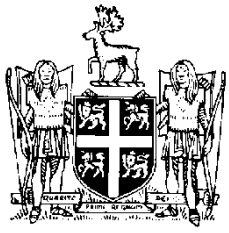

PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

Second Session
Forty-Eighth General Assembly

Proceedings of the Standing Committee on Public Accounts

June 21, 2017 - Issue 1

Department of Health and Community Services

Published under the authority of the Speaker of the House of Assembly
Honourable Tom Osborne, MHA

PUBLIC ACCOUNTS COMMITTEE

Department of Health and Community Services

Chair: David Brazil, MHA

Vice-Chair: Derrick Bragg, MHA

Members: Neil King, MHA
Pam Parsons, MHA
Barry Petten, MHA
Scott Reid, MHA
Gerry Rogers, MHA

Clerk of the Committee: Elizabeth Murphy

Appearing:

Office of the Auditor General
Terry Paddon, Auditor General
Sandra Russell, Deputy Auditor General
Trena Keats, Audit Principal

Department of Health and Community Services
John Abbott, Deputy Minister
Angela Batstone, Director, Medical Services
Michelle Jewer, ADM, Corporate Services
Heather Hanrahan, Director of Regional Services
Mike Tizzard, Department Comptroller
Denise Tubrett, ADM, Regional Services
Deena Waddleton, Health Consultant
Wayne Young, Air and Road Ambulance Manager

Also Present
John Finn, MHA

Pursuant to Standing Order 68, John Finn, MHA for Stephenville – Port au Port, substitutes for Scott Reid, MHA for St. Georges – Humber.

The Committee met at 9:15 a.m. in the House of Assembly Chamber.

CHAIR (Brazil): (Inaudible) 48th session of the House of Assembly's hearings. The hearing today is with Health and Community Services.

I'll introduce myself and then I'll ask Members of the Committee to introduce who they are and the district they represent. Then I'll ask the witnesses and the Auditor General's staff to introduce themselves. Then I'll ask the Deputy Clerk if she'll do the swearing in of the witnesses.

So I'll just introduce – I'm David Brazil; I'm the Chair of the Public Accounts Committee and I'm the Member for the District of Conception Bay East – Bell Island.

MR. BRAGG: Derrick Bragg, I'm the Vice-Chair of the Public Accounts Committee and MHA for Fogo Island – Cape Freels.

MS. P. PARSONS: Pam Parsons, I'm the Member for Harbour Grace – Port de Grave District and a Member of the Public Accounts Committee.

MR. KING: I'm Neil King; I'm a Member of the Public Accounts Committee and the MHA for the historic District of Bonavista.

MR. FINN: Good morning, John Finn, MHA for Stephenville – Port au Port. I'm substituting for Scott Reid today.

MS. ROGERS: Good morning, I'm Gerry Rogers and I work for the good people of St. John's Centre, and I am a Member of the Public Accounts Committee.

MR. PETTEN: Barry Petten, MHA for Conception Bay South and also a Member of the Public Accounts Committee.

CHAIR: Okay, I can start here.

Michelle.

MS. JEWER: Michelle Jewer, ADM, Corporate Services, Department of Health.

MR. ABBOTT: John Abbott, Deputy Minister, Department of Health and Community Services.

MS. TUBRETT: Denise Tubrett, Assistant Deputy Minister of Regional Services with the Department of Health.

MS. WADDLETON: Deena Waddleton, Health Consultant with the Department of Health.

MS. BATSTONE: Angie Batstone, Director of Medical Services, Department of Health and Community Services.

MR. PADDON: Terry Paddon, Auditor General.

MS. RUSSELL: Sandra Russell, Deputy Auditor General.

MS. KEATS: Trena Keats, Audit Principal of Performance Audit.

CHAIR: Okay, welcome to everybody.

I'm going to ask Elizabeth now if she'll do the swearing in of the witnesses, please.

Swearing of Witnesses

Ms. Michelle Jewer
Mr. John Abbott
Ms. Denise Tubrett
Ms. Deena Waddleton
Ms. Angie Batstone
Mr. Terry Paddon
Ms. Sandra Russell
Ms. Trena Keats

CHAIR: Thank you, Elizabeth.

Just to start off the process here, we're looking at the issue identified by the Auditor General, particularly as it pertains to Health and Community services. In principle, what we're doing here is really having six hearings in one day. It's a fairly ambitious agenda. Some of it may be very easily answered and the questions may be poignant and direct, then the answers are good.

We've done it in a format where, from our assessment, we feel the first two or three items may be easier to get through, and then the more contentious ones, or ones that need more explanation, where there may be more questions asked, would take a little bit longer.

So I do ask that when you're asking a question if it's already been asked, fair enough, if we can move for the expedient process; if you're answering a question, if you could keep it to the point as much as possible for relevance purposes. Also, with that being said, we're not going to confine anybody from not asking questions if they have some issues of clarification they need, nor for the witnesses having an opportunity to actually explain exactly what they're doing to be proactive of this.

Periodically, maybe more often than not, we will be asking the Auditor General for an opinion on certain things and for his and his staff's view on specific issues that have been shared with us. It's an opportunity for us to ask questions as a committee and for the line department and officials to explain exactly how you're moving forward, your proactive approach to addressing the issue outlined by the AG.

The first process is that I turn it over to Mr. Abbott, as the deputy minister, to have some introductory remarks.

MR. ABBOTT: Thank you, Mr. Chair.

I certainly appreciate this opportunity. Again, what we will be able to report I think as a result of the Auditor General's report and our initial responses, through the course of each one of these items, we will give you an update as to where we are since June of 2015, as well as November 2016.

Needless to say, we've obviously taken each of the report items seriously. We're working closely with our key stakeholders, and each of these pretty well has been either the regional health authority or the private operators that they oversee.

There's been a lot of progress over the time since the reports have been issued, and we'll be more than happy to speak to those as we go through.

CHAIR: Okay, thank you; we welcome that.

The normal process that we're going to use today is that we'll give five minutes to each of the speakers to ask their questions. You don't necessarily have to take the whole five minutes. Some of them maybe easily answered if the question is relevant to one or two particular issues and it's answered, then we can move on to that. I'll start with Mr. Bragg – and we will start with the first heading, sorry, the Prescription Drug Program.

MR. BRAGG: Thank you very much and thank you, guys, for coming out this morning.

Actually, I won't be too long with you because I just reviewed, the last couple of days, the report you guys gave us and the top two headings are the ones I think we'll look for more of an update on, the progress of these. I may be wrong in how I pronounce this; would it be the Medigent system, refill business? You were saying anticipated in March you are going to have some action on that.

MR. ABBOTT: Yes, that's the Medigent. For the 10 recommendations that have been identified, I think it's fair to say that of those 10, nine have been fully implemented and we can speak to those. The one that you're referring to, Recommendation 1, is partially implemented.

I'll ask Michelle Jewer to speak to the specifics, but we feel that we're not going to be able to, I guess, concur with the Auditor General's recommendation really because of technical issues with that applying the rules under Medigent to our program.

Maybe I'll get Michelle to speak to the specifics of that.

MS. JEWER: The refill business rule that was referred to in the report, we did review that with the vendor and it was determined there are limitations with the rule. There are implications for pharmacies from an operational point of view. It would be a delay in the pharmacies potentially, and that would mean beneficiaries would have delay in getting their prescriptions. So that was one big one for us.

There were also issues with being able to track the original prescription number because of change in processes. Right now, pharmacists are able to extend prescriptions. So that would mean a prescription refill might not get tracked the same way as if a physician would put a prescription in the system.

There are certain limitations with it, that we decided that business rule, we can't implement; but, what we are doing, we are doing post-payment audit of refills. So that would check if there's misbilling for refills. In addition, part of the recommendation was to look at other courses of action in case this business rule didn't work.

So it's partially implemented because we are currently working with the vendor to determine if there's another business rule that we can put in place that could prevent misbilling of refills.

MR. BRAGG: Okay, thank you.

I guess that's the same thing for the second part of that, the second recommendation, is it, a similar answer?

MR. ABBOTT: Well, the second one, in fact, has been fully implemented.

MR. BRAGG: Okay. It says not implemented here when you guys gave it to us. It was to "reduce the risk of unauthorized claims and payments of inappropriate professional fees …."

MR. ABBOTT: Yes, okay.

So, again, Michelle Jewer will respond.

MS. JEWER: So we're saying fully implemented for this one because the recommendation said: "The Department should determine whether modifications to the Medigent system can reduce the risk of unauthorized claims and payment of inappropriate professional fees" for compounds and prescription splitting.

We have determined that rule put in Medigent will not prevent inappropriate professional fees for prescription splitting or compounds. And a reason for that is because the Canadian Pharmacy Association develops claim standards to provide orderly and efficient online processing of prescription claims. Part of those standards does not take into account compounds, and the different ingredients for compounds. Because that isn't in place, it's very difficult for us to put a rule in. So that's one reason.

Another thing, there is a FPT, federal/provincial/territorial group, a director, a pharmacy director forum, that has this issue on its agenda to look at the claim standards and revise it for compounds. So that's one thing that's still in process.

Prescription splitting, again, is something that we can't track by a rule in Medigent. Again, it's the quantities that cover products dispense must be in accordance with prescription to maximize of 90 days' supply, and there are some exceptions to that. So we can't put all the exceptions in as a rule, but what we are doing to ensure that we are paying appropriate claims for compounds and prescription splitting is we are doing a post-payment audit of those claims that come in.

MR. BRAGG: Okay, thank you.

I'm good, Mr. Chair.

CHAIR: Good there, okay.

Mr. Petten, questions on this heading?

MR. PETTEN: The questions that Derrick had was pretty well all I had on that section. It appears everything else seems to be implemented.

CHAIR: Okay, perfect.

Ms. Parsons.

MS. P. PARSONS: I don't have anything on the Prescription Drug Program.

CHAIR: Okay.

Ms. Rogers.

MS. ROGERS: Thank you, and thank you so very much for being with us here this morning.

When we look at some of the findings of the Auditor General, it seems that perhaps it

indicates an audit sector that is somewhat overwhelmed when we look at the finding that 58 per cent of the audits outstanding as of September 30, 2014 had been in progress between three and eight years.

I'm wondering if staffing is one of the issues in being able to do the work that's required.

MR. ABBOTT: Thank you, Ms. Rogers.

I guess the simple answer probably is that was not sort of the issue, but what we have done since this report is looked at our audit process and have revised it. I think we are now starting to see and what, I guess, the Auditor General was really looking at is that we have a much more effective audit program.

So what we've been doing over the past year or so is really being more aggressive with our existing staff complement; having more organized audit process for this. Now, for instance, in the department we audit numerous programs – MCP being the largest.

MS. ROGERS: Yes.

