some negativity. I think the care that we are given certainly waives the negativity that is there. You have to be really involved, not somebody visiting, but somebody who is in the hospital to really see the care that you get over time.

I just wanted to ask a couple of questions with regard to the application of relocation policy; the Auditor General identified some areas there where there was some overspending by physicians. I am just wondering what has been done to correct that? Is there anything being done to correct that? There was identified there where they overspent on accommodations, some were on furniture and some on travel.

**MR. KEATS:** Yes, I will make a general comment. We do have at Eastern Health a new relocation policy that has been recently put in place. That really closely aligns with government's relocation policy. So, we should not have those examples.

I will say that, as you know, the health care world is not black and white. Sometimes we have to make some what I would call a logical, rational exception to a general policy in order to

ensure that we provide and have services available in various areas of our region.

Otherwise if you do not – let me give you an example. There is an example in the Auditor General's report – and the Auditor General has a job to do, and I understand that. They have to say this is a violation or this is outside of a policy and so on. We are concerned about that, and we generally will follow up on those. So there is a comment in there about an individual who was paid mileage for going to and from work from his residence, and that is accurate.

In Bonavista, as an example, we had one person who did lab X-ray. That person has to have some time off throughout the year. You beat the bushes and try to find somebody to replace that person, and you cannot go out and do a job ad for somebody for a short term, and you generally cannot find people who are interested in coming in and working on a job. So, sometimes you have to make do with what you can find.

We found a guy who had worked in Bonavista, who was familiar with the area, who was prepared to do relief and coverage for that one individual when that one individual may not have been available on the basis that we would say we are going to pay your mileage from your residence to Bonavista and back when you do that. We do not like when we have to do that, but sometimes we have to do that; because if that person were not available for the lab and X-ray area, it would have meant that we would have to close down the emergency department and say to Bonavista: You are no long classified to provide emergency services because you do not have the appropriate backup.

So you take whatever measures you need to take. Some of those will carry on into the future, regardless of what policy and procedure and monitoring we have in place. Our objective is not to have to be faced with that, but sometimes we have to do that.

When we look at things like overtime, people might say you are spending more on overtime, or people are making as much on overtime as they make on their salary, why do you not hire another staff member and provide coverage? Well, if we are going to provide coverage, for example, let us take the lab and X-ray situation. If you want to provide coverage or nursing for an extra shift, it is not the matter of getting one body, we need 4.2 bodies to cover an extra shift around the clock. So those 4.2 bodies would cost us a lot more than we would be paying out in overtime.

**MR. PEACH:** Overtime callback – I just have a question here. It has identified Bonavista Home and Health Care Centre, 82 per cent; Placentia Health Care Centre, 79 per cent; and the Newhook Clinic, 77 per cent. Then it says that 48 per cent of the total dollars in 2013 and in 2012 – I think it was 48 per cent in 2013 and 46 per cent related to callback for overtime unworked. Why was that? What is the reason behind that?

**MR. KEATS:** Those would relate to the situation I talked about before, where we have a staff member who works a day shift and is on call and then they will get called back and they may work for five minutes but they get paid for three hours.

**MR. PEACH:** Okay. That is a basic collective agreement, is it?

**MR. KEATS:** Yes, that is basically unworked overtime, but it is part of a collective agreement and part of what we have to do.

**MR. PEACH:** Does that overtime work the same thing for somebody who is on standby, like if you had someone on standby for a weekend?

**MR. KEATS:** Yes.

**MR. PEACH:** It works the same way. Okay.

Being concerned with my district with regard to rural Newfoundland and doctors who have been recently leaving clinics, I am just wondering what Eastern Health is doing right now for the rural Newfoundland for doctors to fill those positions. Can you give me anything on that?

**MR. KEATS:** I will make a general comment and then ask Reece Bearnes, our Director of Medical Services, to make a comment. Eastern Health generally has a really good robust recruitment program for medicine. We generally do a fairly good job in that area.

Primarily, I also need to differentiate, we have 700 or thereabouts physicians on staff; 500 are fee-for-service and a little less than 200 are salaried. We are responsible in the salaried area for recruiting those physicians, so it would be 200 positions.

Generally in an area – so if you picked Come By Chance, for example. If Come By Chance has two fee-for-service physicians who work in the community, when they are about to leave they are generally responsible for finding their own replacements. Eastern Health is prepared to help them. We are doing that now on the Burin Peninsula where we are helping some communities put fee-for-service physicians.

We will help those people recruit those fee-for-service physicians, but it is not primarily our job, it is to recruit people who are salaried. We have something like eight vacancies now throughout our entire region. Some of them are GPs; Terrenceville, for example. Some of them are specialists; it might be a neurologist, for example, at the Health Sciences Centre. We have a good working relationship obviously with the department, with the medical school, with the clinical leaders throughout the organization. We try to anticipate where we are going to be in three years' time or five years' time with various physicians and others on staff and make sure we can recruit, whether it is internally in Canada or somewhere globally. We are in a global, international competition for physicians.

Fortunately or unfortunately, depending on how you look at it, Memorial has a superb reputation so there is a tremendous amount of competition for Memorial students. As you know, the med school is expanding this year by an extra twenty physicians so that will make more physicians available for Newfoundland. That is generally where we are on recruitment.

**MR. BEARNES:** Just to pick up on that, we have been having a great relationship with the Department of Health and the Physician Services Division to roll out some programs where we can incentivize our local graduates and Canadian graduates to come and work at Eastern Health following their schooling.

Two of the programs that have been recently adopted in the Province have been a signing bonus program and a bursary program. Both of those programs are directed at Memorial graduates and Canadian medical graduates. They are to support physicians to be recruited to difficult-to-fill positions. We are actively putting forward physicians who are interested in those rural areas to be supported through those two programs as well.

**MR. PEACH:** I just have a question for the Auditor General. I think it probably would be for the Auditor General. Under the Financial Assets there is one article there that says sinking fund investment. What would that mean?

**MR. PADDON:** A sinking fund investment would relate to, if I am not mistaken, probably your long-term debt that was incurred when the new Janeway was built. Eastern Health or the board at the time were authorized to borrow to construct the addition to the Health Sciences that now houses the Janeway.

As part of the debt covenant, they are required to contribute funds into a sinking fund. It is designed to be there to retire the debt when it comes due. It is essentially like a debt repayment. The Province has similar sinking funds on its own debenture debt.

**MR. PEACH:** They are not sinking.

**MR. PADDON:** What?

**MR. PEACH:** So they are not sinking?

**MR. PADDON:** No.

**MR. PEACH:** Yes, I have no further questions at this time, Mr. Chair.

**CHAIR:** Okay. Thank you.

I would like to do as much as we can – unless somebody really urgently needs a break, I would like to get to Mr. Hedderson to ask some, so every member participates. Mr. Osborne is next and then Mr. Hedderson. If it seems like I am pressing a little bit, it is because we booked more time for this review than we have simply based on the sheer volume and the size; however, if we are able to do more than we thought we could do more quickly, then we

should try to do that because that would give the possibility of finishing today.

I will not hold that out. We should assume we are coming back tomorrow. If we could do that, I would rather not have five and ten minutes as a way where we lose an hour or so in the course of a day if we have to come back and pick up the next day. So, if I am pressing a little bit, then that is why. It is for everybody's interest.

Mr. Osborne.

**MR. OSBORNE:** Thank you.

First of all, I will say I appreciate the answers. You have been very detailed in your answers and willing to provide information.

In my previous questions, I guess part of the drawback of this type of Committee is everybody is allotted so much time, so you are going in a direction and then it is somebody else's turn to ask questions. One of the questions that I had asked was whether or not there was an individual or a group of individuals responsible for looking for cost savings. I guess more pointed towards that – and I think George had talked a little bit about an internal audit division – would an internal audit division pay for itself in finding efficiencies and savings within the organization?

**MR. BUTT:** It might; it is hard to say. The first function of an internal audit division is to ensure compliance with policy; that is what an internal audit division is about. So the board hands down policy, executive interprets it to operational policy, and then an internal auditor would make sure that the controls and the application of the policy is appropriate and is followed.

To the extent that not following policy might cause some funds to be not spent as wisely as they could, it is conceivable that that would add value. I think the first function, though, of an internal audit division is to ensure compliance with controls and policy standards. As I said, that might prevent some things that happened that we would not know are happening. I think the first function of the internal audit division would not be to assess efficiency, I think that is better left to others in the organization.

**MR. OSBORNE:** There are two areas here I would like to explore more and one is compliance with policy. You look at paid annual leave, sick time, purchasing, there are policies there where the organization is so large it is often difficult – and I recognize that – to stay completely within the policies. An internal audit or an internal audit division would help with those areas.

**MR. BUTT:** Absolutely.

**MR. OSBORNE:** The Auditor General has pointed out inefficiencies with purchasing, inefficiencies with sick time, with mileage, and so on and so on. On the other side of that is the position that I talked about earlier, either a position or a couple of employees, would they pay for themselves, somebody specifically dedicated?

I know, Don, you had talked about managers looking for efficiencies, but it is often difficult for managers to find those efficiencies because they are competing to find efficiencies with competing to provide the services and so on. If you had somebody dedicated and looking to finding financial efficiencies within the organization, would that position pay for itself?

**MS LEHR:** That is the function that the performance office – and I take responsibility for the chief performance officer – to look through the organization to find efficiencies. In that portfolio, we have done the operational improvement initiative to work with the management teams to find efficiencies, to do clinical efficiency reviews, and to see if we are using our clinical resources as efficiently and effectively as we could.

We are building very good analytical tools using Cognos, a business intelligence tool, to provide reports to our management team but to work with them. Not to just throw information at them, but to then do the analytics with them to help them see that the way we are delivering our services is not quite as efficient as it could be, and then to help them identify initiatives that we can put in place: detailed budget monitoring, variance reports, labour distribution reports, utilization reports, lots of statistical analysis, scorecards for the services and the programs that we deliver. So, we are using all of our tools and

our budgeting decision support, clinical efficiency, management engineers, lean team, to provide that function. We have dedicated resources in the organization to help the organization be as efficient as it can be, and we are really focused on that right now and we are putting a tremendous amount of effort into getting the organization back to a balanced budget.

**MR. OSBORNE:** Reece had mentioned two incentives to try to recruit physicians throughout the Province: the signing bonuses and bursaries. I know in the response Vickie had provided, number 8 of her response, said that there were no commitments for signing bonuses made by Eastern Health since the directive of the department, July of 2011. So I am just wondering how that has affected or the two incentives that you had talked about earlier, the bonuses and the bursaries?

**MR. BEARNES:** None of our physicians have been committed signing bonuses from Eastern Health since the July 2011 directive. Any of our signing bonuses that have been paid out since then were committed to those physicians verbally or in writing prior to the directive.

What was rolled out this year was a provincial signing bonus program by the Department of Health and Community Services. Any physician that we are try to incent to fill a difficult-to-fill position is now brought through that formalized program – and again, we work very closely with the Physician Services Division around that program. From a go-forward perspective, when the organization would like to support a physician in a signing bonus, it would be directed through that program.

**MR. OSBORNE:** Okay.

Just so that I have a better understanding, I know when I was in the department, Don, recruiting physicians is always a challenge, especially in certain areas, and I know that all of the health authorities had used the signing bonus in that effort. Putting that arm's-length now – well, I guess initially eliminating the signing bonus, how did that affect the recruitment of physicians?

**MR. KEATS:** Recruitment over the years has always been a bit of a difficult problem. I think as time went on we got much better at recruitment and much better at selling our organizations. We, at one time, would pay a physician some moving expenses, for example, over and above, depending on where the physician was moving from. We basically stopped doing all of those because we wanted some standardization and some controls on that around the Province.

I do not think that kind of thing has had any negative impact. It has been offset by the fact that we now have, for example, a physician recruiter who spends full time doing that. The individual doing this is located in the medical school. They have close contact with the medical students and so on. The other RHAs have physician recruiters in addition to the medical directors.

I know in my previous job as the CEO, every year we seem to get a little better at doing physician recruitment and making sure there were things for retention. Just as an example, you go from recruiting a physician to recruiting a family. It is no good to say I am going to bring in a physician if you do not take into account the physician's family. Sometimes the family needs assistance in getting work.

I remember, just as an aside, trying to recruit a specialist in ENT in Central Newfoundland. We had this physician come in; we did all the things we needed to do with the physician and the physician's spouse saying here are the things in the community. We showed them around, showed them all the good things: the fishing, the golfing, and all those things.

At the end of the day he said to me: There is one thing I did not see. I said: What was that? He said: a bowling alley. I said: We have one. He said: Five pin or ten pin? I said: five pin. He said: I am coming. That is the thing that we do as a family for an attraction. We had that physician for about five years. He is still there in the Province now, moved from Ontario.

I do not think there has been any negative impact as a result of reducing those things. We just have a better package and a better mechanism for recruiting physicians.

**MR. OSBORNE:** What percentage of homegrown, medical students from Newfoundland and Labrador – what is the percentage now of retention of our own students?