MR. ABBOTT: So, in essence, we've taken our lessons and best practices from how we do those audits and now applying that to our pharmacy program.

We've had to, under legislation, put the regulations in place, which we have now done. So it was really a large process issue for us. As a result over the past year or so, we have looked at quite a number of audits. Michelle Jewer can speak to the specifics of those, if you wish.

MS. JEWER: Prior to September 2016, we didn't have regulations in place to be able to do audit of NLPDP, so that was something that was put in place in September 2016. As well, there's a provider guide for pharmacists that bill through NLPDP and there wasn't an audit section. That's also in place as of September 2016. Since that date, we've been able to more aggressively audit, as John has mentioned.

Since September 2016, we have audited approximately 470 pharmacists or pharmacies, about 3,500 original prescriptions and about 13,000 claims in to NLPDP.

MS. ROGERS: Great. So staffing is not an issue.

MS. JEWER: No.

MS. ROGERS: Okay. Thank you very much.

You've also said that we now have – can we have copies of the 2014-'15 and '15-'16 annual reports of the audit section? I think that those were mentioned in the …

MS. JEWER: Yes, we can provide those.

MS. ROGERS: Okay, great. Thank you very much.

The department said that a policy in the form of an audit section for the NLPDP provider guide has been prepared. Could we have a copy of that document?

MS. JEWER: Yes.

MS. ROGERS: Okay, great, thank you very much.

There was some talk of problem pharmacies. What would constitute, for instance, a problem pharmacy and how would you define that?

MR. ABBOTT: Do you want a go with that?

MS. JEWER: I can try.

I think it would be hard to answer that question as a problem pharmacy –

MS. ROGERS: Okay.

MS. JEWER: There are a number of different reasons why we find misbilling or incorrect billing, and it could be simply a training issue. I would think the majority of them would be that.

We have identified – for example, compounds is an area that's complicated –

MS. ROGERS: Yes.

MS. JEWER: So we've identified that as an area we would audit. Refills, again, it's probably a difficult, complicated area. We would audit that.

There are some areas within that pharmacists can bill NLPDP for certain, we call, expanded pharmacy services, something like medication review, antibiotic adherence. Those programs would probably be things that we would audit because they're new, to ensure that they're being billed correctly.

MS. ROGERS: Okay.

MR. ABBOTT: If I may, Ms. Rogers, now that we have the pharmacy network in place for all pharmacies, we'll have a lot better information looking at utilization and then how that lines up with claims. So we can be more proactive in looking at problem issues or problem pharmacies, for that matter.

MS. ROGERS: Great.

Also, since the implementation or the discontinuation of the over-the-counter drug program, I'm just wondering, is there any intent to track or audit any of the rollout and effects of that? For instance, will we see a spike in prescription drugs instead of the non-prescription drugs because the over the counter have been discontinued? Is there any plan to look at that in your audit process, kind of tracking some of the potential changes?

MR. ABBOTT: It wouldn't come up in the audit process, but I understand your question. That's why I say the Pharmacy Network now will allow us then to start looking at all prescriptions and then looking at trends so we can look at that – because of this action, what has happened on the other side of things. That's something we'll be monitoring closely.

MS. ROGERS: Great.

MR. ABBOTT: We have been looking at the impact on clients because there are exceptions as well. We've monitored that. There have been few. So, again, we think the policy decision was the right one for a number of reasons, but we are monitoring the take-up.

MS. ROGERS: Okay.

CHAIR: Ms. Rogers, I'm going to go to Mr. King.

MS. ROGERS: Thank you.

CHAIR: We'll come back again as we go through our process.

Mr. King.

MR. KING: Thank you for the detailed package that you gave us. It's quite in depth. I've read through it several times.

This one I'm quite happy with. We got the update on the two outstanding items and I've got nothing to add on this one.

Thank you.

CHAIR: Mr. Petten, any further follow-up questions?

MR. PETTEN: No.

CHAIR: Mr. Finn?

MR. FINN: I'm fine. Thank you very much.

CHAIR: Okay.

I'll go back to Ms. Rogers.

MS. ROGERS: Yeah, I just have one more question.

It came to my attention that someone had a prescription for one medication and it was, I think – something like it had to be 175 milligrams. The pharmacy then had to break it up into three pills for the one prescription: 100 milligrams, 50 milligrams and 25 milligrams. The person was charged for three dispensing fees. Is that something that you track? Is that unusual?

MR. ABBOTT: I wouldn't say it's unusual, but it will happen.

MS. ROGERS: Yes.

MR. ABBOTT: We monitor that and if that is onerous to the client, then we can address that. But it's done based on depending on how the prescription is written and in the judgment of the pharmacist how that should in fact be put in the hands of the patient.

MS. ROGERS: Right.

MR. ABBOTT: That's monitored fairly closely. I mean we will have some discussions with – and, again, sometimes with the claims that had come in, they're the kinds of things we will be looking for to make sure that it's done appropriately.

MS. ROGERS: Okay, thank you very much.

MR. ABBOTT: Thank you.

CHAIR: I'll just intercede on one and just ask the Auditor General if he has any opinion or concern. Or does he feel this moves forward on addressing particularly the recommendations that he made?

MR. PADDON: Thank you, Mr. Chair.

From our perspective, just an overall comment on our audit of the Prescription Drug Program; we thought the report actually was quite positive in terms of what we had found. Some of the issues were – you wouldn't call them major in the grand scheme of things.

When I look at the particular item that the deputy talked about that is not likely to be implemented, I think you'll find that we framed the recommendation fairly specifically to allow them some discretion as to how they deal with it. We knew that there might be some issues in terms of being able to implement that, so we framed it the department should consider, those sorts of things.

I think based on what we've seen, subject to follow up in a couple of years, or years from now, I think we're fairly satisfied with what we see in terms of the implementation.

CHAIR: Thank you, Sir.

Okay, with that being said, if there are no further questions on that heading we'll move into Salaried Physicians and go through the same process.

Mr. Bragg, the opportunity to ask the first questions, please.

MR. BRAGG: Okay, Sir. Thank you very much.

In your report back to us you said: "The Department of Health and Community Services should consider development of province-wide performance appraisal …." That was the recommendation, to have province-wide appraisal standards.

You said that you were going to have standardized position description templates. Where does this stand right now?

MR. ABBOTT: Just bear with me for a second.

In terms of this particular report item, I just wanted to let you know, just as an initial comment, of the eight recommendations that either the department or the RHAs were responsible for implementing, we have fully implemented two of those and five have been partially implemented.

In terms of your question around the standards, that's one that has been partially implemented. We have a committee established to work between the department and the regional health authorities. What we want to do is standardize what performance standards are put in place and that we, in fact, monitor those.

What we've done up to now is left that to each of the RHAs to do that, and we are realizing it isn't really working. The Auditor General has obviously identified that. It's taking more time than we would like, but we have had a lot of discussions over the past while. Angie Batstone can speak to some of the specifics, but we are aiming for this fall to have this recommendation fully implemented because we certainly agree with it, and because we think it will benefit not only the department and the health authorities, but the physicians themselves.

Right now there are a lot of different rules being applied, different expectations of what is expected of the physician working in a community or in a hospital setting and we want to make sure whatever we have in Eastern Health, applies to Western, Central and in Labrador.

MR. BRAGG: Okay, because in Central, I represent an area with two cottage hospitals and I know their challenge of finding doctors.

MR. ABBOTT: Yeah.

MR. BRAGG: So would this help the process? Because the old saying out there amongst the nurses is: We have the doctors until we get them trained and then we move them somewhere else. That's been said for years. I'm sure you've heard it, right?

MR. ABBOTT: Yeah.

I don't think this recommendation in itself is going to change that. It will help so you know the rules of engagement when you come to a community. I think you're asking a much larger issue. We are – and right across this country – struggling in terms of getting physicians to come to rural communities.

In terms of the department's approach here is that we are working with each of the health authorities and the communities to look at what is a better response for the long term, which is certainly developing primary health care teams, so that a physician works with a nurse, nurse practitioners, and we're seeing some, I going to say, early success, but actually Newfoundland is sort of behind the eight ball when it comes to this. We're working quite aggressively now with each of the health authorities to really push hard on primary health care teams and services throughout.

So whether it's Botwood, Corner Brook, down the Burin Peninsula, up in Bonavista, we're seeing some early successes. So Fogo and that area actually has been well served over time, and we want to build on that and really shore up those services so that when a physician is interested, he or she can say, look, actually there is some support there. They're not solo practitioners because that sort of form of practice is really now – nobody coming out of med school is interested in really doing that, and we recognize that.

MR. BRAGG: Okay, thank you.

I know there are numerous questions, so I'm going to let everybody have a chance at this one. I'm going to pass it on to the next person, Mr. Chair.

CHAIR: Okay, thank you.

Mr. Petten.

MR. PETTEN: Thank you very much.

Only a couple of questions; in your second one on my spreadsheet here – actually it referenced a lot of the department's updates. You have a steering committee in place. Who will be part of that steering committee to oversee these recommendations?

MR. ABBOTT: Angie Batstone is chairing, so I'm going to get Angie, if you wouldn't mind, respond.

MS. BATSTONE: No problem.

The committee is comprised of myself, the director of Medical Services, being the chair. One of my consultants, Dan Fitzgerald, is on the committee, and we have the director of Medical Services for each of the RHAs.

MR. PETTEN: Okay.

MS. BATSTONE: And actually Lab-Grenfell, the representative is actually the VP of Medicine – that's one difference – Dr. Gabe Woollam.

MR. PETTEN: Okay.

I see here, I guess the steering committee is going to perform regular performance evaluations; it's going to be overseen by the steering committee. A lot of times we see committees in government and it's a pretty common thing, what powers will this committee have to oversee – because this is a fairly substantial issue when you look at not only the public domain with salaried physicians to the general public –

MS. BATSTONE: Yes.

MR. PETTEN: What powers or what will the steering committee be able to do in the event of – I know you're going to monitor, but what powers would it be in the event that you see

discrepancies or what have you? How will that be addressed?

MR. ABBOTT: When the committee gets its work done in terms of getting the standards in place then, in essence, in one sense, the large part of their work gets done. Now, they will be monitoring on a regular basis, but they will then be reporting up to myself as deputy minister; and if there are issues, then I will engage which health authority or which CEO to make sure there is full compliance. We'll be reporting out publicly. Obviously, at the end of the day, the minister will be accountable for ensuring compliance right across the system.

In one sense, this shouldn't be as large an issue as it is because it's really a process of how we use standardized recruiting and hiring physicians and laying out basically their job description and what we expect of them. What has happened over time, each RHA has going off to do their own thing, dealing with their own and they've been scrambling trying to get physicians in place whenever they can get them. What we've seen obviously over time is that's really not working.

We are the paymaster at the end of the day, so all the information has to come in to the department for what we actually pay. So, at the end of the day, we do sort of exert control to make sure we get full compliance; i.e., if there isn't compliance, then we have an issue or a choice as to what we do in terms of payment.

So really, at the end of the day, the department has to ensure that this is put in place. Again, the Auditor General has pointed out a weakness in our system that, in fact, we fully support needs to be done.

MR. PETTEN: So I guess when you tie Memorial University with the regional health authorities, they will have to work collaboratively to ensure that the value for money is being attained.

MR. ABBOTT: Yeah. The university one is a little bit more complicated on the basis of how they hire, why they hire and the relationship with not only their clinical practice, which we're paying for, but also then their teaching time, which the university pays for.

So we have to merge basically two of our systems to ensure while that physician is recruited that the payments, both for his or her clinical time, is what we're responsible for, is fully identified and measured; and then likewise at the university for their administrative and teaching time, is appropriated accounted for.

As you can appreciate, we have two sorts of payment systems going on; we now have to make sure they're fully integrated.

MR. PETTEN: So there will be like a value for money from both –?

MR. ABBOTT: Well, I don't know –

MR. PETTEN: Because it is the public purse, right?

MR. ABBOTT: Oh, yes. Well, the value is in terms of obviously the clinical time, what hours we're paying for and that we get true value for that, and obviously for their teaching and administrative time and that's what's the university or Eastern Health would be responsible for.

So, as I said, we have a couple of parties involved here and we're talking roughly 95 to 100 positions at the university. We're fortunate because we're able to attract the physician because it's a teaching hospital, but part of that them is having sort of two contracts that we have to administer.

CHAIR: Mr. Petten, I'm going to go to Ms. Parsons.

Ms. Parsons.

MS. P. PARSONS: The regional health authorities, in Recommendations, should conduct performance appraisals in according with their internal policies. And of course in your response in January 2017: Performance appraisals of salaried physicians have been ongoing since the Auditor General's report.

Can you provide some progress on that?

MR. ABBOTT: Well, we have made sure that one has been fully implemented. The RHAs have reported now to us that in fact they have

put those in place for each of their physicians. The process around that, they've put in some reporting templates. So we're quite satisfied that they've achieved what the Auditor General has set out for them.

MS. P. PARSONS: Thank you.

CHAIR: You're good?

MS. P. PARSONS: Yes.

Thank you.

CHAIR: Okay, Ms. Rogers.

MS. ROGERS: Thank you.

When we look at some of the issues that the Auditor General did raise, for instance, there were no procedures for basic policies such as detailed workload requirements for salaried physicians; they identified a need for an accountability system to track the level of service provided by salaried physicians; the department and RHAs not following their own *Salaried Physicians Quick Reference Guidelines* when hiring; no formal evaluation of hiring of physicians provided to the department from RHAs or MUN and no effective assessment of performance.

The department is saying that we're working on that. That's a lot of work and some of it very complex, I imagine.

MR. ABBOTT: Yes.

MS. ROGERS: For this not to have been done over a period of time, I come back to that issue. Is this a staffing issue? When we see that we've seen 96 managers laid off recently, how will all this be accomplished? Is there a staffing issue here?

MR. ABBOTT: Again, I'll have to say no. Really what this demonstrates is – I mean it's a basic human resource management issue.

MS. ROGERS: Yes.

MR. ABBOTT: Over time – or since time, take your choice here – we put physicians over here and everybody else over here in terms of their practices.

What we're doing now is bringing the physician community in to standardized, well-accepted human resource practices. That's all we're doing. In essence, we're bringing in 375 physicians into our larger management practices.

It's been identified and supported by the managers within the system. The Auditor General pointed out, yeah, you need to finally get on with it. We have committed then to putting in processes and procedures to get that done. The committee that we've established is doing that and they're focused on it. We will either have these recommendations completed this fall, some of them; the others will be into the winter.

So I assume the next time we report on this we will be fully compliant. We've been talking how we do that, obviously, with existing resources. Yes, all the departments obviously have seen a reduction in their management and other staffing levels, but we've been able to streamline some of our processes to make sure we get this done.

MS. ROGERS: Do you anticipate that there will be any problem because of staffing levels?

MR. ABBOTT: No, not related to this.

MS. ROGERS: Okay.

The AG identified twenty – before I get on to that; John, how do we do in relation to other jurisdictions, other provinces in this area?

MR. ABBOTT: I would say it's variable right across the country now. We have a high percentage of salaried physicians more so than other jurisdictions, and because our physicians have been really – though, specialists are included in this – relying on that for international medical graduates and what have you, have come through salaried. Because they've been sort of outside the mainstream, we just haven't focused on it to the degree we need to.

Saskatchewan would be probably somewhat similar in some of their challenges because they

have a lot of international medical graduates in their system, probably even more than we do.

MS. ROGERS: If we see more of a movement towards integrated primary health care facilities, will that mean more salaried physicians?

MR. ABBOTT: The trend is in that direction.

MS. ROGERS: Yes.

MR. ABBOTT: So absolutely, yes.

MS. ROGERS: Okay. So then we really have to get on top of this.

MR. ABBOTT: Yes.

MS. ROGERS: Yes. Great.

The Auditor General also identified 22 physicians – in fact, it was approximately half of the 45 doctors that the Auditor General examined – working without an employment contract. How does that happen? I'm curious. It seems to be quite, I would think, a major issue.

MR. ABBOTT: Yes.

MS. ROGERS: Are there any legal ramifications or implications for the RHAs or for the department having doctors who don't have a signed employment contract?

MR. ABBOTT: Well, again, the fact they didn't have them speaks to poor human resource management practices as it applies to that particular group of employees, because they are employees in essence.

MS. ROGERS: Yes.

MR. ABBOTT: But, again, we've had them on a separate track than all other employees. So now we'll bring them in, and that's certainly been put in place.

In terms of the liabilities, well, only when they run into a problem.

MS. ROGERS: Yes.

MR. ABBOTT: Then who can sue whom, as it were, without a contract.

Yeah, I think the health authorities and government in essence, their liability increases as a result.

MS. ROGERS: Do we currently have now any doctors working without an employment contract?

MR. ABBOTT: Well, I would like to say absolutely not, but I don't know that I can say that with 100 per cent certainty. They are to have them in place. That's part of the committee's work now is to make sure we have a reporting system to ensure that is the case.

MS. ROGERS: So you don't have any idea of how many there may be currently without a contract?

MR. ABBOTT: No, I don't know. Angie, any sense –?

MS. BATSTONE: No. Like John said, that's part of the work of the committee, is not only those 22 that were found not to have contracts, that in fact there are contracts drafted. On a go forward, everyone that's hired has to have a contract signed.

MS. ROGERS: Do we still have 22 without contracts?

MS. BATSTONE: They've been working on that, so I don't have the exact number right now.

MS. ROGERS: Do you have a ballpark figure?

MS. BATSTONE: No, I'd have to go back to the regions for that.

MS. ROGERS: Could we get that information?

MS. BATSTONE: Sure.

MS. ROGERS: I think that would be good to have.

MS. BATSTONE: Yeah, no problem.

CHAIR: Ms. Rogers, I'm going to go to Mr. King there now and come back.

MS. ROGERS: Okay.

CHAIR: Mr. King.

MR. KING: Thank you.

I can certainly speak to the success of primary health care teams. We've had those established, I think, in Bonavista for a better part of a year and a half now. It seems to take wait times down. It's been successful, so I just want to congratulate you guys on that.

One of my first meetings I had was with David Diamond on that issue because we lost four doctors in the span of two months, I think, in 2015.

Getting back to this, your steering committee is set up. Is it just for salaried physicians or are you looking – okay, you're looking at just for this individual topic.

MR. ABBOTT: Yeah.

MR. KING: Going back to bullet point 2, I think, it's: RHAs will be required to manage attendance productivity to ensure value for money.

What ramifications are in place, or you're going to put in place, if there are attendance productivity issues?

MR. ABBOTT: Well, the role then of the vice president of medical services in each of the RHAs is really to hold each of those physicians accountable for basically what they have signed on for. Part of this review will – so we will have a contract definitely in place, we will have performance standards in place, how many patients we expected to see, et cetera, those kinds of things. If that physician is not "producing", then it's the VP's job to have that conversation and make sure the work gets done.

MR. KING: Okay.

MR. ABBOTT: If it's not, and if there is not compliance, then there's a choice of: All right, we'll work with the physician to improve or we would have to move to terminate if that's not the case. Again, it's a new way of doing business. It's generally accepted right throughout the health system that we have these performance standards in place for all staff. Now we're just applying it to this particular group of providers. We're working with the LMNA and others as well. So everybody is onside. It's just a matter of now really getting this work done.

MR. KING: Going back, and I know this is relatively new, you guys got the audit report back in, I think, November. So it seems like you've been working pretty hard to get everything up to standard based on the recommendations, but looking back here in the point, you're currently reviewing the benefit of re-establishing the salaried physician approval committee. Why was that dissolved in the first place, and why are we looking at going back to that?

MR. ABBOTT: I think it just flittered away. We've had a number of discussions over the winter sort of bemoaning that that in fact this happened, because some of the problems we see now are a result of that.

Now, that being said, we tried to – in terms of the health authorities – give them as much responsibility and flexibility to meet their staffing needs; but, in this case, because we control the funding at the department, we sort of dropped the ball over time and we realize that that's something we have to reclaim responsibility for. Because we now, if we're – again, moving in towards family health care teams, we want to ensure the physicians that are coming in meet the needs for that community or for that region.

It's not one of, because there happens to be a vacancy that day or that week. We really now want to make sure we've got the right mix of physicians in the right communities, using Bonavista as an example. So when we go out to recruit in the future, we want somebody that in fact now will meet the needs for that community that can work in a team setting, et cetera.

So the rules of engagement are starting to change and we want to take more of a direct hand in what is happening, but working obviously with the RHAs.

MR. KING: I note the Kaizen method was used for the Bonavista Peninsula Health Care.

MR. ABBOTT: Yes.

MR. KING: Are you looking at using that in other areas in the province?

MR. ABBOTT: Absolutely, and it's because of what we've learned in Bonavista. We're now down on the Burin Peninsula, sort of taking what we learned there, modifying it for the Burin Peninsula area. We were out in Botwood; we were out in Corner Brook, out in Grand Falls, Gander, right around the province.

MR. KING: Thank you very much.

CHAIR: Mr. Petten, any further questions?

MR. PETTEN: (Inaudible) I want to go back – the main thing that stands out to me with these salaried physicians is the fact that they're working in MUN, they're teaching academically at MUN, they're also in the hospital as salaried physicians. How do you determine a work week? Something that I've always questioned is what's the work week for salaried physician to be able to hold down two of those duties and to do merit, to do justice to both of those – what is a work week for a salaried physician?