**MR. BEARNES:** We again actively recruit specifically for Memorial graduates in many ways – through the recruitment office and through the recruitment co-ordinator. We also work with MUN to help build an educational experience whereby medical graduates want to stay and work at Eastern Health.

The question around the number of retained graduates from the medical school, I do not have that number. I can say anecdotally that any of our medical graduates from Memorial who come and work at Eastern Health, we have seen very little turnover. In fact, all of our specialists who return as Memorial graduates to Eastern Health have been retained.

So we have seen great retention of our local graduates, and I think it really goes back to building that relationship with the Memorial students very early in their career and working with them to understand where they see their career journey. That is why we have a dedicated resource that, as Mr. Keats said, works actually within the medical school to help build that relationship and help open opportunities throughout our region so that we can be sure that we are retaining those graduates.

**MR. KEATS:** Just add one thing to that – the medical school has changed the way its program is provided now, they do it in streams, and there is a greater emphasis throughout the medical school term that you are in medical school on rural Newfoundland and getting physicians out to do their rotations in rural Newfoundland.

I think that will add to the successes of recruiting Memorial-trained physicians throughout the area. With the twenty additional physicians through Memorial, it should lead to a greater percentage in overall relative terms staying in Newfoundland. I do know from experience once you start recruiting physicians and you get physicians from Memorial to set up in your communities, they attract a greater percentage of Memorial graduates, whether they are from Newfoundland or from rural Newfoundland or from other provinces. So the success breeds success in that particular case.

**MR. OSBORNE:** Okay.

The Auditor General had found that were no return-in-service agreements for physicians who were reimbursed relocation costs. Can you elaborate on that?

**MR. KEATS:** Yes.

We do now have a new return-in-service agreement that is essentially the government's return-in-service agreement. There was not one in place before then, but looking at it retrospectively, there was no evidence that anybody who received a return-in-service agreement actually left before their term was up.

**MR. OSBORNE:** Okay.

Just to go back to an earlier comment - the signing bonuses - am I to understand that the discontinuation of the signing bonuses has not had a negative impact on the recruitment and retention of physicians?

**CHAIR:** Mr. Bearnes, is it?

**MR. BEARNES:** No, we have not seen any challenges due to that. What we had was an overlap of time as well with the two programs. Where we had not committed to any signing bonuses there were signing bonuses that, as I said, were paid out following the directive, but those were committed to prior to the directive.

With the new signing bonus program, we do have a mechanism now whereby those folks who are interested in coming to our difficult-to-fill positions are brought through that program. To your question, we have not seen any negative impact in the time between the rollout of the provincial program and the 2011 directive that negatively impacted our ability to recruit physicians.

**MR. OSBORNE:** Okay. Why was the new signing bonus program implemented if there was no negative impact or if we saw no reduction in the recruitment of physicians?

**MR. BEARNES:** It was an initiative of the Department of Health and Community Services to roll out a consistent approach across the Province around how each of the regions offers signing bonuses to potential recruits. The focus of course was on retaining medical graduates from Canada and also from Memorial University. There was an intentional shift in the program that we were to focus on Canadian-trained graduates and also graduates within the Province.

The other piece of the program was to focus on those positions that are difficult to fill. There is a criterion now within the program that deems when a position is difficult to fill. Now where there is consistency across the Province, we are not now competing with the other RHAs in relation to trying to recruit these physicians who are often very difficult to fill into these positions.

My understanding is that through the rollout of the program, it is now creating a consistent approach across the Province in terms of how we are incentivising physicians to come and work in Newfoundland.

**MR. OSBORNE:** I appreciate that, because I remember the different health authorities actually competing –

**MR. BEARNES:** Yes.

**MR. OSBORNE:** – and upping the ante with signing bonuses, competing against each other, and physicians playing one authority off against the other. So, I agree with having a more centralized approach and a consistent approach across the Province. The disconnect that I am trying to understand is between the time that the signing bonuses were discontinued and the new program initiated through the department, if there was no negative impact on the recruitment of physicians, why would there need to be a signing bonus program implemented through the department?

**MR. KEATS:** It may be because of the overlap. For example, we committed signing bonuses to people that were effective after 2011. We had some people who got signing bonuses, I think, into 2013. So a part of it may have been the overlap, the fact that people were getting signing bonuses that were already prior commitments; but also, with the signing bonuses, as Reece had said, they are more targeted.

The other factors are still in place, and sometimes a retention bonus helps with your recruitment bonus. So we still have these retention bonuses that are across the Province and they now apply not only to salaried physicians, but they also apply to fee-for-service physicians. So putting those in, people may have said I do not care, really, if I get a signing bonus, but if I am getting a retention bonus every year they take the place of signing bonuses. The retention bonuses have been expanded right across the Province and they apply to all physicians right now.

**MR. OSBORNE:** Okay.

One final question on physicians, I think Mr. Hedderson is anxious to ask some questions.

There was a physician who received $1.5 million in payments over an eleven-year period when there was no additional workload. Can you explain that?

**MR. KEATS:** I will make a general comment on it; again, Reece may want to add to it.

There is a program in place so if let's say there are two physicians required for an area, or 1.7 or 1.8 and if somebody is doing the work of two physicians they get the double pay, or they get the part of the pay. There is a formula for determining how much they get.

In this particular case in 2002, I believe it was under the Avalon institutions board, two pathology positions – the physician was given an option of do we try to recruit, and it was extremely difficult to recruit physicians at the time. If we do not, you get the double bonus if you want to work and if you are able to provide the work. That is what happened in that particular case. The individual opted to say yes, if you cannot get somebody, I am quite prepared to work for the extra pay.

I should note as well, and as you have indicated, this was over an eleven-year period. A large part of the payment – the individual was a pathologist. When the physician started out

getting double pay, I think the pay for a pathologist was under $100,000. Since the ER-PR, pathology incomes went up significantly for comparisons with the rest of the country and in line with what our oncologists were getting in the Province, and a fair bit of that money related to the last few years of work as opposed to the eleven years. Nonetheless, the money was there.

This individual no longer gets that workload because the workload has been redistributed to other areas of the region to pick up the pathology workload. There are examples around the Province where individual physicians may still get double pay – it is not quite double pay – for doing the work of extra. Sometimes it is on a short-term basis for relief purposes. You provide the work for your colleague for an extra month or two months and you get paid for it. The idea of providing for two people used to happen a fair amount in the past when we could not recruit the specialists. It is not a widespread initiative right now.

**MR. OSBORNE:** If I could, Mr. Chair, just a very quick follow-up to that before we move on to Mr. Hedderson. The $1.5 million that was paid, am I to understand that the additional pay, even though there was no workload, that payment was justified?

**MR. BUTT:** The second position in Carbonear – and I was CEO of Carbonear at the time actually, so I have some history in this even though it is not my area now – was created based on a workload study that was done at the time. I think it was sanctioned by the Department of Health and Community Services. Based on an analysis of the workload in 2002, the Department of Health actually approved a second position for the service. So the additional pay was predicated on a need for a second position. The workload was there at the time to justify the second position, obviously.

**MR. OSBORNE:** Okay.

I beg your indulgence, Mr. Chair; I will ask the Auditor General: Can you add any further insight into this?

**MR. PADDON:** I guess the issue that we were raising – one was the length of time that this additional pay was paid, and it really related to the issue, as Mr. Butt just indicated, that a second position was created and presumably then it was the funding from that position that was used to augment the pay from the physician who was in that position. Our issue was that it did not appear that there was any posting to recruit into that second position. So this really did not appear to be a short-term measure to get over a hump. It almost became part of the norm, as opposed to just a temporary thing.

**CHAIR:** Maybe one of the Eastern Health witnesses would like to respond to that, because I do not know the answer. Maybe it is a legitimate response; maybe it is not.

**MR. KEATS:** I can give you some other examples. When I worked in Central Newfoundland we had approval, and the workload was there for two urologists – actually, when you looked at the units and so on it was about 1.8 or 1.9 urologists. Several times we tried to recruit a second urologist. A couple of times we were successful in getting somebody who came for a short period of time and left, and then they came and left.

That creates a problem because you are the guy who comes and you are Doctor X and a bunch of patients will get an appointment with you as opposed to the urologist who is already there, and then suddenly you leave again. So you have to get your workload transferred to somebody else and go on another schedule. People would look at it and say, well, if I had stayed with the other guy in the first place I would have been further up the wait-list, and now I am just getting added to (inaudible).

For a variety of reasons, we said it is not efficient and effective for us to recruit another urologist. They are not there. We know they are not there. We scoured the country. It is no point advertising a job; we could not get anybody. So the urologist who is there agreed that I will carry on, I will work the extra time, I will do the extra call, I will do whatever is necessary if I get a portion of the pay of that urologist in accordance with the formula that the government has put in place.

So, it was not that the individual was getting double pay for not doing work; the individual was getting double pay for doing the work of

what normally would be two specialists. We were in a situation where we knew we could not recruit. We just could not find urologists across the country. Even big cities could not find urologists at the time.

**CHAIR:** Mr. Keats, are you saying in that case it was selecting the lesser of the two evils which then became the normal for the long term? Is this is the same thing that happened here that the Auditor General's Office picked up?

**MR. KEATS:** Yes, and I think you would find several instances of that across the Province in the last several years if you looked at that scenario. Specialists were doing the work of two people and getting pay. You may find that there may have been three specialists doing the work of four people and they were dividing up the pay.

If you are a fee-for-service individual, you do not come across that because presumably – so again I will use the Central Newfoundland example because I know that one. At one time we had four general surgeons who were generating the work of four general surgeons and that was the number that was deemed necessary at that time. One of the general surgeons for family reasons left the region, so the three other general surgeons said we will continue to do the work. They did the work basically of four general surgeons. Because they were paid on a fee-for-service basis their incomes all went up by approximately one-third, but that does not show up through any mechanism.

They actually went down to two general surgeons. These two young general surgeons said we are prepared to do the work under the watchful eye of the Medical Advisory Committee to make sure that it was safe work to be done before they were able to recruit the other two general surgeons, all of whom were on a fee-for-service basis. That would never be picked up in a review by anybody in terms if somebody is getting extra pay because they got paid on a fee basis. If these surgeons decided they did not want to do the work, they would not get the pay.

**CHAIR:** We should go on to Mr. Hedderson, and then we will take a brief morning break. We can revisit that subject if Mr. Osborne is not satisfied that the answer is as complete or was what he was looking for.

**MR. HEDDERSON:** Thank you, Mr. Chair.

A welcome to our people on the other side; I do not often welcome people on the other side here.

**WITNESS:** Play nice.

**MR. HEDDERSON:** Okay. Get used to it.

As you know I am a fill-in this morning because unfortunately Eli could not be with us. I have just been picking up on some of the questions and going over the report. The deficit is front and centre, but just a little bit of clarification: the last five years was $80 million, so that is about $15 million or $16 million a year on average. What percentage again is that of the $1.4 billion?

**MR. KEATS:** Over the five years, the budget for Eastern Health is somewhere around $5.57 billion, the approved budget, and the deficit was in the range of $80 million-something. That is less than 1.5 per cent of the overall budget.

**MR. HEDDERSON:** Don, you talked about benchmarking with other jurisdictions. Is that really a terrible thing? Comparative analysis across health boards in the Province or whatever, where do we stand? Are we the worst there? You know what I am looking at.

**MR. KEATS:** It varies at times when you look at organizations. We have looked at organizations in Western Canada, in Alberta as an example which has lots of money who have had significantly higher deficits over a period of time. The objective all the time is to make sure that this is your budget and you live within your budget because if everybody did the same thing, we would be bankrupt pretty quickly.

Because of the nature of regional health authorities and the nature of the business of regional health authorities, it is really difficult to – we do not know how many people are going to show up in our emerge today or tonight and we do not know what is going to happen out in some of the rural areas or whatever. We do not know if we are going to get a sudden loss of

staff and suddenly we have to pay a bunch of overtime for other staff and so on. We can control a lot of things; there are a lot of things we cannot control.

As we said, there are two things we want to do. We want to make sure right now that there are no permanent or part-time people who are laid off and we want to make sure we do not have a reduction in services. When you take out all the factors that impact on that – so if 75 per cent of our budget relates to compensation and another 10 per cent or 12 per cent relate to fixed services, it does not matter if you have X number of patients or X plus Y number of patients, we are still going to have a lot of fixed services. A lot of it relates to the consumables for those things, or the supplies and the drugs and so on. We do not have a lot of flexibility in what you would call discretionary expenses to make the savings.

I think Eastern Health has done a tremendous job. I have only been there for two months and a bit, and I think they have done a tremendous job trying to get this budget down. Last year we were down to $8 million, and that is half of 1 per cent of your overall budget.

**MR. HEDDERSON:** You know my point. My background is education, and education is as flat as this, but I know you are like this – if I can just point out – up, down, spikes, so on and so forth.

**MR. KEATS:** Right.

**MR. HEDDERSON:** So again it begs the question – we are going for a balanced budget, but obviously I am hearing from you that not at the expense of good quality care.

**MR. KEATS:** The first priority of Eastern Health is to provide safe, quality care to the people of Newfoundland and Labrador.