MR. ABBOTT: Well, again, I will say they are paid based on a five-day work week, for the typical case. They will then divide their time and that's negotiated between their clinical practice. So the time they will be in practice and dealing with patients and their administrative time, and then their teaching time, all that is documented.

We will have cases where we will move some of their clinical time into teaching time and vice versa so that each one of that gets negotiated. Those discussions generally take place between Eastern Health and the dean with the School of Medicine and they work that out for each physician. Then we meet our obligations as a result of those contracts that they enter into.

MR. PETTEN: So there's not like a clear guideline. There's no real, you can look straight at it and find out what your requirements are?

MR. ABBOTT: As I said, it's going to vary by each physician. So if you take a psychiatrist who may come in, he or she is going to be seeing patients, so they'll allocate so much clinical time during the week and, in that, he or she will see so many patients. We're not involved to that degree, at this point, as to how many patients they will see, then it will be their teaching time, which they negotiate with the dean of medicine, and then they're given some administrative time as well to manage their office.

MR. PETTEN: There are cases where – and the Auditor General pointed out – they were overpaid based on their salary package by upwards of 14 per cent, I know one case I was reading there.

MR. ABBOTT: Yes. We are looking at that and part of that is how their employer costs are attributed, depending on again when they were initially hired to where they are now, the salary increases have changed, how those things should be calculated. Again, those contracts were not structured, in our view, appropriately so we have now to go back and work with the physicians, and in consultation with the NLMA and the health authorities, to basically rewrite some of those contracts.

MR. PETTEN: Right. So I guess in a nutshell, to sum it up, there should be a top-level salary cut off for any of those salaried physicians or whatever their profession. If they reach that by just in the hospital, we'll say, or in a combination of that and academic, shouldn't that be the cut off? Would there be some guidelines put in place to be able to monitor it that way? Wouldn't that be the most simplistic?

MR. ABBOTT: If I understand your question, the clinical time is funded in one way. Their teaching time would be funded separately and then combined. Then their employer costs may be on top of that.

They're indifferent arrangements at the university. Some have shared salary with their colleagues and how that gets done. So it is a very complicated bit of business at the university, because we are bringing all those payments together under one contract. It's not typical in, really, any other profession that I know of that you would do it this way but it

works for us. It's just that we haven't managed it as well as we should.

MR. PETTEN: Thank you.

CHAIR: Mr. Finn, any questions?

MR. FINN: Thank you, Mr. Chair, and thanks, folks, for being here this morning.

I'm just kind of flicking through some of it and, as I mentioned early on, I'm substituting today for Mr. Reid on short notice. But just having gone through some of this just this morning, I can certainly appreciate and understand the challenges from the Department of Health and Community Services, some 40 per cent of our provincial budget being accounted for and I guess the complexities with respect to three different health authorities, in particular, and every health authority operates a little bit different.

Mr. Abbott, you made a statement in the beginning there around just HR; you said, essentially, they were all physicians being here and everybody else was here.

MR. ABBOTT: Yeah.

MR. FINN: And that's kind of like, I guess, just a philosophical look at – that's the big statement on the problem essentially, and each health authority then operating a little bit differently in terms of the practices.

MR. ABBOTT: Yes.

MR. FINN: Some of the documentation there reflecting performance appraisals, some being done in Western are going to be this number is lower than what was being done in Lab-Grenfell. So I guess you guys have the task of pinning it down to the RHA level and finding the problem there.

MR. ABBOTT: Yes, right down to the individual level, yes.

MR. FINN: Right.

With respect to some of the appraisals and the workload requirements that aren't detailed, I'm wondering, I'm just musing, if I'm a health authority and we have the ability to hire a new physician, they must just be excited. Yay, we have a new physician. So they don't jump into some to the nuances. Is that kind of …?

MR. ABBOTT: I think you're –

MR. FINN: Do you know what I mean?

MR. ABBOTT: That's, I think, part of this –

MR. FINN: Yeah.

MR. ABBOTT: – is that they spend a lot of time on recruiting, somebody does say I'm interested and then it's sort of like, all right, don't forget that you have these processes that you need to follow. A lot of times the paperwork just is pushed aside; it doesn't get done.

MR. FINN: Okay.

MR. ABBOTT: As I said, part of this is how it is managed within the health authority. The approvals are usually done through the VP of medicine and then the CEO. A lot of times the human resource department would not even be directly involved. They may process payments at the end of the day, kind of thing, but aren't, as I said, bringing in their practices to say where's the contract; where are the terms and conditions of employment; where are the standards, what have you, that they would have for all their other employees, but not for these.

MR. FINN: Sure.

MR. ABBOTT: But the way you described it is exactly how it sort of plays out in real time and we have those conversations. I get a call: We've been fortunate, we've got a specialist that we've been looking for now for two years, but can we sort of break some rules here to get the individual in place?

MR. FINN: Get him started, yeah.

MR. ABBOTT: We'll have a discussion as to what the rules are, but we are insisting on documentation, we are insisting that we have a discussion and that we apply the existing policies and payments for any new salaried physicians, whether it's a GP or a specialist. If there are exceptions, then they would have to

come into the department and be approved by the minister.

MR. FINN: Right, yeah. That's kind of what I was musing, right?

MR. ABBOTT: Yeah.

MR. FINN: The approval process, to question the fact that we're approving the hiring of a doctor, I mean, my God, if there's a doctor that wants to come, let's open our arms. I can understand some of the work there, so that's kind of what I was musing at.

MR. ABBOTT: Yeah.

MR. FINN: One other small question, and I don't know if it's directly stated there, but with respect to we have salaried physicians and we have fee for service as well. Some are availing of both in that regard. Is there …?

MR. ABBOTT: I'm not sure if I understand.

MR. FINN: Salaried physician at the hospital and also does fee for service in clinic as well.

MR. ABBOTT: Again, there are different payment plans and maybe this is what you're getting at. There are payment plans where in fact they will pool, for instance, their fees and then they will – so that's a group. At the university that happens quite often where a group will pool their fees and then they will draw "a salary" from that. But that's different from, dare I say, the salaried physicians.

Then we have approved payment plans in place, which is sort of negotiated and it's similar to a salaried physician construct, but in fact, again, they're a fee for service. So, basically, it's a blend there.

MR. FINN: Sure, okay.

MR. ABBOTT: There's a certainty of payment in place. So we would have – Angie, correct me if I'm wrong here.

MR. FINN: Like a hybrid model.

MR. ABBOTT: In some cases where we have specialists, but the volume of work wouldn't allow them a reasonable salary. So some of our pediatric surgeons, for instance, the work they would do and on and on. So we will come up with a payment plan for them to meet their – a salary requirement based on their profession, but it's built off a fee schedule.

MR. FINN: Okay.

MR. ABBOTT: Yes, so there are a lot of nuances throughout that.

MR. FINN: Sure.

CHAIR: Okay. I'm going to go to Ms. Rogers now.

Ms. Rogers.

MS. ROGERS: Thank you very much.

In your report, you were saying that performance appraisals of salaried physicians have been ongoing since the AG report. How is that going?

MR. ABBOTT: As I said, they put them in place. Some were doing them anyway and they had the mechanisms to do it.

In a lot of the medical staff bylaws for Eastern Health authorities, they would be doing that or a version of it in any event for their fee for service. Now they would bring that same process into the salaried. It should have been happening and it wasn't, but there hasn't been any resistance to doing this. I think, as a matter of fact, it's been encouraged. We meet regularly with the vice-president for medical services for each of the health authorities. They are really pivotal to making sure this gets done because they oversee that process in each of their authorities.

MS. ROGERS: If you can help me understand a little bit, John. So a performance appraisal for a fee for service, is that just around billing?

MR. ABBOTT: No, no. It would be around what patients you are seeing, what your –

MS. ROGERS: Outcomes.

MR. ABBOTT: Ideally outcomes; but, to be honest, it wouldn't be getting there at this stage. That's somewhere, obviously, we would like to for all our physicians.

It would be looking at attendance in clinic, how you're utilizing resources of that health authority, those kinds of things, and I guess any complaints that might come in from patients and how they get addressed.

MS. ROGERS: So who would do this, and how would it be done? Is there a standardized process across the province, or …?

MR. ABBOTT: As I said, in the medical staff bylaws you will see the processes and we would make sure that they would be following that, but it is. Basically, at the end of the day, it is the VP of medicine, or his or her designate, who would sit down with the physician, at least on an annual basis – ideally you would do it more than that – to review their performance. There would be a standardized performance appraisal document that you would use.

MS. ROGERS: Okay.

I know you cannot reveal or release specific appraisals about specific doctors that have been done, but can we have some information vis-à-vis how many have been done since the Auditor General's report, how many should have been done and how many you've been able to accomplish.

MR. ABBOTT: Sure.

MS. ROGERS: And then also, are you seeing any trends at all? Again, I appreciate that personal information cannot be released, but really what are you finding in these appraisals?

MR. ABBOTT: Fair enough. Yeah, I understand your question. We'll follow up on that.

MS. ROGERS: Okay, great.

Thank you.

I also have just a few other questions. "The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should develop an accountability system to track the level of service provided by salaried physicians."

We see that we have the provincial steering committee. When did the steering committee start meeting? What has been accomplished so far? Who is the steering committee reporting to? Is there a reporting mechanism? Are there written reports from the steering committee meetings or minutes? How is that going?

MS. BATSTONE: We started work on the steering committee – and I'm new to the position as well. We started work in February with respect to our terms of reference, our mandate, et cetera. We had a meeting set for May which had to be cancelled, so we met early June. But this group of directors I meet with outside of this steering committee as well. So we've been having ongoing conversations since the report came out.

The steering committee ultimately reports to the deputy. We do keep notes of the meeting, high-level minutes of the meetings and action items.

MS. ROGERS: The steering committee has only met once then, has it?

MS. BATSTONE: Met formally once, yes.

MS. ROGERS: And that was this month?

MS. BATSTONE: Yes, early – I forget the exact date.

MS. ROGERS: Okay. This is based on a report from November '16, the Auditor General's, so here we are. Okay. This steering committee has really just been pulled together.

MS. BATSTONE: Just met formally, but multiple conversations since I would say February, since I came into this.

MS. ROGERS: Yeah, so the whole steering committee having a meeting conversation together?

MS. BATSTONE: Having a conversation, yes; informal conversations, because I connect with the directors of medical services in the regions on a regular basis.

MS. ROGERS: Okay.

So that would be individual ones, not as a committee.

MS. BATSTONE: Sometimes a conference call if there are a number of issues, and this may have been discussed at some of those meetings.

MS. ROGERS: Okay.

MS. BATSTONE: Sometimes we'd be pulled together as a group to discuss whatever the issues of the day are.

MS. ROGERS: Okay.

How often do you anticipate this committee meeting?

MS. BATSTONE: We committed to meeting monthly. That's what in our terms of reference.