**MR. HEDDERSON:** Absolutely.

With regard to accreditation, again, can you just go back over that for me – your accreditation designation or something, the latest one? You made some reference to it. Again, you also referenced that you did a benchmarking exercise a number of years ago and we are the worst in the country –

**MR. KEATS:** Yes.

**MR. HEDDERSON:** – but obviously there has been some significant improvement since then where you now have accreditation and some accommodation or whatever it was. Just go back over that again for me.

**MR. KEATS:** Accreditation Canada will do accreditation surveys of all health care organizations across the country, and they have a series of rankings that they will provide you based on their reviews, and they have a large number of standards that you have to meet. Eastern Health received – I think it is the highest standard that you can get – Accredited with Commendation. They were very positive about the level of services and the quality of the services and so on that we provide.

There are some areas, though, in doing that, in doing the standards, that patient flow may not have been the best. So, can we move more patients through the OR if we put in a lean process and figure out how to do that? Can we move more patients through our ambulatory clinics and those areas? Those are the things that we are working on, and those are the things where we are finding the money. Because if we can put through patients quicker, in one way it makes us more efficient; in another way, it might make you more costly. If we can put more patients through the same number of beds, it might mean more money for us, but it means better care and less wait times for our patients.

**MR. HEDDERSON:** So, having been tasked with the aspect of having a deficit, and a consistent deficit, you had to take some measures, and those measures were obviously looking at the HR and so on and so forth. Despite that, you have raised the quality, obviously, through accreditation and so on and so forth. Obviously, you are doing something.

When you talk about deficits, and trying to take care of deficits, the first thing people think about is you are cutting services, you are cutting this and you are cutting that, but in actual fact in your exercise, to have control of that deficit, you have in fact increased the quality, as is evident by this particular accreditation that you have gotten.

**MR. KEATS:** Yes, I think that is a correct statement. Sometimes the general public will think that if you want to resolve a problem or if you want to get better quality care, you need to throw more money at it. The two do not necessarily go together.

Other times – we will get this a lot – if you reduce your budget, it means you are reducing quality of care. That is not necessarily true either. In fact, if you have your staff on a quality, safety, risk-free philosophy, you provide the services better. You do not have to redo services. You do not have to rework the things you are doing. By increasing the quality and the throughput, you can actually reduce the costs at the same time.

**MR. HEDDERSON:** Mr. Chair, I am going to leave it at that point. We have been sitting here for a long, and I just wanted to get that thing in. So, with your approval, we will take a well-earned break.

**CHAIR:** I am going to ask people if we could take the shortest break as possible, say, ten or twelve minutes and we will just keep on going. I am quite impressed with the comprehensive nature of the answers. Members have gone longer than usual, but I think we are covering a lot of ground fairly comprehensively. If we could get back here, say, 11:15 a.m. on that one, that would be good.

**Recess**

**CHAIR:** Okay, thank you.

We are back in session and we will resume with Mr. Murphy.

**MR. MURPHY:** Thank you, Mr. Chair.

I would like to thank the members of Eastern Health for their co-operation again. Hopefully we will not keep you too long before we get you out to the barbeque. The weather is absolutely gorgeous out there today.

I want to come over just very briefly to the point that the Auditor General made where he said that there was no functioning internal audit department during the period of our review. A couple of things jump out at me too when he says that point. In numbers 26 and 27 on page 9 of the Auditor General's report – in number 26 he says, "The purchasing function was being performed by individuals outside of the Material Support Department. There were 243 users that are able to create purchase orders, however, there were only 140 employees in the Materials Support Department."

I take it that the Materials Support Department – maybe the Auditor General can answer this one, just as some background. When you are talking about the 140 employees in the Materials Support Department, were you referring to those people as being the only ones responsible for filling out of purchase orders, or the only ones who would have the authority to do it? (Inaudible) mike over to Mr. Paddon.

**MR. PADDON:** Yes, the Materials Support Division are the ones who would be responsible for the purchasing function in the organization. It would be those people who you would expect would have the authority then to create purchase orders and those sorts of things. What we found then, there was 140 – I cannot remember how many now –

**MR. MURPHY:** Two hundred and forty-three users.

**MR. PADDON:** Two hundred and forty-three users, but there was only 140 employees in that division. So you had effectively more people authorized to create the purchase orders than you had in the division or the department responsible for purchasing.

**MR. MURPHY:** Okay.

In your audit, did you uncover any reasons as to why these 103 people would have had that authority?

**MR. PADDON:** The 140 are not the problem; it is the additional ones (inaudible) –

**MR. MURPHY:** Yes, the 103 difference.

**MR. PADDON:** Maybe I will ask Brad to comment on that.

**MR. SULLIVAN:** I think at the time most of the reason may have been related to timing.

People left the department and moved on; however, their access was not cut off. These people could have moved to other divisions or departments within the authority. They could have retired or have been terminated. They were the main reasons provided to me at the time.

**MR. MURPHY:** Okay.

I guess the question then for Eastern Health, there is no internal audit department, so I am wondering about the possibility – there was a window here for the potential of abuse, possibly, that could have happened with these 103 people. Do you have the reasons why these 103 still would have had signing authority? There is a lot of turnover there, if it was just for people leaving.

**MR. KEATS:** Brad is right. The main reason is you work with Materials Support today and you leave and your authorization stayed with you when you left, as opposed to it being – so there were more people with the authorization than were in the department, and I think a retrospective review indicated that none of these people had been doing purchasing after they had left.

We do agree that our purchasing area needs some work – needs a fair bit of work. One of the things that is happening with Eastern Health and all RHAs around the Province, all four RHAS, we are having discussions with the Health Department, and have been having them for some time, regarding the possibilities of consolidating a lot of back office services, such as purchasing, for example. So, we changed the controls in the purchasing area, but we are not going to make any substantial investments in inventory or in purchasing areas until we figure out if we are going to go with some shared service arrangement around the Province.

**MR. MURPHY:** Okay.

In section 27, "Internal controls over cheque processing are inadequate. As a result of improper segregation of duties and authorization requirements, there is an increased risk of fraud and error occurring." My only point in bringing up these two particular sections has to do with the good case for Eastern Health to have more resources to dedicate to internal auditing, have a separate department set up to look after the needs and the taxpayers' money.

**MR. KEATS:** Thank you for that, and we accept that. There is no doubt that there is a great need for an internal audit function; however it is performed or wherever it is, if it is a risk management area or whatever, we need that internal audit to complement the external audit that is being done.

**MR. MURPHY:** Okay, thank you for that.

I wanted to come back again to some other sections that were touched on already. As regards additional workload benefits, the education differentials that were paid out, how is it that executive and management employees could be paid educational bonuses for qualifications that they needed to hold the job in the first place?

**MR. KEATS:** I will make a general comment on that. I guess that was one of the things – in order to function well in a complex environment like Eastern Health, you have to have certain expertise and skills. The organization said we would like our leadership team to have the best skills that they can have to help us run this organization on a daily basis. To do that, we were prepared to assist them. Some of the programs, services were offered for educational support. One of the key things in any health care organization is having the proper skilled people in there, but, secondly, making sure that you have professional development, continuous learning, and so on.

I guess I could also make the argument – although it is probably a moot one, but I will say it at any rate. When managers are classified under the Hay classification system if you look at it, there is nothing that talks about educational levels. An individual can be given the job without any education as long as they have the expertise and the skills, however acquired, is what the actual description says. I could argue on the one hand that having a master's degree has nothing to do with your classification, but on the other hand you need a master's degree in order to do the job that we expect you to do in today's environment.

**MR. MURPHY:** No, and I can agree in some aspects of that where the department, for example, might have to go ahead and develop its own skill set. For example, they might want to get somebody who has been totally inexperienced with it to break him into the system and train him under their own guides, so to speak. I can understand that. If that is what that is, then I am good with it.

A basic management question then – I would think that people being told that they were getting a cut in pay, for whatever reason, they would not be happy – what was the average drop in reimbursement for people in this particular category? Were there some people who faced cuts?

**MS MOLLOY:** There were two differentials that were changed as a result of the educational differentials being changed. One is for a baccalaureate degree and the second one is for a master's degree. If you had both, it was around $200 to $300 annually.

**WITNESS:** (Inaudible).

**MS MOLLOY:** It was $2,300. Thank you. Sorry.

**MR. MURPHY:** Okay, so it was not too serious.

**MS MOLLOY:** Yes.

**MR. MURPHY:** Yes, okay.

**CHAIR:** Ms Molloy, you were attempting to elaborate on the earlier answer from Mr. Keats. If you wanted to go back and do that, please feel free to do so if it was not complete.

**MS MOLLOY:** Thank you.

The education differentials came about – quite some time ago, the Nurses' Union put in differentials within their collective bargaining. It is something that you get as a nurse if you go on to receive your bachelor's and your master's degree. Quite a long time ago that got extended through to nurse managers. Eastern Health then further extended that to all of its management group to encourage people, as Don had said, to pursue higher education. We had not gone through the process, though, of asking or applying for a market differential to do that, which is the policy within government that you have to follow in order to give differentials like that. Hence, the Auditor General was quite right that we had not gone through that process. We did follow through that process and unfortunately the market differential was not maintained.

**MR. MURPHY:** Yes. What was the reason for circumventing the process, though?

**MS MOLLOY:** I just think at the time perhaps people were not aware of it. The expansion that happened, there was an original approval that went to nurse managers, and then through internal discussions it was well, we believe in education and we think people should be pursuing education and we would like to even out the playing field for that. So, I think it was just a lack of knowledge that it was something we needed to do.

**MR. MURPHY:** All right. So there have been corrective measures –

**MR. KEATS:** I just want to add to that. As indicated, going back to the late 1970s in the nurses' contract, this education differential was there. If you had a BN or an MN, you got a differential, if you were supervising nurses. So you needed the two things; you needed the education degree and you needed to be supervising nurses.

When that came in play – for example, the Health Sciences Centre was a traditional organization and generally it was nurses who supervised nurses. The problem it creates when you have a large organization that operates under program management is that we now have people in the organization who are not nurses who have master's degrees who supervise the nurses, but they do not get the differential.

**MR. MURPHY:** Yes.

**MR. KEATS:** So, there is a little bit of an inequity that exists there, and that was part of the rationale with Eastern Health saying so, if Sharon is a nurse supervising nurses and gets the differential, and for some reason there is an organizational change and I become the person

supervising nurses and I have a master's degree, but it is in physiotherapy or something else, I do not get the differential. So that was part of the rationale to try to create equity across the organization, and unfortunately we still now have that inequity. It is really tough to explain to people who are your front-line managers: Sorry, you have to lose that, but your other colleague gets to keep it.

**MR. MURPHY:** Yes.

Do you have any idea how many of your employees might have been affected by that?

**WITNESS:** We can get the exact number (inaudible).

**MR. MURPHY:** Yes, I would not mine knowing, out of curiosity.

I want to come back to –

**CHAIR:** Mr. Murphy, they can supply that number; it can be part of our findings at some point. If you are able to do that (inaudible) –

**MR. MURPHY:** It would be great if we can get it, yes.

I want to come back to the reimbursement for personal vehicle usage, the mileage; you touched on it earlier. In an answer to a question on compliance with the mileage reimbursement policy, the authority reported that audits would be completed to ensure compliance. Have you done that?

**MR. KEATS:** Generally, we have compliance with that. Again, we have travel claims for 5 million or 6 six million miles of travel every year. Most of them, the vast majority of them, are all done in compliance. Occasionally we miss some of them, but it is always picked up through one system or another. So if it is not on a travel claim, I think it is picked up through our payroll system. Is that correct?

**MR. BUTT:** I think two years ago we paid 5 million kilometres to our employees. As a result of our austerity measures, we moved that down to 4 million. Our kilometres are paid through our payroll system. Basically, the employee submits a travel claim to the manager who signs it and it goes to the payroll system for payment.

In the incident cited, the people entering payroll did not pick up on the fact that the claim had not been signed. The claim was fine, the director supported the claim and everything, but it had not been signed. It comes back to the broader question of internal controls. I think the Auditor General rightly cited a concern about lack of documentation to support what is actually entered into the payroll.

We are doing two things to address that and that should address this problem as well. One is our payroll people are working with our learning and development people to develop a re-education program for managers and for time keepers so that their knowledge of this will be refreshed. The other thing is as a part of the EY, the scope of the EY studied that we have commissioned, payroll tracking authorizations is one of the things that we are asking EY to look at for us and give us some recommendations on how we go about improving that. That is our two sort of responses to that concern.

**MR. MURPHY:** Five million miles in the run of a year?

**MR. BUTT:** Kilometres, yes.

It is a big organization. We have a lot of public health nurses, people who just drive for a living, so we pay a lot of mileage.

**MR. MURPHY:** Would ambulance be included in that?

**MR. BUTT:** No, that would not be included in that.

**MR. MURPHY:** It would not be. Okay.

**CHAIR:** We should move on to Mr. Parsons now.

**MR. MURPHY:** Yes, sure.

**MR. K. PARSONS:** It is difficult sometimes to line up your questions because usually there is someone asking them beforehand, so I am going to be a little bit all over the place for the next little while.

I want to go back to recruitment bit that you were talking about earlier. In the general sense, I want to know where we are. Because I know we have more doctors and nurses than ever before in our health care system and obviously we are doing a good job in recruiting people.

With the additional twenty or so that were mentioned, new doctors that will be coming out, where are we to in the future? Are our needs right now where we need to be? Do we need more doctors? Do we need more nurses? Is that what our focus is on? Every time you hear in the news, one of the negative things that come out, especially in the summertime – and I know it happens a lot in the Central part of the Province. There was a big discussion on it about the availability of nurses and availability of doctors.

I just would like to know in the general terms where we are. I am sure it is an issue because I recently was over in Nova Scotia and basically I heard the same thing. It was identical to what was happening in Central with nurses taking leave and holidays. People were complaining about how they have to be on standby for twenty-four hours. It was almost identical, the same thing. I just want to know in general where we are as a Province when it comes to recruitment and what we are looking for in the future.

**MR. KEATS:** I will talk about the nursing thing and Reece will talk about the physicians. From an overall perspective, in Newfoundland and Labrador we have more nurses per capita than any other province in the country. Of course, we have a rural issue. All the other provinces have rural issues but we have, I think, a different type of rural issue. We have a short summer, so everybody wants to take leave the same time this time of the year. We try to find replacement nurses to provide relief so people can get their leave.

It is noted in the AG's report in another recommendation, by the way, that we allow people to carry over leave above and beyond the policy and the collective bargaining agreement. The simple reason for that is if we cannot give you your leave, we cannot take it from you either. We allow you to carry it over above the limits that we should and that creates ongoing accrual problems for funding levels down the road when these people leave.

Generally, in terms of nurses, we have the best in the country. I can remember a few years ago that every nurse who graduated from Memorial pretty well had a job in the Province. Now we have situations where nurses are leaving the Province because they cannot find full-time or part-time, permanent jobs in the Province.

People will say: How come you do not give every nurse full-time, permanent jobs? Newfoundland and Labrador also has the highest percentage of nurses with permanent positions. I cannot remember the exact numbers, but years ago around 80 per cent of all of our nurses had permanent positions when the Canadian average was like 52 per cent. That creates a real problem in a way in terms of efficiencies because every time you hire a nurse in a permanent position – which is what you would like to do because that gives them benefits whereas when they are casual, they do not get benefits – you have to give them a six-week schedule. For the summertime period, it is kind of tough for us to give every relief nurse a six-week schedule because we do not know where the demand might be two weeks down the road.

That creates kind of relief problems, particularly as I say when the vast majority of people want to take their vacations in a short period of time. From an RN-BN perspective, we have the most in the country. From an LPN perspective, we have the most in the country.

We do have some problems now in the PCA category, Personal Care Attendant category; we do not have as many of those in the Province as we would like to have. You would think in a Province like ours with our unemployment rate that you would have a lot of people who would be anxious to take a thirty-week program to go out to pretty well a guaranteed job – it is not a full-time, permanent job at the start, but it quickly becomes a full-time, permanent job.

The problem it creates, though, is they can get work with no education in some of the trades in other areas. Instead of getting $18 an hour, they might get $24 or $25 an hour. From a nursing perspective, we are generally pretty good, but it

does create problems in the summer getting people for relief.

Reece – physicians?

**MR. BEARNES:** At a high level, we are in a very good position right now with regard to physician recruitment. As was said earlier, we are competing in a global market for physician talent. Newfoundland has always been a wonderful drawing card for physicians who are practicing outside of the Province to come to Newfoundland. Again, because we educate and train our physicians so well in this Province, they are sought after around the world. So, developing recruitment plan that is consistent with what our population needs are is the approach that we take.

Just some numbers – currently Eastern Health has 196 approved salaried positions for physicians across our region. We also have about 500 fee-for-service or alternative payment plan physicians. Of the 196 positions, as was said earlier, we only currently have about fifteen vacancies, and half of those have already been actively recruited to.

At a high level, we are doing very well in terms of our physician recruitment and retention. Part of the work that we do, of course, is to support our physician recruitment in our rural communities particularly, as was said earlier, family practice physicians. Although Eastern Health does not have employment relationship with those individuals, we do recognize that reduced access to family practitioners in those areas has a direct impact on the citizens in those areas. If there is not access to family practitioners in rural communities, then we see an impact on our emergency departments and on our services.

We are actively working with communities and with the Division of Physician Services to come up with strategies to recruit family medicine practitioners into rural communities and I had mentioned the signing bonus program and the bursary program as well. If we can say where is the greatest need right now, I think, to your point, it is in rural communities that are having challenges with community practitioners. We are ever vigilant about how we recruit people to those positions, particularly among graduates.

**MR. K. PARSONS:** We could probably sell them on our weather and tell them that we are having the same weather for twelve months of the year. That would probably be the best way to do it.

I want to go back a little bit. I talked a little bit earlier about sick leave. Sick leave concerns me. I know when I worked in private industry there was a little benefit that you would have if you did not use your sick leave. Is there anything like that in Eastern Health? I am not sure, is there something there that they offer to employees say, if you do not use your twenty sick days or your ten sick days, I am not sure how many they get – is there any kind of benefit to anybody?

**MS MOLLOY:** There was within one of our collective agreements, NAPE. Quite some time ago they put in an incentive within the laundry department that did see a small payout if you were not using as much leave as the average. It has not been as successful as they had hoped initially, so it was not expanded beyond that one small area.

Incentives in general, when you do some research around it, do have some short-term benefits. Sometimes in the longer term it is concerning because then you have people who are because of the incentive coming to work when they are not well. We as well are very interested and focused on our sick leave and how to handle that.

**MR. K. PARSONS:** I believe, though, that with some incentives – I am not saying that all sick leave is abused or whatever; that is not what I am saying. I am thinking that if there is an incentive there that a person realizes, listen I got up in the morning and I have twenty sick days left, I have not taken many; but if there was a benefit at the end of the day that they went to work, it may improve when you look at the health care system.

The health care system is way different, I understand, from government because of lifting and moving and everything else that is done in the health care system. When you look at the overall 20 per cent more sick leave than in other departments, I am just wondering if there was an incentive program that may reduce this by a

certain period of time. It may be something you could look at going out.

I am sure you do look at other authorities all over the country. Maybe there is something there that is available that they use that may be a good incentive for people not to be taking so much sick leave. That is something that I think should be looked into, and you probably already have done that.

**MS MOLLOY:** We certainly are researching it, absolutely. We do have a pilot project that is going on right now in a couple of our facilities. One of the things – while we are not incentivizing directly – is we have joint committees with staff and management. We are asking people: How would you like us to recognize you? Because we want to recognize if there is success.

If there are people who are using less sick leave on average than they were the month before, for example, or two months before, we want to recognize people for doing that. It is important to acknowledge that, where we have had high levels of sick leave. We are absolutely looking into that.

**MR. K. PARSONS:** In the industry that I came from we only had six sick days a year. If you used four, come Christmas time, you got paid for the two sick days you did not use. It was a little incentive, and I think people will use it if there is something there at the end of the day. It will benefit, obviously, with all the other costs of overtime, and then the care would be whole lot better also.

Also, we talked a little bit earlier about the shifts, like three overtime shifts in an hour-and-a-half, but we did not come up with any solution to that. I know people have to be called in for specialties with X-rays and on the weekends. Sometimes you could be almost home but they have to call you back again.

I think the instances that the Auditor General – there were a lot there, and it is a real area where abuse can happen. I am just wondering if there are some procedures or something that you can put in place. I understand that if a person is called in on the weekend, they get three hours. I agree with it 100 per cent.

If they are called within an hour-and-a-half and get three shifts, that is nine hours of overtime. That kind of hits me, as it could be a real way to abuse the system for one thing. It may happen. It may be legit that it does happen, and that is it. I think there should be some kind of a policy or something, or if you are working on anything in those cases.

**MR. KEATS:** It is going to be very difficult to get a change in the collective agreement with that, because it is there.

**MR. K. PARSONS:** Yes, I know, it is a collective agreement.

**MR. KEATS:** We do need to make sure that our physicians – who are the ones who are primarily the people who say I need a callback – understand that there are certain time frames. Don't call back somebody at 7:45 if somebody is going to be at work at 8:00 o'clock. Or don't wait until 4:20 if, say, you need a test done, if somebody is going to be at work and leaving at 4:00 o'clock. We have to do those things better, obviously, and manage those areas. We also have to make them aware of the consequences of the callback and the cost of the callback to the organization.

Over the years we have tried a number of things to see if we can get reductions made. It is a difficult area to make a change. Initially, when these things came into the contract – so in a regional hospital like Gander or Grand Falls and Corner Brook you may have had your staff working eight hour shifts and the cost of this callback became so great that it was cheaper to put on extra shifts.

The people who then worked in the labs and the diagnostic imaging lost a lot of money. They did not like the idea that you were putting on extra shifts because they were used to a level of income and developed a lifestyle based on the income they were getting. Until you get into an area where it is more cost effective to bring on the extra staff and you can get the extra staff, a lot of this stuff, I think, is going to carry on.

**MR. K. PARSONS:** I can understand how difficult it is. My thing is, if you have three shifts and in an hour-and-a-half there was some – if you get called in for overtime you have to

stay there for half the time for the three hours or something like that. I am not saying it is abuse; I am just saying the optics are not good when you look at the instances that are there. I am sure that you guys are working on it to make sure.

The Auditor General also mentioned about management overtime and it was not consistent with the government policies. Have you done anything to change that?

**MR. KEATS:** Yes, effective April 1, the week off in lieu of overtime has been taken away. Managers are eligible to apply for overtime consistent with the government policy. My own personal view, as somebody who has worked in the health sector for over forty years, is I think the time off in lieu of was a good system.

We have managers who work an inordinate amount of time under an incredible amount of stress. Probably the most undervalued people, amongst the most undervalued people, in the system are front-line managers. Nobody likes to pick up for managers. It is easy for everybody to say they are overpaid and underworked. I think it was a good system because it was clean, it gave them access to some time off, and it was appreciated by managers.

Now that it is gone you know how people react. I no longer get some time off in lieu of all the overtime I put in so maybe I am not going to put in all the overtime. Instead of travelling after hours, like most of them would do – so if you come in from Burin for a meeting or for something that is on the go you would come in on your own time travel and leave on your own time travel. I think we will get circumstances where people are going to say I am not going to travel on my own time anymore, I am going to travel on work time.

You are going to have a less productive management force in a way. The government overtime thing is so cumbersome in the health sector that a lot of people will not put it in. Eventually I think they will do it and we are going to pay out more money for overtime than we were paying when we had time off in lieu.

**MR. K. PARSONS:** I would like to ask the Auditor General a question. It is just basically the same question. Understanding the answer that you were just given, would it make more sense to stay the way that it was rather than go with the policies of government?

**MR. PADDON:** Essentially you are asking me to comment on a government policy.

**MR. K. PARSONS:** Yes.

**MR. PADDON:** Which is not in my mandate, and in fact I am specifically precluded from commenting on government policy.

**MR. K. PARSONS:** Yes.

**CHAIR:** As is the Committee.

**MR. PADDON:** The point is government has directed that boards and agencies comply with government policy.

**MR. K. PARSONS:** With the government policy, okay.

**MR. PADDON:** Whether the policy is the most efficient policy, well that is obviously a debatable point. I take Don's point: you do end up with likely behaviour changes as a result of changing policies, and whether that is for the better or not.

**MR. KEATS:** Just to reiterate, we have changed that policy effective April of 2014.

**MR. K. PARSONS:** To be honest, I understand that people, especially management – any position, managers in particular – often do put a whole lot more time into it than what they are getting paid for, the extra hours and everything else. That is usually in any corporations or government or whatever, and sometimes it is not recognized. When it comes out that it looks like they are getting something extra, I guess a lot of times it is not looked at for what they put into their positions either. It is not a negative thing, really.

I know Mr. Murphy talked a little bit about purchasing. I just have one question there on the purchasing. There were 103 other than in the department to purchase. Are there other areas in the health care corporation where you can sign a PO? Is it different departments or anything?

**MR. BUTT:** I can respond to that. When the Auditor General made us aware of that, it was a surprise to us actually. We were not aware that people outside the purchasing department had access or continued access. We did have a look to see who in fact had actually issued a purchase order just to be sure that nothing untoward had happened.

When we looked we found that only thirty-two users had actually issued POs in one of those years. They were all in materials management. Nine people in pharmacy would have, and they would have for drug orders. That was appropriate as well. In another year, I forget the exact number but it was roughly the same number of people. Even though the potential for someone outside of purchasing to issue a PO was there, in fact no one had done it.

Back to our engagement with EY, that is a priority area for us, to look at our whole regime around granting access to anything so that we have the proper procedures in place to grant access to make sure that accesses are consistent, and do not create an opportunity for misappropriation. The best guard against these kinds of things is to have a segregation of duties, so one person can only do something and would need the help of someone else to get away with it sort of.