MS. ROGERS: Okay, and you're hoping to be able to complete the work that you need to do by this coming January?

MS. BATSTONE: January or winter, we're – yeah.

MS. ROGERS: Oh boy, that could be a long time with our weather.

MS. BATSTONE: That's true. If it was summer it would be short, yes.

MS. ROGERS: It would bring you right into May and June, who knows.

Okay, thank you very much.

MS. BATSTONE: You're welcome.

MS. ROGERS: The GFT physicians –

CHAIR: Ms. Rogers, do you have many left on that?

MS. ROGERS: No, I don't.

CHAIR: Okay.

So I'll let you complete that and then see if there are any other (inaudible).

MS. ROGERS: Okay, great.

MUN and the department indicated that GFT physicians receive additional remuneration because of the work they do, both clinical and academic. I think Barry was getting at a little bit of this. So the GFTs have higher expectations for job performance and output – I understand this to be very complex, I really do – and are therefore required to work in excess of hours specified in their job descriptions; however, our testing found that GFTs were not required, contractually, to work longer than full-time clinical physicians.

You may have addressed that in various questions. Do you anticipate a change in that?

MR. ABBOTT: I'm not expecting there will be much change because each one of these sort of gets negotiated on a case-by-case basis. What we want to ensure is there is a template that each is used that we accept, and then there is a contract in place and that all parties abide by that.

What happens from time to time, despite having some of this in place, other arrangements are getting made that we at the department are not aware of. Eastern Health may not be aware of what Memorial is doing. Memorial may not be aware of what Eastern Health is doing. So part of this exercise here will be to ensure that this should not happen going forward.

MS. ROGERS: Right, but we may still be in the same position that, contractually, GFTs will not be expected to work longer than full-time clinical physicians.

MR. ABBOTT: But at the end of the day, Ms. Rogers, whatever is in that contract is what we have to hold them and all parties –

MS. ROGERS: Yes, I understand that.

MR. ABBOTT: And that hasn't been documented appropriately in all cases.

MS. ROGERS: So you're looking for something that's more of a uniform expectation rather than –?

MR. ABBOTT: Yes.

MS. ROGERS: Okay, great.

And then back to the 14 per cent for the salary in lieu of benefits for the GFTs.

MR. ABBOTT: Yeah.

MS. ROGERS: So we see in the Auditor General's report that 14 per cent is paid although those benefits are provided through the MUN contract. Is there an intention to address that?

MR. ABBOTT: Yes.

MS. ROGERS: Okay. What is that intention?

MR. ABBOTT: We've done some work on that. We've done some calculations. We now have to engage the university and, most likely, NLMA, but we will be going forward to amend those contracts for those payments on a go-forward basis.

MS. ROGERS: Okay. I understand the complexities of attracting physicians for different speciality areas, different parts of the province and I understand, yes, the complexities and challenges there.

Thank you for answering all these questions.

MR. ABBOTT: Thank you.

CHAIR: Mr. Bragg.

MR. BRAGG: I have one more question.

If you have fee-for-service and salaried doctors in the same clinic, is there a standard where the salaried physician would be expected to see a certain number of patients, or would it be a case where the fee for service takes everything away from the salaried person?

MR. ABBOTT: Well, it can work some days and it could be a challenge another. Really, what we're getting at, whatever arrangement we have with the salaried physician would be through their contract and their performance standards that we'll put in place, the expectation of how many patients they will see, whether it will be a day, a week, a month, whatever makes sense.

We have no control around the fee for service, how many he or she sees. If they are seeing appropriately and bill appropriately, that's really the extent of the discussion there. So at times, and it may not be in the same clinic, but they may be in different parts of the community, where that sometimes works as a bit of an issue.

Some of what you will hear, but there is no particular evidence to support either side of this, some will say that salaried physicians aren't as productive as fee for service, and some will argue that fee for service are over-seeing patients because of the way that payments system works.

Now, we don't have any evidence that says one is better than another. Our job is to make sure that all patients get seen when they need to be seen. We have to make sure we have the physicians, nurse practitioners and others in place to meet that demand.

At the end of the day, we will move dollars from one budget to another to meet where people are. As I said earlier, we are seeing a trend that newer physicians are more comfortable to meet what they want out of life and moving towards some salary or equivalent type of payment. So they want certainty and they want to be able to practise their full scope. But we have a generation of fee for service that they're happy with that and we will continue to continue with that system.

MR. BRAGG: Thank you.

It actually answered the second question I had, so thank you.

CHAIR: Mr. Petten, further questions?

MR. PETTEN: No, I'm good on that topic.

Thanks.

CHAIR: Ms. Parsons.

Ms. Rogers.

MS. ROGERS: I'm fine. Thank you very much.

CHAIR: Mr. King.

Mr. Finn.

MR. FINN: That's what I was referring to with the fee for service that I had brought up and the salary at the same time. I can understand the pros and cons matrix of either getting paid by the hour or getting paid by task done in said hour. That's the challenge, I guess, there.

MR. ABBOTT: Yes. Again, the issue is played right out across the country. There's no right answer.

MR. FINN: Yeah, exactly.

CHAIR: Thank you.

I would ask the Auditor General again if there are any comments he'd like to make.

MR. PADDON: No, Mr. Chair.

CHAIR: (Inaudible) from the responses.

MR. PADDON: No, I'm happy. I don't think there's anything I need to add at this point in time.

CHAIR: Okay, perfect. Thank you.

I think if everybody is good with it, we'll take a 10-minute break. You can stretch our legs and that, if you need to make a call or go to the washroom. We'll come back here – let's say a 13-minute break – at 10:35 a.m., please.

Recess

CHAIR: We'll start now, and I'll start with Mr. Bragg. You can start with any questions you may have or, as you noted, an observation.

MR. BRAGG: Okay, thank you very much.

On the nutrition of long-term care facilities, I guess I have a broad question. I know the AG came in and they had four objectives in mind. Since the AG came in, how much has nutrition improved; and – two-part question – if I visit any long-term care home tomorrow, would I be able to view my grandmother's or my mother's file on the type of food they're eating?

MR. ABBOTT: Good question.

Just, if I may, as a start, of the 10 recommendations that were in the report, two were obviously specific to our department and our mandate, and then eight were specific to the regional health authorities. I just want to let you know where we are of the two recommendations that are specific to us, and then I'll get to your question.

One has been partially implemented, related to the operational standards review – I'll speak to that in a minute – and one has not been implemented yet to date, and that's in terms of the performance indicator benchmarks.

For the RHAs, five have been fully implemented, and three partially implemented by Eastern Health; and for Western Health, seven have been fully implemented, and one partially implemented.

In terms of your question on has nutrition improved. I can't answer that, to be honest. What we're looking at is the processes around to ensure that the quality that is expected is there. So that's as far as I think I can go on that. Now, Deena Waddleton can speak to some more specifics.

In terms of looking at what a resident would be, in terms of the menu, then within this review, we looked at that. I think where the health authorities are, they're certainly prepared to put up the daily and weekly menus, but not the longer term menus that were suggested.

So yes, you should be able to as a family member going in – and one, you should see what obviously is on the menu. You can obviously encourage and question as well, as many of us have done in that situation.

The department is, again, working closely with the health authorities and Deena Waddleton is leading some of the work here on the department with the health authorities. Again, we have a committee in place that is actively working on finalizing and upgrading the standards. Then we're also developing a monitoring framework so that, ideally, I should be able to answer that question better the next time around.

MR. BRAGG: Okay.

I guess the other thing I would ask is if they're looking for a hot meal, would they expect it to be hot and a cool meal to be cool, at the end of the day?

MR. ABBOTT: Yes.

MR. BRAGG: I have some experience – I never worked there, but my wife is a manager into a facility out in Central. I know there have been some great changes, and I think this might have come up a couple of years ago over the can of spaghetti, I think, was the issue.

You may have someone in the facility where that is what they want every day of the week, so how do you sort of deviate from that if that's what someone wants.

MR. ABBOTT: Yes.

MR. BRAGG: Okay, thank you very much.

CHAIR: Mr. Petten.

MR. PETTEN: Thank you, Mr. Chair.

I have a couple of questions and mine are probably under general form as well. Nutrition in long-term care facilities, a lot of people are kind of familiar with it, especially if you had a loved one that had spent any time in one of those facilities.

The question that comes out to me and it's from a personal perspective – I experienced it over a number of years. My mother-in-law passed away with dementia. My wife went every day – for 2½ years, I never ate supper with her because she went over and fed her mom and several other residents their supper or their lunch, mostly supper.

I still know people that go back and forth to our long-term care facilities and I'd like to be able to say that things have improved but, unfortunately, that still exists – not maybe across the board everywhere. There are certain areas I'm sure that's fine, but that is still a real problem. Whether it's staffing levels; is it the most vocal family that gets the most attention. Then that all ties to the quality of the food.

So I know that it's good that the AG has brought this up because that jumped out at me on a personal level when I saw it. I was glad to see it was addressed. I don't know how far along, how much improvements we've actually made to make that better because I do know staffing is still a problem when it comes to that sort of thing. You have meal times and certain ones are independent. There are a lot of them that are not independent. You get in line and there are only so many hands to go around and some take longer to eat.

Derrick just pointed out the hot meal being hot and the cold mean being cold. It's a question, and I don't know if you can add anything to that to explain it, to address – what improvements have been done?

MR. ABBOTT: Mr. Petten, how we would look at that and answer the question is that we have obviously ongoing conversations with the health authorities, particularly around this area in terms of the long-term care facilities looking at all aspects – the nursing care, which oversees this area as well. We have the dieticians, we have the nurses, we have the LPNs and the other attendants that are there.

We have not had any representation to the department that I'm aware of, certainly since I've been there in the past year, around staffing levels and around meal times, but I understand what you're saying because I've observed it.

The conversations we then have with the managers around long-term care is that in terms of how they manage their staff and staffing levels, do they have the right positions in place. We are funding them to ensure that they have the staffing levels. We have not touched those budgets at all.

It boils down to how those facilities are managed. So we think by going back to the standards that we expect and putting in the monitoring framework and the benchmarks that we will be in a better position to identify where the weaknesses are and if staffing turns out to be a weakness through that, then we'll have no choice really other than to support a budget increase to allow that to happen – all things being equal.

Again, this is an issue that takes place at least three times a day, 365 days a year in each home. We need to ensure that the administrators are staffing and supporting that daily activity. There is no really strong reason why they can't and shouldn't be doing that.

Again, the Auditor General has pointed out a weakness there and I think the professionals involved here, the dieticians and the nursing staff, have to make sure and be held accountable to ensure that the service is delivered as expected. In my view, there is no reason why that isn't the case.