That is a big focus of what we want from EY is to look at our whole regime, how we award access, what access is appropriate within the system that we have, and how often should it review these kinds of things. It is an area for improvement.

**MR. K. PARSONS:** I understand for a corporation as large as this the purchasing just must be amazing.

**MR. BUTT:** We do 65,000 purchase orders a year.

**MR. K. PARSONS:** Yes, to try to control it, understand what has been done, and who is doing it and whatnot -

**MR. BUTT:** One other point: the Auditor General rightly detected that we had a buyer who actually can also receive. That is not good, because when a buyer can receive and you can buy, receive and have it delivered to your house, who would know? We have taken a step to address that immediately. The reason we have that is a lot of the things we buy, there is nothing coming in the door. If I buy a suture or I buy a catheter, it is delivered, somebody somewhere else will do a receiving report, I will get it. When I get the receiving report, I will pay the bill.

For a maintenance contract, nothing is coming in the door. In order for us to pay the bill we have to get a receiving report from somebody so our buyer generates them. What we have done is segregated that duty now so that only one person can issue receiving reports for sort of the soft items that we are paying for. That is an immediate step that we have taken while waiting for this EY report.

We are also cleaning up the accesses that we know about now, that are not appropriate; people had them who should not have had them. With respect to cheque processing, I think we have that down now to eight people. We had a look at that, and most of the others who were there were actually people who work in IT, who maintain the system, so they had access to the system. We have taken that away; we have it down to eight, but we have asked EY to look at, are we at best practice when it comes to cheque issuance, cheque requisition?

**CHAIR:** Mr. Parsons, if I could go to Mr. Osborne, the Broadcast Centre has asked what time we are going to break for lunch. I would like to break for lunch around 12:15. If we could come back by 1:00 o'clock, which is a much shorter than normal lunch, at the rate we are going there is a really good chance we will conclude today. Hopefully that works for people.

**MR. K. PARSONS:** That is okay, yes.

**MR. OSBORNE:** Thank you.

Just one comment: again I thank the witnesses for your honesty today, and the level of detail in the responses you are giving.

Don, you had mentioned about the time off in lieu of overtime. I just want to make a

comment. It is not a question to you, but I concur with your comment in that regard.

It is a small city, it is a small Province. We know of individuals who have basically said I am off at a certain time; I am going home at a certain time as a result of this. These individuals were very dedicated and oftentimes put in a half hour or forty minutes to an hour almost every day beyond the time that they were supposed to work and never really questioned it. They had their week off.

I concur with the comment that you have made. Maybe that deserves another look, because sometimes you can try to save a penny in one place but you are losing a dollar and another because of that.

When it comes to purchasing, I forget the name of the company now, but I know that there is a company now supplying a number of the soft items I guess you would call it. Some individuals I know working in health care are saying that the quality of the products are not nearly the same as the quality of the products under the older system of purchasing.

I am wondering if in the long run that is costing the health care authority more money. You may be able to tell me the name of the company.

**MR. BUTT:** I think you are referring to HealthPRO.

**MR. OSBORNE:** HealthPRO it is, yes.

**MR. BUTT:** In the interest of full disclosure, I am Chair of the Board of HealthPRO.

**MR. OSBORNE:** Okay.

**MR. BUTT:** HealthPRO is actually a national reciprocal buying organization for health care in Canada. It is owned by its members, which are hospitals. The board of directors is made up of representatives of the hospitals. We operate on a non-profit basis.

HealthPRO has, I think, now, about $1.5 billion in consumables under contract. HealthPRO goes through a very comprehensive, thorough process in acquiring goods and services for hospitals in Canada. The process they follow is made up entirely of donations from the member organizations. Our nurses will be on HealthPRO's evaluation committees. Our pharmacists will be on their committees. Our equipment people will be on their committees.

They go through a much more rigorous process than we could have ever gone through – and I have been there a long time – as a Province in terms of product evaluation, compliance with quality standards, and in trying to meet the needs of clinicians. Clinician acceptance is a big thing in health care. You can tender what you want, but I mean if the doctors will not use they will not use it.

HealthPRO recently has gotten so big; they have all of British Columbia, Alberta, Saskatchewan, most of Manitoba, most of Ontario, Newfoundland, and Nova Scotia. It is the national - it is one of two national GPOs for health care.

They have recently changed their contract strategy to allow for multi-vendor awards. They will do a tender and people bid. Then they will say, okay, 80 per cent of what we give to you, we will give 10 per cent to you and 10 per cent to you so that our clinicians have a choice. We are not saying to the clinician you must use this particular thing. You can use that or you can use one of the other two things that were awarded in the tender.

I am not aware of quality complaints. These are the same vendors we would deal with anyway. They are the same companies that we deal with anyway. I do know that I think maybe what you are getting at is the issue of clinician acceptance of what is put before them to use. It has been a big issue and I think their recent strategy with multi-vendor awards will address that issue.

**MR. OSBORNE:** I guess, to be fair, I mean it was a physician who had indicated, and probably because they are used to using a certain product and were forced to use another that they said was -

**MR. BUTT:** That is exactly the issue we are finding right across the country. That is why we have gone to the multi-vendor award, so that we do not say to that physician now you have to use

this; we can say you can use one of three or one of four.

**MR. OSBORNE:** Yes. After speaking to that physician I have actually spoken to a couple of others who have echoed that same concern. I do not know; maybe the new system will give them some choice.

**MR. BUTT:** It will give them choice.

The other point I would make, though, is that it has always been that way. No matter how you tender, you will never please all of the users who are out there who are likely to use a product.

It is a concern and we just do not want a doctor using something that he is not comfortable using. It is just not something that we want, so we do everything in our power to make sure that they can.

**MR. OSBORNE:** Okay.

We often hear of individuals who are utilizing a hospital bed after being released, waiting on long-term care or what have you. Has Eastern Health looked at possible solutions to that? That is obviously tying up very valuable resources. It is obviously a big cost to Eastern Health.

Prior to answering the question, do we have enough long-term care beds? Is that part of the problem? What are the problems? What are the solutions to that?

**MS LEHR:** We call that alternate level of care. The alternate level of care rate in the organizations in Newfoundland probably ranges from 10 per cent to 30 per cent. Those beds are being occupied by people whose acute episodes of care are over and legitimately should be in a different place than a hospital system.

At Eastern Health in our strategic plan for 2014-2017 we have committed to developing an alternate level of care strategy. One initiative that we are looking at is something called Home First. Ontario, British Columbia, and Halifax have recently, over the last couple of years, implemented such a strategy.

Once the acute episode of care is over, the patient goes home with support. Then ultimately if they cannot restore, to stay at home, after a thirty-day period, in Ontario, the model is that the social admission to long-term care happens, and that is done from the home. If they need other care models, then that is also done from the home.

That is an initiative, that we are doing an environmental scan right now. We have committed to our board that we will put a strategy to them that they can look at by the September 24 board meeting.

Do we have enough long-term care beds? If we continue to deliver services the way we deliver them, no. We will keep building long-term care facilities, but I do not think that is a sustainable model. We have to change the model of care to not have seniors go to long-term care, and elders go to long-term care, as early as they do, and to try to maintain them in their home as long as we can. I think that is a model we will work towards.

The majority right now of alternate level of care patients, if I did a snapshot of the Health Sciences today, there are forty patients there who should not be there or should be somewhere else. Forty percent of them are waiting for long-term care, but 60 per cent are waiting for something else.

We have to make sure that we understand the problem, and that we start looking at means and ways of moving the patients to the right - the phrase we use is - the right patient in the right place at the right time so they get the right care. That is the ideal state that we are working towards. Our goal would be to do some model changes so that we can do that.

**MR. OSBORNE:** You partially answered my next question, actually, which was: should we be looking – because many elderly people who are slated for long-term care would rather stay at home if the supports and so on were there for them to be able to do that. It would be far less costly on the health care system to allow them to do that. Eastern Health is looking at alternatives in that regard?

**MS LEHR:** That is correct. That is the initiative we are working on. The strategic plan for 2014-2017 is that very initiative.

**MR. OSBORNE:** Okay.

I do not envy Eastern Health looking at the future. I mean oil royalties, which have driven the economy to a large degree, are slowing down. Hopefully they will find more oil, but looking at today's revenues and projected revenues, we have the highest per capita spending for health care in the country. We also have the highest level of some of the health concerns: diabetes, blood pressure, heart disease and so on. We have a population that is aging. I forget the statistics, but I think it is four in ten people in our Province are going to be over the age of fifty-five by 2025. I believe that is the right number.

Obviously Eastern Health is going to have to find efficiencies. Whether that means an internal audit division or somebody to look at saving financially, I mean that is something - my recommendation. It is obviously not coming from government, not yet, anyhow, but my recommendation would be to look at finding ways of finding those efficiencies, improving spending, and reducing demand. By demand I guess reducing the need for health care, whether it is wellness programs or prevention or whatever the case may be.

I am going to put the ball back in your court now and ask you what you see as some of the solutions to finding efficiencies, to reducing the demand or reducing the need on our health care system.

**CHAIR:** If you would like to take the lunch period to reflect on that, and we could start with your answer when we come back.

**MS LEHR:** I can do that.

**CHAIR:** I told the Broadcast Centre 12:15, so my hands are sort of tied.

**MS LEHR:** Okay.

**CHAIR:** So, if we could come back at 1:00 o'clock. You may need more than three quarters of an hour to reflect on that question, but nevertheless that is what we have.

**MS LEHR:** It is a three-year strategic plan period.

**CHAIR:** Thank you.

**Recess**

**CHAIR:** I apologize for my lateness getting back. I encountered some construction work on Columbus Drive. Going to that part of town does not allow for any margin of error in forty-five minutes.

If we could hear from one or more of the members of Eastern Health in response to Mr. Osborne's question, then we will go to Mr. Murphy.

**MR. KEATS:** I will start with a few comments and then Sharon will take over.

It is a tough question. If we knew the answer we would be all rich in this. There are a lot of people looking for the answer around the world in what to do in this.

I just wanted to make a comment on the fact that people will say our aging population is really going to bankrupt us. We have people aging, but they are still relatively a small percentage of our population.

Over the last several years the percentage increase in spending in health may have been around let's say 7 per cent. What people have found out, the people who have done the research into it, is about 1 per cent of that 7 per cent increase, or one of the 7 per cent is for aging, the effects of aging and what they will do; 3 per cent is because of general increased utilization; and, the other 3 per cent is related to salary levels, changing levels and so on.

**CHAIR:** Excuse me.

Is that adjusted for inflation, or is that included?

**MR. KEATS:** For the last several years that has been the percentage breakdown. If you say, okay, if it went up by 7 per cent, if it went from 100 to 107, the 7 per cent increase is a result of aging, utilization, and salaries. That has been consistent for a period of time.

Part of the thing we need to do is related to utilization. We have a change in focus now. If you look, at one time we had one CT scan in the

Province and it ran for eight hours a day, five days a week, and there was no wait-list. We now have the most CTs per capita in the country, and even though the time frames have expanded when it is available, the wait-list goes up.

MRIs the same thing: the more we provide, the longer the wait-list becomes. It is because we have health care practitioners, primarily, who have become dependent on technology in the first instance for making their diagnosis, as opposed to saying: I think this is my diagnosis; I need a test to confirm it.

There is a tremendous increase in health technology, and we have to do something with the way health care practitioners focus, and get them less dependent on technology, very expensive technology. As you know, every time somebody brings in a new piece of equipment it rarely replaces something else. It is always a complementary thing to it.

The big thing we have to do in Newfoundland and Labrador is to try to change our culture, which is not a short-term thing. People think health equals health care, so there is really a lot of pressure. We want the facilities, we want the beds, we want the technology, and we want the drugs.

I have a friend who is a physician and he does not prescribe drugs. His patients always argue with him: What kind of a physician are you? You do not give me drugs when I ask for them.

We have that kind of a culture that we need to change. We need to understand that health care does not equal health. To go with that we need to make sure, as we said earlier, we change the models of care. We are working with the department and others to look at that.

We are working with the other RHAs and have adopted the philosophy that essentially you do not have to be one board to act like you are one board. Recently we consolidated, for example, the electronic health records between Labrador-Grenfell and Eastern Health. We have the same health record now, so if you are in Labrador or Eastern Health you should not have to repeat all the information when you get admitted to a clinic. They will look it up, have your name and so on.

We are starting a process to move that across the Province. We are looking at shared service arrangements. We are looking at a bunch of things, particularly the back-office things that will save us money, but not the kind of money you would need once we get into a time when revenues decrease.

Those are some of the things we are looking at. The development of community-based services is a top priority in my mind. Unless we get there we cannot sustain what we are now doing, and we certainly cannot sustain what is happening in the acute care system. There has to be change in the model.

I have been in the business for forty years, so people ask me what is the number one problem in health care. The number one problem in health care is inertia. We talk a great game about changing this and changing that and changing this. I hear the same conversations about home care, community clinics, and primary health care today that I heard forty years ago. We have not moved near quick enough to move into that model of care. Big change - it has to be cultural change, and a change in the models of care and delivery of care.

Do you have anything to add?

**MS LEHR:** No, I think that is a good answer. I think we have to work with our colleagues in the Province and our colleagues in the ministry to bring forward initiatives and strategies – the long-term care strategy, and alternate level of care strategy – that work for the entire Province. We are a small Province, 500,000 strong population-wise, big geographically. We can work together and start to reach out to our peers across the country.

We do not have to reinvent wheels. If there are organizations out there that are doing really good work in the Home First strategy or in a long-term care strategy, then we can reach out to those colleagues. In health care we have the benefit and the privilege that everybody will share what they are doing, and what they are doing well. They will also share lessons

learned. They will tell you where the radar traps are so that you can avoid them or slow down.

We have the privilege of working in a system where people are very generous with their knowledge. We need to be looking outside of our own organization, outside of our Province, learning from our peers in the country, across the world really, the national health system, and start implementing some of the initiatives that are working there.

An example that the Province has just recently announced is a rapid response team. That is to avoid admitting a patient to the emergency department. If they have a chronic disease that we can manage in the community, how do we case manage them so they stay home and stay close to their home, as opposed to being hospitalized? Those are the models that we have to continue down the road, and those are specific examples.

The clinical utilization review clearly outlines to us that we have too great of a reliance on the hospital system. Our length of stay is a little bit too long. We admit patients for conditions that we should be able to look after in the community. We have to continuously improve every day, look for other things that we could be doing, and never be happy with the status quo. I think we are absolutely going in the right direction.

**CHAIR:** We will go to Mr. Murphy.

**MR. OSBORNE:** If I could, just prior to that, I appreciate the responses. I agree that it is going to take a cultural change to convince people in the Province that if you are going to have your salt meat and cabbage and your turkey and gravy every Sunday that you cut back on your french-fries, dressing and gravy on Monday or Tuesday type of thing. I understand that.

Changing lifestyles, changing a culture of the Province, is one thing. Just to go back to Eastern Health, that will reap rewards several years down the road if we can do that. If we can implement wellness and implement a culture of healthy diet and healthy exercise, we won't see those rewards for many years down the road. Next year, the year after, and the year after that, when we see less revenue coming to the Province and therefore less revenue going from the Province to Eastern Health, what are you guys going to do to trim the budget at Eastern Health without the conflict of reducing health care services?

**CHAIR:** If I may, I am not sure that is really a fair question to ask these witnesses to forecast what they would do in a hypothetical situation. I do not think that it gets the Committee anywhere to advancing its report.

Maybe government will have to run a big deficit; who knows? That type of question offers a multitude of answers or potential answers. Presented as a hypothetical, it does not help the Committee to be able to address the issues raised in the nuts and bolts part in the Auditor General's report.

You might want to rephrase somehow, but I do not think that we can go down that road and do the job that we are really mandated to do by the House of Assembly.

**MR. OSBORNE:** Carry on.

**CHAIR:** Mr. Peach.

**MR. PEACH:** Thank you.

First of all, I find your answers very informal and certainly an education to me for a lot of things that you are answering. Also, the questions that are being asked by everybody on this side certainly bring out a great light in how things are being done in your department, and to help us understand more about what you are doing from day to day.

Since we are on the long-term care, when I listen to you saying that you are looking at a model, maybe changing a model, we certainly have a lot of bridges to cross for sure, because it is not working in some areas. I want to ask you a question about something that you tried a couple of years ago in some places. You looked at a Level 2 and you went with a Level 2-plus. Did that work out in some of the long-term care homes in Level 2, can you tell me?

**MR. KEATS:** Going back over the years when we look at nursing home utilization and personal care home utilization, there was not a lot of

difference in them. They were all basically Level 1s and low Level 2s.

I remember back in the 1980s, when we had people who stayed in nursing homes their average length of stay was twenty-five years. To be admitted to a nursing home you had to be able to walk in carrying your suitcases, was the thing people would say. The department and government said we have to look at making a change to the levels and moving people into the appropriate facilities. The average length of stay in a nursing home now is a year to a year-and-a-half probably. When people get in there, they really need to be in there.

The Level 2 and the Level 2.5, when that actually started, what the department was looking at was: is there a level of care between the Level 2 and the Level 3? The low Level 2s went to nursing homes or personal care homes. They were trying to make maximum use of the personal care homes so they said, let's put in a Level 2-plus so you are Level 2.5 or whatever. Are there personal care homes around the Province that could accommodate a Level 2-plus?

They tried. A lot of the personal care homes just did not have the type of accommodations. Their facilities were not suitable for doing that. Some of the newer, bigger homes are a bit better at doing that today, but I am not sure that they have a Level 2.5 now.

**MR. PEACH:** That was a pilot project, was it? Was that a pilot that was on the go at that time?

**MR. KEATS:** That was a pilot.

**MS LEHR:** That was a pilot. They did it in two personal homes, I think, in Eastern Health. I believe that is going to be expanded. I believe that is still an initiative that is being followed by the provincial Department of Health.

**MR. PEACH:** Okay, because you mentioned earlier about trying to get them out of the hospital quicker than they are. A lot of the cases that I find in my district, and I guess others in others, is that if they are slated to go into a Level 3 home, then in most cases the family has to travel a long distance. The family is probably some of the reason why they are staying there. They more or less do not want them to come out of the hospital because they have to travel that long distance to visit them.

That is where the Level 2-plus sometimes would come in. I am thinking about the home that is there in Arnold's Cove. For instance, there were four or five beds that are empty, and then there are probably two or three sitting in the hospital down in Clarenville waiting to get into a Level 3; where maybe they may be able to temporarily stay in that home until a Level 3 bed becomes available. I just want to make that comment.

I am looking at the public tendering. I am just wondering, do you have a standing offer for public tendering?

**MR. BUTT:** We would participate in provincial government standing offers. We also negotiate some of our own standing offers as well.

**MR. PEACH:** Okay. I was just wondering about that. I was looking at the AG recommendations. I am just wondering, it seems like a lot of the recommendations have been worked on or have already been completed maybe. Can you give us any percentage of where you are at right now with the recommendations that were made?

**MR. KEATS:** I don't know if I can give you a percentage right off the top, but we can provide you with that information once we are doing it.

**MR. PEACH:** Or what you have been working on; it doesn't necessarily have to be (inaudible).

**MR. KEATS:** We have talked about the Ernst Young report, and what they are going to do for us and so on, and we are saying that is going to be done by the end of September.

Just to tell you what the scope of that project is, they are going to look at our HR and payroll issues, and particularly the issues with respect to leave and leave management; in terms of payroll, all the overtime tracking, overtime authorization, and those sorts of things; our purchasing, our purchasing orders, cheque processing and proper controls for cheque processing; segregation of duties, making sure we have the proper segregation of duties in the organization; for the purchasing orders, the

authorization and review, assignment of access, authorizational limitations, disbursements, cheque processing, purchasing authorization limits, overtime callback process, and risk control matrixes for each process, and identify the control gaps.

Those are basically the kinds of things we will have done by the end of September through this. We will know what the best practices are and we will put those in place. We can provide you with a list saying here is where we are with these things or at a certain period of time what we have done with them.

**MR. PEACH:** Thank you very much.

Just one more question, Mr. Chair. I am not sure if I am going to be on a guideline here with a policy question or not. I am just wondering if somebody is working for Eastern Health and they request leave to go back to school to further their education so that they can become a qualified nurse or in some other field, do you have a policy in place where that can happen? Is it based on the requests that come in and then you take them on an individual basis?

**MS MOLLOY:** Yes, we would take them on an individual basis. We certainly do. As one of our lines of business we believe in learning and we believe in furthering expertise within the organization. Wherever it is possible we would provide a leave of absence for people to pursue higher education.

For our management group we have a tuition reimbursement program. If people are going back to school on a part-time basis, then they can apply. We have a small fund that is available for people to avail of that.

**MR. PEACH:** Okay, thanks.

That is all I have, Mr. Chair.

**CHAIR:** Mr. Murphy.

**MR. MURPHY:** Thank you very much, Mr. Chair.

Before I get into my last line of questioning, I want to come back to leave and overtime. Under Leave and Overtime, the authority, in a response to a question from the Committee, noted a 2011 research study that indicated no strong evidence that absence and overtime are positively correlated at the individual level. I want you to elaborate on exactly what that statement meant, and at the same time ask you if we can get a copy of that 2011 study that you were referring to.

**MS MOLLOY:** What we did in 2011, there was some suggestion that people were taking leave in order that their coworkers could avail of overtime. There was an urban myth, if you will, within Eastern Health, that was happening.

We wanted to explore it. We asked our research department if they would conduct a study for us, go over the last number of years and look at whether there was a correlation at the individual level between someone taking leave and then someone having overtime on a unit. The findings were that was not the case. I can certainly have our research department get a copy of that report.

**MR. MURPHY:** Please, yes, that would be great. Okay.

Coming back over then to Tender Exceptions under 5B in the Auditor General's report, and that would be page 65, "All tender exceptions require a 'Form B' to be completed and tabled in the House of Assembly." The Auditor General found that Form Bs are not always being submitted on a timely basis. I think in the report he noted anywhere between five and 255 days.

As a result, "the Authority is not in compliance with the PTA and is impacting the timeliness and relevancy of the information being reported to the House of Assembly." This impacts somewhat my ability to do my job too because they report to the House, then it is tabled in the House, and of course this is at our fingertips to have a look at. I am wondering when the authority is going to be fixing this problem or if it has already been addressed?

**MR. BUTT:** Yes, so I sort of have to take personal accountability for this because I am actually the person who submits the Form Bs. It takes time. When I get them for signing, I always research them and see what is going on. It has taken some time to do that.

I actually was not aware, to be perfectly frank, that there was a deadline because I was moving along pretty quickly. I had never been told by GPA, where we send them, that there was actually a problem. Now that we are aware, since the AG's report came out, we have submitted them all on time I am told. I think we have remedied that.

**MR. MURPHY:** Okay, so that has been done.

**MR. BUTT:** Yes.

**MR. MURPHY:** In that same section of the report, too, the Auditor General notes the rental of two suites to the tune of $23,922 as an example of the incorrect use of a Form B. The authority indicated on the Form B that there was not enough time to tender. The Auditor General says that there was time to tender.

I am just wondering, number one, if you can justify that $23,922 and why there was not enough time to tender. The second part of the question is - it is a lot of money - can we get some information as regards to what these suites were used for, and where were they, that sort of thing?

**MR. BUTT:** Sure. The issue was accommodation for a flight crew that we were recruiting. Our HR department indicated to our procurement department that they needed these – these are furnished apartments, basically. I am not sure where –

**WITNESS:** Torbay Estates.

**MR. BUTT:** Torbay Estates, I think, is where they are.

We thought we would recruit the team February 1. There was no time to tender, because we thought they were coming. We got three prices from known providers and went with the lowest price, obviously.

As it turns out, the flight crew was not recruited until later but we had already issued the PO for the accommodations. It was just a matter of not knowing at the time that it was going to be delayed, so that is what accounted for the delay.

**MR. MURPHY:** How many people were in that flight crew? What were they, air ambulance?

**MR. BUTT:** Yes.

**MS MOLLOY:** It is the medical flight team that we have in Happy Valley-Goose Bay. The accommodations were actually for two people who we had recruited from the Happy Valley-Goose Bay area. They had to come here to St. John's so that the full team, because it was a start-up team, could be trained by – it was co-ordinated and many of the providers of the training were here in St. John's.

They were actually here for I think about five months. We put them in an apartment. It seemed like the most rational thing to do at the time. It avoided them in a hotel room with meal expenses and whatnot.

**MR. MURPHY:** Okay, so for the five months' rent, did you have two separate apartments or both together in the one apartment?

**MS MOLLOY:** I would have to check that for you.

**MR. BUTT:** It says two suites, but I expect it is an apartment for each of them.

**MS MOLLOY:** Yes.

**MR. MURPHY:** Yes, okay.

I would imagine that is over there on Torbay Road and MacDonald Drive; Hillview Terrace Suites, I think it is. Is it?

**MS MOLLOY:** That is correct.

**MR. MURPHY:** Not the ones up on Highland Drive that you referred to, or Torbay Road, Torbay Estates.

**MS MOLLOY:** No.

**MR. MURPHY:** There were two separate apartments and everything. The time frame of the classes, you said for five months, so obviously the cost of that is probably about $2,000 a month, with taxes on top of that of course.

**MR. BUTT:** I am not sure. We would have gotten three prices and gone with the most competitive price.

**MR. MURPHY:** Okay.

I am just wondering, did the authority look at the possibility of renting an apartment, say, in a house, or something like that, because it sounds like the $2,000 a month might have been a bit excessive in this case.

**MR. BUTT:** That is an option sometimes but it is not easily done. Then you get into furniture, and then what do you do with the furniture after a short period of time, and these kinds of things.

**MR. MURPHY:** Okay.

**MR. BUTT:** We really had to look for someone to provide us basically a turnkey solution for this, because then we have to get into household effects, linens. That just becomes difficult to achieve.