Now, it may – and I've seen it myself. If there was a family member in, so they can – and that's a positive thing. Obviously, if you're calling on volunteers in the community that needs to happen, but, at the end of the day, the administrators need to make sure the meals are served hot when they're supposed to be hot, cold when they're supposed to be cold, in the time frames that have been set for that facility.

One of the things we are hearing more of, which is how to support individuals who want to have their meals at different times, in their rooms as opposed to the dining room, things like that, and their choice. So there's a bit of a balancing act there as well, but the administrators are handling that quite well we think.

As the residents are going in now, they are more informed. They're stronger advocates, either themselves or their families. So we are seeing sort of a change happening in the delivery of that aspect of nursing care. We think with the work we're doing now, that we should see improvement in the process, as I said. The nutritional side of this will always be challenged as to sort of resident choice, but in terms of the quality of their food and how it is prepared, those standards will have to be followed and we'll be certainly monitoring those very closely.

CHAIR: I'll go with Ms. Parsons.

MS. P. PARSONS: Thank you very much.

Yes, I want to elaborate as well on nutrition, because obviously when we're talking about long-term care facilities nutrition is the main topic of priority.

I want to reflect back on a conversation I had with a professional living in my District of Harbour Grace – Port de Grave who is working at the long-term care facility in Carbonear. The new implemented facility which replaced the Harbour Lodge – and, again, this is a concern with food temperature. She used a hard-boiled egg as an example, and she expressed her displeasure, of course, with the quality or lack of. Her words and I quote: When those eggs come and they're to be served to our residents you can literally take them like balls and bounce them. That's a main concern of course. Nutrition keeps coming up a lot. I wanted to elaborate on that.

Based on the review here in Nutrition in Long-term Care Facilities for 2015, it states: "The Eastern RHA and Western RHA should provide meals to residents in accordance with their prescribed meal plans and at the appropriate temperature." Of course this, again, relates back to the hard-boiled egg story.

MR. ABBOTT: Yes.

MS. P. PARSONS: In response in January 2017, I see here working groups reviewing policies and establishing audit processes, exploring medical directive for diet orders and finalize policy by June 2017. From what I understand, this was to be finalized by June '17. So can you elaborate on that?

MR. ABBOTT: Okay, and maybe I'll ask Deena.

MS. WADDLETON: In terms of the audit process question that related to that, Eastern and Western have implemented audit processing around food temperature, in one case. The policies that you're referencing, we're meeting actually in a week or so to approve those, finally. There's a couple that need final approval and will be implemented provincially. So that is on track.

Those policies will really outline what the RHAs need to do. They are already doing, in practise, some of this work around auditing, but it will clearly define what they all need to do. That will include also Lab-Grenfell and Central Health, because it's a provincial working group that we have. Then we will be – as John mentioned

earlier – establishing a monitoring framework, and they will have to report to the department on the outcome of their audits. So that will help address some of that.

MS. P. PARSONS: Okay, thank you.

Also, on another topic here, and it's mentioned by my colleagues, how essential and paramount it is that we follow the Canada Food Guide and that we have a registered dietitian, of course, to monitor regularly these menus. You mentioned, as well, dialogue, even with residents to inform them about nutrition. I can't emphasize enough how important this is. I guess it's more a comment than a question.

That's all from me now. Thank you.

MR. ABBOTT: With that, about what the AG said and your comments, I think the role of the dietitian has to be given higher recognition in each of our health authorities. We had some internal discussions as to some thoughts on how that needs to work better.

Though I will say, just as my personal comment, in relation to one that you made, is that if there's anybody working in the system – manager or whatever – and the example you use, we definitely encourage, and I say the onus on them is to bring that issue – that's really a complaint, and that needs to be brought forward to the administrator and needs to be addressed because that should not be happening.

We have systems in place and that's a brand-new facility. There should be no reason why something like that is happening more than the one occasion. Because once it's identified, then it obviously needs to be addressed.

MS. P. PARSONS: How was the flow of communication with, say, front-line staff, such as professionals who are first-hand caring for residents, to take these concerns, I guess, to the appropriate positions?

MR. ABBOTT: Yes.

MS. P. PARSONS: How is that dialogue? I mean, I can't emphasis enough how important it is to have a free dialogue, to eliminate any fear of being punished or for bringing complaints forward because it's all about communication. Again, this is the quality of life of our seniors.

MR. ABBOTT: Yes. Again, we would, based on our – encourage that, I mean it is front line. They have their supervisors and there's that process for those that are unionized, and there's also that process to bring to their shop steward because it's a quality issue. We're all responsible.

MS. P. PARSONS: Yes.

MR. ABBOTT: We now have patient safety legislation, which these kinds of issues now will be picked up as well. We will have more obligations on each of our health authorities to identify and report true incidents, and our nursing homes will be captured by that legislation.

MS. P. PARSONS: Thank you.

CHAIR: Okay, thank you.

Ms. Rogers.

MS. ROGERS: Thank you very much.

Again, this is such a complex issue in terms of the whole issue of care for seniors. We know the research that has been done shows that the majority of seniors want to age and stay in place at home, and many of them, that's not possible because we don't have a fully, publicly administered and delivered home care program. So, consequently, many seniors have no choice but to go into a long-term care. We all know that, and we all know how tough that is. We also know for some seniors perhaps that's the best solution.

We're also dealing then with seniors who are far, far away from family and community. So, even the issue of family helping with nutrition is not a possibility because some people are so far away from their families and their communities, even volunteers don't really quite address this issue.

We know how important nutrition is, not only for the physical health of a person but the psychosocial health of a person as well. We have such a high rate of depression among our seniors

in long-term care facilities, and that too needs to be addressed. When we think of depression, that also really affects appetite. So we have a real complex problem here.

I would hope that we would be able to be – because of our small population which provides extreme complications, but also provides opportunities. Why in God's name can't we be a centre of excellence in how we take care of seniors who have built this province?

We also know that so many of our seniors live in poverty, particularly women. We have the highest percentage of seniors living on GIS and OAS, and a lot of women who were of that generation didn't have paid work outside the home. So they're very vulnerable, we all know that. They're extremely vulnerable.

I'm wondering, when the Auditor General found a number of RHAs that were examined did not even follow the Canada's Food Guide, how can we explain that? When we spend so much money in health around prevention and encouraging people to eat properly for health benefits, for prevention, yet we're not providing that in our institutions where we have complete control. Is there any explanation as to how that could possibly be?

MR. ABBOTT: Ms. Rogers, in terms of what the Auditor General has pointed out, I think part of this is, as I said, the role of the registered dietitian in the planning and I think we may need to make sure his or her role is given more prominence in the planning. So it isn't based on what's in the – shall we say, what's in the cupboard, what's in the freezer, what the budget says we can or cannot do.

We believe they should be following much closer the Canada's Food guidelines, no doubt about that, but the dietitians, that's their job and their professions – their own right. They have to insist on making sure the menus and the food preparation is complaint. So we have to encourage that.

I think what has happened – again, over time – with the best intentions, is people have deviated for their own particular reasons within any one facility. As a department, we have not gone back to make sure they are meeting those guidelines and any other criteria. So as part of this – obviously, the Auditor General has pointed out a significant weakness in our role in monitoring – through reviewing the standard and then particularly developing this monitoring framework, that now we will – because part of that framework will talk about adherence to the guidelines. Now we can follow up where they've been deficient and to understand why. Then, obviously, change that behaviour.

MS. ROGERS: Are we ensuring there's enough money allocated to our long-term care facilities for proper food and nutrition?

MR. ABBOTT: Again, as mentioned earlier, we don't think that's an issue at all. We're roughly spending $10,000 per bed, per month, for the facilities. That's just the large number.

If you look at what we are spending per resident, it's roughly $16,000 a year when it comes to the overall budget per person for food. So there's sufficient funding in the system. Again, nobody has come to us to say because of budgetary considerations that we haven't had the right food, the right amount of food or ability to serve it appropriately.

So, again, it speaks to how we're managing within each of those homes. Some are doing it, obviously, better than others. We want those that are doing it best to help those who are struggling.

MS. ROGERS: And how are we going to make sure that happens? I think, you know, to say it's up to an individual dietitian –

MR. ABBOTT: Yeah, but as I say, we're ceased on this, through this monitoring framework, that we now have a tool to go back in, in a more objective way, to find out what in fact is happening. We can then obviously be more proactive.

MS. ROGERS: Is the food in all of our long-term care facilities – we have how many, I forget now?

MR. ABBOTT: 41.

MS. ROGERS: In how many of those is the food prepared on site?

MR. ABBOTT: Now, I don't know if I know the answer to that one.

MS. WADDLETON: It would be most. We have a philosophy that long-term care homes are home.

MS. ROGERS: Yes.

MS. WADDLETON: And food is prepared on site.

MS. ROGERS: Yes.

MS. WADDLETON: There could be a couple of facilities that are very close, if not attached, to an acute care centre where food would be prepared there.

MS. ROGERS: Understood, yeah.

MS. WADDLETON: But in most cases, and certainly in our stand-alone facilities, food is served on site; prepared on site.

MS. ROGERS: Okay.

CHAIR: Ms. Rogers, I'm going to move to Mr. King.

MS. ROGERS: Okay.

MR. KING: Just going back to a statement Mr. Petten put, and we can all certainly relate to having family members in long-term care homes. I go back to 2002, when my grandfather was in Golden Heights Manor in Bonavista. If we didn't have the family support there then, I don't know if he would have eaten or not. He was at that point where he needed an assessment.

You go to point number 8, the first point on the second page there: The Eastern Regional Health Authority and Western "should ensure residents are appropriately supervised during meals in accordance with the Operational Standard for Long Term Care Facilities in Newfoundland and Labrador and applicable RHA policies."

So getting back to that, where are we? I know you discussed it a little bit, but 15 years on from that it's shocking to see we still have that issue.

MR. ABBOTT: I guess I would have to agree in terms of your assessment, but the onus is on the administrator and the nursing staff to oversee each of those dining rooms, and they are staffed to do that.

MR. KING: Yes.

MR. ABBOTT: So if they're not doing it, that's an issue.

MR. KING: And this goes back to actually patients that can't get out to the dining rooms and in their rooms themselves.

MR. ABBOTT: Yes.

MR. KING: You have the tray put there, they did their job to that point and the tray doesn't get opened up until 7 o'clock in the evening when a family member or someone comes in, if at all.

MR. ABBOTT: Yes. Again, part of their role in their job is to manage that.

MR. KING: Yes.

MR. ABBOTT: As I said, they're doing this 365 days, full-time. So they have to and can figure out some process changes to support that. In some cases it is going to be a little bit of creative thinking on their part as to how to manage that, but then they have to call in other resources if they need it. We will, as a department, obviously support that. We're not getting any pressure on the department from the RHAs to say they can't meet that requirement. Again, it boils down to the administrator managing that operation each and every day based on these standards.