**MR. MURPHY:** Understandable, okay. Perfect, thanks.

Down to section 6 under the monitoring of capital assets, the Auditor General reports that the authority did not have a policy to conduct regular capital asset inventory counts. By not having this policy, the authority was at an increased risk of not detecting lost or stolen capital assets.

I am kind of surprised by this one, actually, that you did not have an actual ongoing inventory. I know for bandages and that sort of thing that you would, particularly when it comes to these little cabinets outside the room, and you get staff to look after that. I am surprised there was nothing there to look after the major capital assets.

I am trying to understand why this was not considered as a priority by management in this particular case. Do you have a system there that we do not know about? What do you do in a case like that?

**MR. BUTT:** We have a computerized maintenance management system for all of our biomedical capital assets. We have 5,000 biomedical capital assets. They are over more than ninety sites. Many of them are mobile, so if you are going to go look for a transport ventilator, or a cardiac monitor, or an IV pump and pole, it could be anywhere on the site. It could be at another site; it could be in an ambulance between the sites.

I guess we struggle with the idea that at some point we can actually count all of this. We do tag it; we assign numbers to it. We assign it the home location as to where it is supposed to be. We program in the required maintenance for it, and we document the maintenance we do on it. The other thing is a lot of these things are in ORs, ERs, and ICUs. Just to get in there to count it is very difficult, so we do not know how really to approach this recommendation.

We are not saying it is a bad recommendation; we just cannot sort of get our minds – the Auditor General had some more concerns about our CMMS. We are going to implement a new one this fall which I think will address some of those. We might turn or minds to maybe periodic test counts where we will pick, say, twenty items; let's go find them, something like that. To actually have a day where we can get all of that equipment counted at all these sites just cannot be done.

**MR. MURPHY:** Okay. I can appreciate that it would be a little bit hard to do. I can see, for example, where you can lose track of some items and everything. Smaller items it is probably understandable, everything from a facecloth to a towel to bandages might be a little bit easier because it is on hand and everything. The capital assets, I think –

**MR. BUTT:** Sorry, not to interrupt.

**MR. MURPHY:** No, no, go ahead.

**MR. BUTT:** They do require, almost all of them, annual or at least annual maintenance checks and things. We do find them, repair them, and do what we have to do with them. If they are not there, then obviously we know they are gone. We do that. What we do not do is have a point in time where we count them all.

**MR. MURPHY:** When it comes to acquiring new capital assets like medical equipment, it

could be heart monitors; it could be something innovative for stroke victims, for example. I note that last week in the paper, for example, there was a piece of equipment somebody was going to donate and Eastern Health, I think it was, refused it. Why they did that I do not know.

I look at the acquirements of new technology, for example, in the medical field. I wonder at the same time when it comes to capital asset management, are we up-to-date with the rest of North America when it comes to the acquirements of new technology when it comes to treatment and that sort of thing, just as a sideline question here.

**MR. BUTT:** As someone said earlier, Eastern Health is a big, diverse organization with a lot of players and a lot of people with input into what we should have and what we should do. The process we have put in place: we have a capital asset sort of requesting system that is automated. People put it in at different levels. It gets to a point where we agree we should have it.

We have two, kind of, paths: one is replacement equipment, things we have now that we know we are going to have to replace; and the other is new technologies, things that are out there that we would not know they are on the horizon but clinicians would. When we go out in the fall to begin our capital budget request to the Province for the coming year we will go to our programs, to our directors, and to our clinical leaders. We will pretty well have a good handle on what we need to replace because we know these things, but we also give them an opportunity to tell us what else is out there that we might need that we do not have.

This is documented. It comes back to our capital infrastructure review committee. That committee consists of three or four of the VPs plus the director for procurement, equipment management, these kinds of things, and then we will sit and we will prioritize our recommendation to executive on what we think we should acquire in addition to our replacement items. That is sort of the process we go through.

The state of our equipment - I am a long time in the health system - I remember years when something pretty well had to break to get fixed. I think some years ago Eastern Health, when we looked at the state of our equipment, maybe 10 per cent of it was in good condition and maybe 80 per cent needed to be replaced. I think it is flipped now; we are much better. Our allocations over the last few years have been very, very good.

We are in a good state. The new technologies, emerging technologies, as I said, we scan the horizon, we look at them. If we think they are going to drive cost, we have to do an operational impact analysis on them because we just cannot accept them. Of course we cannot introduce new tests or technology without the approval of the minister so we will consult with the department on that. That is basically their process.

**MR. MURPHY:** Okay, thanks for that.

Mr. Chair, I have nothing else, outside maybe I will drop an e-mail with another personal constituency matter later on and I will not bring it up here.

**CHAIR:** We will move on to Mr. Hedderson then.

**MR. MURPHY:** Absolutely.

**MR. HEDDERSON:** To be quite honest, Mr. Chair, I have listened to the questions and the answers and I am quite satisfied that any issues or whatever have been brought forward. I will not delay the proceedings any longer by coming up with the same questions.

The only thing is the educational leave and professional development. I do not know for sure why, but education allowances were brought into question as well as educational leave. My question is: Are you not doing enough, or are you doing too much, or what?

Professional development and educational leave are crucial to where you are going with your strategic planning. You cannot go ahead with models without people knowing what it is or what needs to be done dealing with the culture and everything.

Just a little comment on that if you wouldn't mind. Are you satisfied perhaps that you are

where you should be with professional development? Is there anything that you can see we would have to go to?

**MR. KEATS:** My own personal view is that we never do enough professional development and education in health care.

**MR. HEDDERSON:** I agree.

**MR. KEATS:** I do not know that we can do enough. We have a philosophy in the organization that we are a continuously learning organization and you should never stop that process.

We are doing a bit more than we have done in the past, and we will strive to do a bit more. One of the things is when you get really tight for money –

**MR. HEDDERSON:** It is the first to go.

**MR. KEATS:** – and you have a service or an educational thing, the educational thing usually ends up at the end of it and then you try to pick it up some other time. My own view is we never do enough professional development.

**MR. HEDDERSON:** Thank you, Mr. Chair.

**CHAIR:** Mr. Osborne.

**MR. OSBORNE:** I am done with the questions. Thank you.

**MR. K. PARSONS:** I just have a couple. I was just looking at the Auditor General's report and it talks about infrastructure projects that you have in place. He noted that the change orders were not in compliance with what is in the Public Tender Act. Is there anything that has been done to fix this issue?

**MR. BUTT:** The Public Tender Act sets limits on contracts. If you award a contract for a purpose you can approve a change or up to a point, I guess 10 per cent. Depending on the value of the contract there is a 5 per cent or 10 per cent allowance for change orders. Beyond that there are approval requirements. In government they would go to, I think, Treasury Board. I think the deputy minister has the authority to approve them in a report of the Treasury Board. We do not have access to that process so we try to replicate the process in our own organization. We, with our change orders that are outside the legislative limit, bring them to our own financial committee of the board and report it to our own board.

One of the issues with the change orders is that the act requires our board actually approve them in advance of there being X performed. We simply cannot operationalize that because our board meets maybe six times a year, every second month, and not at all in the summer. We would have to stop our projects. Most of our projects are in our buildings where we have ORs taken apart, and labs taken apart. We just cannot operationalize that.

We looked at that because we want to comply with legislation, obviously. The Auditor General is not wrong; it should be approved in advance. We are aware of a provision in the act which says we can request of Cabinet, authority for our board to delegate their prior approval responsibility to the CEO. That way then we could have the CEO – and I am usually designated to do it anyway. I could have the ultimate authority to prior approve.

I have given that to our legal services and they are looking into that. They are, I think, in consultation with the department helping them approach that. That would take care of the prior approval problem that we have.

**MR. K. PARSONS:** Okay, that is a good answer.

I have one more that I want to go back to: your answer on long-term care. You talked about right now at the Health Sciences there are about forty who are there right now. This is just from what I hear from constituents of mine.

When you have a person who needs care, they cannot take them home, we do not have the ability to take them home. Sometimes there is what is called a respite that they offer, like a nine day thing I think it is – nine days in one case that I had. After the end of nine days their fear was that this is going to become a family thing. It is huge for the family.

The reason why people want to leave their loved ones at the Health Sciences or St. Clare's or wherever is because they get the feeling they are going to get good care here, and the only way to get a long-term bed is to leave them in the Health Sciences. The pressure is on you guys to get that person out of there because that bed is available. I think that is common knowledge among most people who are at it. It is a huge problem.

I do not know what the solution is. I know that when you look at people who are down in emergency – and I have had it a couple of times that I have been there myself and saw people on beds in hallways and someone there for a long period of time - you have forty beds that are tied up. I am wondering if there is something better that we could do. I know the beds are beds no matter if it is a long-term care facility. I hear it a lot from constituents of mine. They call me and say: Listen, Kevin, can you get them into the home or whatever? We are going to leave them there until they stay.

It is a huge problem because it is a snowball effect. Once that person has that bed, someone down in emergency is not getting up to the floor, and vice versa. I am just wondering, because it is a huge problem I would assume. What are you are going to do?

**MS LEHR:** You are absolutely right. That is why we work as a system toward delivering the care differently, and informing the public as well so that they are aware of what it is we are doing and why their loved one goes home first, and that does not take them out of the queue for long-term care if that is where they ultimately need to be, and that they can trust that we will ensure the philosophy of the right person in the right place at the right time can be furthered.

You are absolutely right; if we are not going to move the ultimate level of care patients out of the hospital system, then the emergency department is going to be backed up. You do not want to be in the emergency department for too long. That is a very difficult episode of care for the patient, and it is not fair to the family or the patient, so we really want to pull them up to the right unit so that they are getting the care they need. I think it is building a strategy and communicating that strategy so that people know what it is we are doing, why we are doing it, and trusting us that they can take their loved one home, and that we will ensure they get the right care appropriately in a timely way.

**MR. K. PARSONS:** I know where I am from, the Flatrock, Pouch Cove, Torbay area, it is very hard; what a hard area to get for home care. In the St. John's area you will find that people will travel on the Metrobus and get from one place to the other, but down there it is very difficult to get home care. It is a problem because people have to go back to work and they do not want to leave their loved ones there. They are better off leaving them at the Health Sciences. It is a huge issue.

The only solution that I thought of – and you just mentioned it with the policy that you are looking at like in Ontario – would be a longer respite that will supply that home care worker until you do get into the long-term facility. That may take a bit pressure off the system. I am not sure if that is a solution. There are a lot of ways.

I am sure you are after looking at thousands of ways. I just wanted to say that it is a huge issue when it comes to people. I know I went through it with both my parents. It is really, really hard on the families, families who try to take care of their loved ones at home, and the stress that it puts on them, because some put more time in than others. It really causes a lot of problems.

Long-term care, when it is needed, the families really do need it. When you go to the Health Sciences or whatever and you are left to hold a bed and that is the only solution you have to be able to get in long-term care, it is difficult on everyone and difficult on the system.

I am just concluding. I would like to thank you all this morning and this afternoon. You did a fantastic job. It was a great learning curve for me today; I tell you the truth.

Thank you very much.

**CHAIR:** Mr. Peach, do you have questions?

**MR. PEACH:** No.

**CHAIR:** I have a few questions. Usually I wait. Like other members have said, somebody else

asks all the questions; and, of course, if they have then that is a really good thing. Sometimes their questions give rise to other questions.

A number of years ago I benefited from being a health law intern in a US hospital as a part of a US legal course of study. In that hospital they had a risk management department which was actually a couple of lawyers, someone who was not really an insurance adjuster but pretty close, and an intern who was me. We would handle around 250 files at the same time. These could be anything from a slip and fall in the parking lot to a medical malpractice where somebody had died.

As you know, Americans are considerably more litigious than we are, up until now. Does Eastern Health have a risk management department or something in-house, with the benefit of your own in-house council and/or risk managers where Eastern Health might have certain exposures to risk?

**MR. BUTT:** Yes, we do. We have a full risk management division. They integrate with quality and they look at patient incidents. From that, because you are familiar with the process, they try to identify what is likely to be a claim. We are members of the Healthcare Insurance Reciprocal of Canada, so our potential claims are reported to them. That is the flow.

We have in-house three physicians, one of whom works in our human resources department and basically deals with labour relations issues, negotiating, these kinds of things, and HR issues. There are two who report to me. One deals in health law, so this individual deals with our claims and our potential claims. She also deals with questions about application of law, privacy, consent that the programs would find from time to time when you have questions as to what is legal and what is not. We have a third lawyer who reports to me. She deals basically with contract issues, tender issues, and these sorts of corporate issues that we have. Our risk management department is not a part of our legal department but they work hand in hand to deal with claims.

**CHAIR:** This hospital also had a discharge manager, and with insured health, which we do not have here, mercifully, although it really is insured because it is insured by the taxpayer overall, they would have certain procedures that should take a certain length of stay in a hospital, not measured in minutes but measured in increments of less than a day. If you wanted to stay longer than that, if you wanted the insurance company to pay you for longer than thirty-six hours for whatever, then you had to paper it up so you could get that extra payment.

I wouldn't want to see us go there, but do we have discharge management so when somebody comes, you know how long this person should be here for an appendectomy or whatever?

**MS LEHR:** Yes, based on national Canadian Institute for Health Information, all hospitals in the country submit their data to CIHI. Based on that, we get expected lengths of stay for specific procedures. If I had my hip replaced, I would expect to be hospitalized for 5.1 days. We are very specific.

The whole discharge planning process then used to be really housed in clinical efficiency. The changes we are making is that it is really every single unit. The front-line staff and the care facilitator on that unit are actually accountable for ensuring that discharge planning happens appropriately.

We are working with our front-line staff and our care facilitators to ensure that, with the orthopedic surgery unit, the patient goes through the operating room process, they do recovery, they go to the unit, and they are ambulated out of bed on the first day. Then we do what we call bullet rounds.

Every single morning every patient is presented. There is a nurse, physiotherapist, OT, social worker, and a physician. We quickly walk through each patient. We know when they are going home. If today is Thursday, three days from now they are expected to go home. We work our way through that. We make sure we have put all of the processes in place so that they can go home on that day.

We are piloting an initiative where the physicians are writing the order the day before so the patient can go home early the next day. That triggers us arranging transportation so that we can talk with their loved one to ensure that

they are here early in the morning on Tuesday. That is when their family has a discharge appointment.

Then we are working through the system so that the family comes and gets them. That person leaves before noon. The goal is 10:00 o'clock, but before noon is a softer goal. We can then pull the next patient from the recovery room. If we are not doing that efficiently, then the patients are delayed in the recovery room and then surgery is delayed.

Yes, absolutely, with every episode of care we know the expected length of stay and we know our actual length of stay. If we are not making those targets we are working towards improving them.

If you stay longer because you do not want to go home, that is when we alternate level of care you. We actually can medically discharge you because your acute episode of care is over. There is a fee that can be charged on a daily basis. It is less than $35 per day. It is not a lot of money, but it is more important for us that the patient moves through the system, and the patient flow is happening efficiently and effectively so that the next patient can access service.

**CHAIR:** Something else that I became familiar with around twenty-five years ago, and you seem to have referred to it in passing: the elderly patients. The Ontario Ministry of Health in the early 1990s, I think, maybe under the Harris government, did a pilot program in the Windsor, Ontario area. They had done the demography to know that the Ontario population would be the same age more or less as the Victoria, BC population was twenty-five years down the road, because Victoria, BC has all the retirees.

A big concern was having geriatric patients come in with all sorts of issues. They would stay too long and the average length of stay was quite high, maybe fifteen or sixteen days. So they put together what they called a quick response program. There were half a dozen nurses, and I think three or four of them had master's degrees. When an elderly patient would present, then the quick response program would be engaged. Then that qualified and trained nurse would meet immediately on admission and participate in the assessment. If the person did not need to be hospitalized, they would actually divert that person back home to a facility. They would find out what sort of supports they might have in the community, whether it was family.

Maybe the patient simply had a doctor who was on vacation, who was not getting medicated properly or whatever, some sort of an issue. Sometimes if a person like that is admitted for no apparent reason except there is something wrong with them, they stay too long and then they have other issues. Do we do something like that, or is that happening now?

**MS LEHR:** There are a couple of points you have mentioned. Once they are hospitalized there are models that are called acute care for the elderly unit. There is a model where you cohort that specific group so that you get them out of hospital as quickly as possible. That is something we are actually exploring now to see if that is the best model for the Health Sciences site.

In addition, recently we did a pilot project on the visits to the emergency department, particularly elderly patients with multiple comorbidities. They might be diabetic, with some chronic diseases that if we management them better they could stay at home. To avoid the admission, we case-manage them to keep them home. So that is a similar model. That is a model that the Ministry of Health is actually building on right now as well; it is the rapid response team.

It is an interdisciplinary team. We have physicians working with us as well so they will do home visits. It is the case-manage to avoid admission, because hospitals are not the safest place for our elders to be, certainly not for long periods of time. Evidence and literature shows that they decondition 5 per cent every day they are hospitalized and often cannot go back home if we leave them in hospital too long. So, avoiding the admission is the ideal solution.

**CHAIR:** Okay.

On the issue of callbacks for people who then have – I think I heard the word pyramiding today. I think what it means is – I had not heard that word before – when there are multiple

callbacks between the same periods of time. Does Eastern Health flag which physicians have more callbacks than others, and maybe engage with them and explain to them exactly what is happening here?

Are there some who just feel, well, I will just phone the tech or do whatever? Whereas I think Mr. Keats or one of the witnesses said, a physician could know if somebody else is coming on in a little while, and maybe this test does not need to be run right now, and maybe just to manage that side of the time a little bit better. If the physicians are aware – and I am wondering if, in fact, they know what their callbacks are costing – then maybe they can make a more efficient assessment of callbacks.

**MS MOLLOY:** We have not gone that particular road yet. We do know where the callbacks are happening. They tend to happen in our more rural sites that do not have management in evenings and on weekends, so a very small staff complement during afterhours and on weekends. We do know where. We have not looked at who, primarily, I think, because we know the situation. It is something we could certainly look into.

We have considered when this pyramiding is going on, is it costing us more money than if we had a staff member there? Many of these areas, though, are very difficult to recruit to. You have to sort of weigh that off, and you also have to weigh how much they are being utilized after hours. All of those kinds of factors we are looking at, and we hope to move forward and improve that over time.

**CHAIR:** I would like to see if any of the Committee members have any further questions.

**MR. PEACH:** (Inaudible) reminded me to ask a question, if you don't mind, on mental illness.

**CHAIR:** Mine usually says pick up groceries.

**MR. PEACH:** This lady, a few weeks ago, e-mailed me - with a mental illness. She went to the Burin hospital. At the Burin hospital they did not have the care there, nurses or beds, so that she could stay, so they had to send her directly to the Waterford in St. John's. Is there anything that we are doing to improve the care in these hospitals, to be able to accommodate those people?

**MR. KEATS:** Just from a general perspective, we would like to be able to have all the people we would put in these areas to provide the services. Generally, because of the size of our population, and because we need critical masses of patients in order to – because generally now with physicians, when you recruit, a lot of specialists will not go to work in an area unless there are three or four specialists. Putting people in an area on a full-time basis, if there is a relatively small catchment area, is not very practical.

One of the things that we can be doing better, though, is having a centralized pool of specialists who can go out on visiting rounds every so often to the various areas. They will not be available in the particular area around the clock, but they will be there over a period of time. If you can get five psychiatrists or six psychiatrists stationed, on a regional basis, doing visiting clinics around the areas mostly every day, that is a much better provision than not having any services there at all.

**MR. PEACH:** Okay. Thanks.

**CHAIR:** Mr. Paddon, are there any areas that we should be asking about that we have not asked about, or any observations that you have, maybe you or your auditor? It was a very comprehensive audit and extensive information there.

**MR. PADDON:** Generally, the questions have been fairly comprehensive. I think they have touched the breadth of sort of the report and considerably beyond that in terms of the general discussion. I just have a couple of comments and perhaps an observation, if you permit it. Since the microphone is on, I will take the opportunity anyway.

This is a relatively large report, seventy-five pages, but really it reflects the size of the organization. Eastern Health is, by provincial standards, probably one of the larger organizations that we have in the Province. For me, it is not surprising that you would come up with a reasonably voluminous report.

When I look at the types of items that we have found, there is nothing in there that I would describe as sort of so devastating that you would want to put the brakes on things. These are things that you want to raise because they are things that management should consider and should look at to the extent practical that they might put some procedures in place to make some change.

We have had issues around documentation, and those are pretty easy to change. Control issues, you talk about the EY process that you are going through, all of that is fairly positive.

I will make a note that when we started to do this review, I think Ms Molloy had talked about the anecdotal stories that you hear, the folklore things about people calling in sick so somebody else can get the overtime. I had asked Brad to take a look at that while he was at it, and I think consistent with the answer Ms Molloy made, we did not find any systemic problems, and we did not pursue it in any great length.

I think of all the things in my report that I probably have some strong feelings on – and it is probably one of the smallest in terms of line items – is the issue of internal audit. I think that an organization the size of Eastern Health spending $1.3 billion to $1.4 billion, plus capital, would deserve to have some resources devoted to internal audit, and appropriately resourced. I do not know how you define that - that is obviously an operational decision - but more importantly reporting appropriately.

Generally, internal audit will report to the board of directors, not to management, so they would have that independence to pursue their own course of investigations and those sorts of things. I feel fairly strongly that is something Eastern Health should pursue.

Just in terms of an observation, and this is probably a bit gratuitous more than anything else, I heard Don talk about community-based care and different models of care. I have been around the system a very long time, too - not as long as Don - but certainly on the periphery hearing issues around problems with health care. Not problems with health care, but challenges with health care, is probably the better way to describe it.

I have been hearing issues about the skill mix of staff and the location of services and those sorts of things. Inertia is probably a good way to describe it. Probably it is harder to make the change, and easy to identify some of the broad problems.

From the perspective that I also comment on the Province's financial position, I certainly have concerns as I look forward. Don talked about demographics, and where the increase in health care is coming from, a relatively small amount due to demography, but I still think that is going to be a challenge going forward. As more pressure on provincial revenues occurs, it is going to be more and more of a challenge to fund adequate health care.

While efficiency is obviously a great way to go, and obviously Eastern Health and all the health authorities have to look at that, it becomes more and more of a challenge to find more and more resources as you become more efficient. As revenues shrink, either you reduce services or you reduce services elsewhere in the provincial government. There is only so much money to go around. I just throw that out as sort of a concern I would see in moving forward.

I also found this a pretty informative discussion. I have enjoyed the comments from the representatives of Eastern Health and just enjoyed the tone of the questioning. It has been quite informative for me, so thanks very much to everybody.

**CHAIR:** Mr. Keats, you began with an opening statement. I think in fairness I should ask you if you want to close as well. I know it is not a trial.

**MR. KEATS:** I have a closing one.

**CHAIR:** You do not have to if you do not want to.

**MR. KEATS:** Somebody asked a question earlier about educational differential and how many managers have lost their educational differential. Five hundred and three people lost the educational differential, and 109 still have an educational differential by virtue of being nurses supervising nurses.

Thank you, Mr. Chair. I do have a short closing statement.

I just wanted to thank the members of the Public Accounts Committee for the invaluable discussion we have had today. We have responded to the best of our abilities, and I trust we have answered all the questions you have had to your satisfaction. However, should there be any further information or clarification that you require, please do not hesitate to follow up with us and we will provide you with the information.

I also want to thank the representatives of the Office of the Auditor General, both for their attendance today and for their work as they prepared their findings and recommendations about Eastern Health during 2013. I understand the AG representatives were very professional as they conducted their review. They did receive co-operation from employees with Eastern Health. We view a visit from the Auditor General as a quality improvement initiative as we would in any other area, and take it that we will become a stronger organization as a result of the work of the AG. I appreciate the work that the AG is doing in helping us do our jobs better.

On behalf of the Board of Trustees of Eastern Health, the Executive Management Committee, and all of our managers and employees, I want to assure Committee members that we are committed to ensuring that we do use our public resources in the most appropriate, efficient, and effective manner possible. We know this is a large responsibility, considering the scope and the size of Eastern Health; however, we understand the trust that has been placed in us.

I believe we can all agree that the provision of safe and quality health care services continues to be challenging, due to the increased demands and the increased costs, and Terry mentioned those. As we move forward into the future we have to be ever cognizant of that.

At Eastern Health we do not have our heads in the sand. We are embracing those challenges and working extremely hard to find solutions by taking advantage of the knowledge and skills we have within the organization, and by seeking out what our peers across the country are doing. We will remain vigilant. We will remain diligent. We will remain, as Tennyson said, "To strive, to seek, to find, and not to yield."

Just on a personal note that relates to my position, I have been with Eastern Health a short period of time but I have worked in many areas around the country. I worked at senior level jobs in government and in health care. I truly believe that Eastern Health is a tremendous organization with13,000 employees. They have the skills, the expertise, the talent, and the determination to do tremendous work.

I truly believe that Eastern Health can become the best RHA in the entire country. I think that in the near future it will continue to strive for that. We will hopefully get that designation sometime in the not-too-distant future.

Thank you all. We, as well, enjoyed today.

**CHAIR:** I have two sets of minutes from yesterday. I need a motion to pass the minutes yesterday morning related to the Department of Justice, Fines Administration.

**MR. K. PARSONS:** So moved.

**CHAIR:** Seconded?

**MR. PEACH:** Seconded.

**CHAIR:** Moved by Mr. Parsons and seconded by Mr. Peach.

On motion, minutes adopted as circulated.

**CHAIR:** I also need a motion to pass the minutes for yesterday afternoon for the Department of Health and Community Services, the Audit Process.

**MR. PEACH:** So moved.

**CHAIR:** Seconded?

**MR. K. PARSONS:** Seconded.

**CHAIR:** Moved by Mr. Peach, seconded by Mr. Parsons.

On motion, minutes adopted as circulated.

**CHAIR:** We need a motion to adjourn.

**MR. MURPHY:** So moved.

**CHAIR:** Moved by Mr. Murphy.

We are concluded.

On motion, the Committee adjourned.