So what we will be looking at now, much closer, is to say definitively what the expectation is and then reporting back against that, and where we are seeing that is not happening, then, obviously, we'll be having conversations with the CEO to make sure those issues are addressed.

MR. KING: Okay, thank you.

Getting back to point number one; "The Department should conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador as

required." The response to this was: Working group with regional representation has been established.

So my first question: Who is on that working group and how did the meeting go, if it did go, for March 21 and 22?

MR. ABBOTT: Okay, I'll ask Deena.

MS. WADDLETON: I'm on that committee as a representative of the department, and there are also the four regional long-term care directors, as well as an additional person from Eastern Health who is a manager for long-term care and who's also a dietician.

What we've been doing, we did hold that meeting in March where we established a plan to have these standards reviewed and revised by the end of this fall. Each of the people on that committee are taking a number of standards and are working on those, bringing it back to the larger group for feedback and revision and then to finalize the policy. So we, I think, are on track to have that completed by the end of June – sorry, end of fall, not June. That's only next week.

MR. KING: You're pretty much on track with the summer of 2017 into that.

Just one more question with my time I guess, and I might have a couple after. The department and the RHA should establish benchmarks for performance indicators; review them on their actual financial statistical data, including performance indictors against these benchmarks that follow up on significant variance.

The question I have with that: What determines the benchmarks being developed and how often will follow-up take place to establish the variances?

MR. ABBOTT: (Inaudible) we will be looking across the food service industry as to what are the best practices for that. We'll look at what's happening across the country and then we'll determine that in consultation with each of the health authorities.

Once we have those in place, then we will start collecting the data from each of the health authorities that report in for each of their own. Our intent is that information would be made public for each of those facilities so if it is families, anybody else, can then have a good sense of how that particular nursing home is complying and operating their food services.

MR. KING: Thank you.

CHAIR: Good? Okay, Mr. Petten, any further questions?

MR. PETTEN: I just have a couple of short ones here. Just to go back to the quality of food and the staffing and back to one of my original questions. Ms. Rogers, you referred to a couple of questions she asked, that you will have a mechanism, your tools in place to review this.

Basically, in a nutshell, what quality assurance measures, checks and balances – because right now it's separate; there are two different silos. So they're given a budget and the staffing to do these things. Who is going in to make sure that it's actually being done to the expected level of quality and care?

MR. ABBOTT: We haven't gotten to that stage where we would sort of send in an auditor or an inspector to do that. We are going to be reliant on each of the health authorities to self-report and then we will deal with that, which is common in our health system in any event.

As I said, we want to try and we are trying, through the patient safety legislation, an overall reporting so when there are critical incidents, if there was an issue in the dining room, if there was a resident who because of food had some reaction or what have you that then will get captured and reported out provincially.

So I think we've upped the standard and expectation right across the system. But they will be dependent, largely, on self-reporting, and against the monitoring framework we'll have in place, then we will issue reports on each facility.

MR. PETTEN: So in the event of a family member had concerns they'd report it to the manager, or the –?

MR. ABBOTT: Yes.

MR. PETTEN: It's incumbent on the manager, obviously, to address that concern or push it further. That's the concern I have sometimes. I don't know how far up the line the concern is. Sometimes you're given an answer, oh, it's being addressed. I guess it all depends on individual families sometimes. Some of them just take it in their own hands and deal with. They have so many other – the stress on them in general.

Again, it comes back to the quality assurance piece and the checks and balances. I think that is an important feature that should be, for all our long-term care facilities, to make sure that we have consistent care across the board for the most vulnerable, some of the most vulnerable people in our society.

MR. ABBOTT: I would certainly agree and we, with our CEOs right throughout our Health and Community Services system, more or less are taking a similar approach. If there are issues of quality, each of the health authorities has a quality department that oversees each of their operations, including the nursing homes, including their food service. So we're reliant on them doing their work.

In the issues where there are complaints or concerns, each of the health authorities has their own process as to how they receive those complaints and process that. We're actually looking at that as a department, because we want to make sure that is done appropriately and that the complaints aren't just pushed aside. That if there is a formal complaint, then there is a formal response, and the complainant, shall we say a family member, can then, if not satisfied, elevate that concern up the line. Obviously, as far as the minister's office, if need be, and we do that on a regular basis. But that's sort of where we are.

Our expectation is that once we get the monitoring framework in place, we'll have much better information, and the system will know and those that are delivering the food service know that there is actually a concern and a responsibility by the department to actually report out. I think that will help address, not necessarily all the issues, but most of the ones that are there today.

MR. PETTEN: Okay, thank you.

CHAIR: Mr. Finn.

MR. FINN: Yes, thank you, Mr. Chair.

Just short notice filling in here myself; I'm just having a quick flick through and it certainly looks like there's been some great work Western Health identified and, on the back, within a year, most of these things have been implemented, so it's certainly kudos there.

Just in terms of the compliance of the Operational Standards, two things sticking our here with me, and it could just be timing. I know the dietitians quite well in the Western region and I know some travel constraints when you're going from Lark Harbour to Bay St. George and then across to Burgeo –

MR. ABBOTT: Yeah.

MR. FINN: – and some of the time constraints there, but two things stated here with respect to just timing. The regional health authority policy requires an interdisciplinary conference be held with a resident within 10 weeks; however, the Standards state eight weeks. So standards being different from what the RHA is saying there.

MR. ABBOTT: Yes.

MR. FINN: And then further with respect to complaints: The management requires then five days; however, the Standards require two days. So those are just very small compliance issues but I'm just curious, I guess it's highlighted here as something you've been working towards in indicating the meeting did occur.

MR. ABBOTT: Yeah.

MR. FINN: I guess some of those have trickled down probably already I'm assuming with small …

MR. ABBOTT: But you do point to an issue not only in how nursing homes deliver this service, that's sort of a consistent kind of theme throughout a lot of the other services that we're sort of funding. And under Dr. Haggie, the minister, what we are attempting to do here with

all our services is to define a provincial standard to which then all health authorities must comply.

If they have a policy and it's different from the now new norm, new provincial, then they have to now follow the provincial standard. So we are going to try to apply that right across the board, whether it's mental health, food services, what have you.

So there's an example here, once we finalize these standards, then each of the health authorities, their policies have to comply with ours. They'll have some deviations on some small points but not on the significant ones. If it's a committee and that has to meet or report, then they will be consistent across the province.

MR. FINN: Right. So bringing each health authority in line with a provincial standard is the ultimate goal.

MR. ABBOTT: Yes.

MR. FINN: Fair enough, that's fine.

Thank you.

CHAIR: Ms. Rogers.

MS. ROGERS: Thank you very much.

We've heard a lot here today about sort of anecdotal evidence and people's own personal experience with seniors in their families, and I think we all hear it too as MHAs, and all of us, across the province, we hear the stories of people where the trays are put in front of them, their loved one, and if it wasn't for family members or volunteers, somebody wouldn't eat.

MR. ABBOTT: Yes.

MS. ROGERS: The other thing that we hear is people praise the staff in our long-term care facilities. Staff who are attentive, staff who really care. Oftentimes, they are taking care of people that they've known in their community. So I believe it's not simply a situation where staff have to buck up and work harder. There seems to be a systemic problem here and I am just wondering what's going to be done about it. We hear from family members that they see that the staff is working so hard, yet trays are left in front of people, not because staff aren't working hard enough, not because staff don't care. And people are not able to feed themselves or eat. Perhaps there is a resource issue here.

MR. ABBOTT: I would answer this a couple of ways. One, the onus is on the administrator and those supervising that floor, that dining room, that day, to make sure that every resident is fed and trays are not left in front of a resident. That should not happen.

Now if, at the end of the day, the result is we do not have sufficient staff, then we will address that as a department. That is not coming forward to us.

MS. ROGERS: Okay. So they have to advocate for more resources then if that the case.

MR. ABBOTT: If that's the issue. Secondly, what we want to do here is make sure we get the evidence so that it is documented and we'll deal with that.

Third, if there are complaints and observations and that is happening – I'm not going to argue it doesn't happen – then they have to be brought forward and we address that. So part of this monitoring framework will be how many trays have been left, because that information is recorded in each of the facilities. So it would suggest to me if you know that today, how are you addressing it today?

MS. ROGERS: Yes.

MR. ABBOTT: So we will be and are using that data now to go back and inquire as to how they're addressing it and then, as I said, if there is a complaint by a family member or other, then we will record that and then address that with the CEO and their staff as to say, look, this is happening; why.

As I said, all things being equal, if it's a resource issue then we have to address that. No different than if it's an emergency room, surgery – we wouldn't and shouldn't be making any difference or distinction between the demand for service and our ability to respond. But that is not what we are being presented with.

MS. ROGERS: We're hearing from family members about if there's a shortage of staff, if the night staff know that there's going to be a shortage, someone is calling in sick for the next morning, that's there's going to be a shortage of staff in the morning, residents who are taken out of bed really early, between 4 and 5 in the morning because they need to be dressed and washed because there's a shortage of staff in the morning.

So it seems to me that a lot of the complaints that we do hear, whether they're formally registered, really are about staffing and resources.

MR. ABBOTT: Yes.

MS. ROGERS: The other thing I wonder – I appreciate the issue that if people need to complain – is there any proactive measure to survey residents, survey family members about satisfaction with nutrition, that more proactive approach?

MR. ABBOTT: Yes, the health authorities and the individual facilities do these surveys. The interesting thing, and that's why – most of those are responses. The survey responses, to your point earlier, they rate the service, the staff and the accommodation, quite favourably.

MS. ROGERS: Yes.

MR. ABBOTT: Are we talking about 1 per cent, 5 per cent where we need to make a difference and that's really what, through this process, we will be able to focus because if it's the quality of the food in facility A, then we obviously have a conversation about that; is it left trays in facility B, then we deal with that.

MS. ROGERS: Okay.

I'm also curious because the Auditor General, in his report, also looks at the social needs of residents around nutrition and I would say also the psychosocial needs. What measures are being taken by the department to ensure that a person's dietary needs are met? For instance, religious beliefs, kosher, halal; Indigenous people who have been raised on country food; Asian food; folks who are vegetarian or vegan – how is that being handled or is there a plan to address that? I believe with the current aging population that those issues may be arising more.

MR. ABBOTT: I would agree with you in that as our society changes that's definitely the case. Again, we leave it to facility to identify and work with the resident and the family as to meeting those needs, and that's where the dietician would certainly come into play to work with the kitchen to make sure the appropriate meals are put in place.

We haven't, at the department, taken any particular policy direction on that, obviously, because we support that. That, for us, is a given and as each individual has certain, particular needs then they're addressed as well.

MS. ROGERS: So will that be –?

CHAIR: Excuse me, Ms. Rogers; I'm going to go on to other Members (inaudible) then I will go back to you.

MS. ROGERS: Could I just finish that one?

CHAIR: You're almost finished?

MS. ROGERS: Just this question.

Will there be a directive, a stated fact that that, in fact, is important?

MR. ABBOTT: I think in the monitoring framework it's are you meeting sort of really basically resident choice, whatever that choice may be.

MS. ROGERS: Okay, great. Thank you.

CHAIR: Mr. Bragg, anything further?

MR. BRAGG: A final question, I guess.

Do you track or monitor your complaints and, if you do, can you tell if the volume has decreased? I'll be honest, in my two years since I've been doing this, and I have two long-term facilities in my district, I don't hear the complaints that I hear from Ms. Rogers. I'm not saying that that's wrong or anything, so I don't know if one being Central and one being Eastern.

MR. ABBOTT: We don't at the department receive those unless they actually came –

WITNESS: (Inaudible).

MR. ABBOTT: Pardon?

WITNESS: We do.

MR. ABBOTT: The ones that come right into us?

WITNESS: Yeah, the ones that come to us we try to keep.

MR. ABBOTT: Yes, so to go there, the ones that the RHAs themselves receive, we don't track those.

MR. BRAGG: Okay.

MR. ABBOTT: But the ones that come directly to the department, we would track those. Again, from the long-term care, there are very few.

MR. BRAGG: Yes, okay, because I'm thinking coming to our level that the family members are probably really upset because they've probably exhausted whatever avenue they could at the front level.

MR. ABBOTT: Yes.

MR. BRAGG: Okay, thank you.

CHAIR: Mr. Petten, anything further?

MR. PETTEN: No, I am good on this topic, thanks.

CHAIR: Ms. Parsons, you're good?

Ms. Rogers.

MS. ROGERS: Yes, this may seem like an odd issue but the issue of teeth. I know that the Adult Dental Program has been cancelled and we see more and more seniors who have lost their dentures or their dentures have broken and they may not have the money. The whole issue of nutrition and teeth, has that been an issue, or will we see that as a growing issue as we monitor what is happening with our seniors who are unable to get dental care?

MR. ABBOTT: I'm going to say it is an emerging issue, but that may not do justice to it. It's been an issue longstanding, really. We've had conversations with the health authorities around dental care; we've had conversations with the Dental Association who are advocating and certainly recognize that is as an important health care matter as anything else. We're working on that. We haven't come up with any particular solution yet as to how do we address that, but it's certainly on our radar.

MS. ROGERS: Okay.

Great, thank you.

The issue of weighing and any unplanned weight change, what is happening now in terms of addressing that? It seems to me it's a crucial issue, and without that kind of information we really aren't quite sure what's happening with some of our folks.

MR. ABBOTT: Again, the Auditor General speaks to that matter and his finding – that will be one of the factors in the monitoring framework, that in fact we will now start getting regular reporting on meeting the standard.

Deena, I'll ask you to speak to that.

MS. WADDLETON: There has been a policy drafted and ready for approval on weights in long-term care. In practice, the RHAs have been doing that since the review, but we'll have a finalized policy on weighing residents approved very soon.

MS. ROGERS: Okay, because this was two years ago that this report came out.

MS. WADDLETON: Uh-huh.

MS. ROGERS: So we're going to see one this June, this month?

MS. WADDLETON: This will be done, yes, within a month or so.

MS. ROGERS: Okay.

Do you have any empirical evidence as to how it has improved? How do we know that?

MS. WADDLETON: Until we get, as John has mentioned, the outcome of the RHA monitoring, then I can't really speak to that right now. But that will be something that we will be asking them to report on.

MS. ROGERS: We really don't have any reports on that?

MS. WADDLETON: I don't have a report on that, no.

MS. ROGERS: Okay, so we don't really know.

MS. WADDLETON: No.

MS. ROGERS: Okay.

All right, thank you.

How will you ensure that this is happening? It seems to me that it's such a fundamental practice in terms of knowing how our folks are doing.

MR. ABBOTT: (Inaudible) to the department on meeting. Again, we will have both standards; we'll say it needs to be done. Now we'll know how often it is done or not done and where that is.

MS. ROGERS: Yes.

MR. ABBOTT: And then we will follow up with each of the health authorities to find out if, in fact, there are cases, whether it's weighing the resident and monitoring and, more importantly, monitoring that resident for any issues, health or other. Then we'll now have a database to draw on. Right now, we are working in a vacuum.

MS. ROGERS: It seems to me it's such a crucial –

CHAIR: Excuse me, Ms. Rogers. I'm going to go to Mr. King and we'll come back to you.

Mr. King.

MR. KING: First of all, I'd like to correct a misleading statement stated by Ms. Rogers where the dental program has been cancelled. That's not entirely correct. The days of everyone having two sets of dentures, one for their mouth and one for the cupboard, those days are over. I'm sure you can attest that it's done on a case-by-case basis. So let's get that correct.

Just one final question: Why is Western Health ahead of Eastern Health with regard to the full implementation of these policies?

MR. ABBOTT: One, I guess, really their system is a bit smaller. So they have opportunity to focus a little bit more on that because the problem is that Eastern is a little bit larger and a little bit more dispersed, but nothing fundamentally different. I think it's just really a timing issue there.

MR. KING: All right.

I'd like to thank you for all the work you do. It's come a long way. You can see the effort the department has put into this nutrition issue, and the RHAs. It shows quite a bit of dedication over the past two years to get it from where you were to where you are now, and I just want to thank you for that.

MR. ABBOTT: Thank you.

CHAIR: Mr. Petten.

MR. PETTEN: No.

CHAIR: Mr. Finn.

MR. FINN: I'm fine, thanks.

CHAIR: Ms. Rogers.

MS. ROGERS: Yes, going back to the weigh – I'm going to weigh in again on the weigh. It just seems to me that it's just so fundamental. Why do you think that in a number of cases it hasn't been done, or hasn't been done as frequently as policy would – what's going on?

MR. ABBOTT: Again, I'll go back to some of the earlier points we were making. We have within the health authorities professionals whose jobs it is to undertake this. So we are dependent and reliant on them doing their jobs, and their managers need to oversee this.

The Auditor General went in and found out what – to your point, we'd assumed this would be

automatic. If you know your resident, you would know if there is weight loss and you'd want to make sure you address what the issues are, health or what have you.

I think it circles back to the quality of care and the responsibility within each of the health authorities; and, in this case, the nursing homes. It was very specific and identified specific cases. We, at the department, don't see any reason why this hasn't been done as required. It was certainly an eye-opener for us that a very basic measurement tool, in terms of care, wasn't being implemented.

MS. ROGERS: Again, I would think that those professionals who are providing that care want to provide the best care they possibly can.

MR. ABBOTT: Yeah.

MS. ROGERS: So I would raise the issue again: Is it a resource issue? I know there is a lot of stress on our long-term care facilities, that there are wait times.

MR. ABBOTT: But it's a standard of care. In any of our facilities in our health services, if a standard of care is determined, then they are resourced to meet that standard.

MS. ROGERS: Okay.

In response to my colleague, Mr. King, there, can you give us just an accurate explanation of the policy of the Adult Dental care program, just to clarify?

Thank you.

As it stands right now, my understanding is the Adult Dental care program is available for people on Income Support, there are further limitations.

MR. ABBOTT: That's right.

MS. ROGERS: But for people who not on Income Support, it has been cancelled.

MR. ABBOTT: There's no funding for that. That's correct, yes.

MS. ROGERS: Thank you. Okay.

I have a concern around nutrition for our seniors who are waiting to go into long-term care who are in acute care beds. I know we have a number of them. Is that concern under examination? Because some of them are in there for a long time.

MR. ABBOTT: That's right.

MS. ROGERS: Yeah.

MR. ABBOTT: Well, they would fall under, then, the food that is provided by the hospital, if they're in a hospital setting. We haven't flagged that as a particular issue at this stage.

MS. ROGERS: I think it might be kind of interesting again because – and in fact they are waiting for long-term care.

MR. ABBOTT: Yeah.

MS. ROGERS: Acute care, feeding nutrition may be a little bit different. They're in there for a long time. I was just curious about that.

The department noted there is a working group that met in March. Can we get an update on that meeting? What is happening now? Will there be a formal review? How long will it take? Is there a report from that? What is the scope?

MR. ABBOTT: Yes, we'll provide that information.

MS. ROGERS: Great.

Thank you very much.

I don't know if I have any other questions. I think I'm okay. I just want to look at one more issue – almost there.

I was looking on page 210 of the Auditor General's report. It looks at the shortfalls to Canada's Food Guide. We can see that it was inconsistent. Some of the shortfalls are more pronounced in some facilities than in others.

It was very interesting that milk alternatives, for instance, in the St. John's long-term care facility; there were a lot of shortfalls there and vegetables, fruit and grain products. Dr. Albert O'Mahony Memorial Manor seems to have

fewer shortfalls. It was just kind of interesting to see the differences there.

I would imagine then, your standards of care that you are developing will look at that for your monitoring framework?

MR. ABBOTT: Yeah, and I think that's a good indication then of the kind of reporting we now will expect. We can start looking at that and say: All right, why the deviation from what the established norm is and what is the authority doing to address it.

MS. ROGERS: Okay. Thank you very much.

Again, I know how complex this is. Wouldn't it be wonderful if we could become a centre of excellence for how we care for our seniors? I know it's a challenge.

MR. ABBOTT: Thank you.

CHAIR: Okay, thank you.

If there are no other further questions, we'll finish with the Nutrition in Long-term Care Facilities and move on to Acute Care. I have to step out for 15 minutes but Mr. Bragg is going to take the Chair while I'm out.

The process will be to start then with Ms. Parsons as the first line of questioning on Nutrition in Long-term Care Facilities.

MS. P. PARSONS: No, acute.

CHAIR: (Inaudible) the standard is to ask, do you have any closing comments on the previous heading that we just talked about.

MR. PADDON: The only comment I'd make, I mean I don't underestimate the challenges and the complexity of this particular issue. As some of the Committee Members have talked about personal experience, we've all had those experiences. Fortunately, mine have been fairly positive.

I am encouraged because anecdotally I hear within Eastern Health, just from acquaintances and people I know, that there's been a fair bit of work occurring to address the recommendations. That's quite encouraging to us.

At the end of the day, all our recommendations should be designed to ensure that we have a better system and sort of care appropriately for people who are fairly vulnerable in society. That's really what's driving us. We're quite encouraged by what we've seen so far and, hopefully, we'll have a better system at the end of the day.

CHAIR (Bragg): Okay, thank you.

Moving on, our next heading is going to be Acute Care Bed Management. It is section 3.3 of the November 2016 report.

The first question, I'll go to Ms. Parsons.

MS. P. PARSONS: Thank you, Mr. Chair.

Based on the review for Acute Care Bed Management in 2016, the recommendations, "Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator."

I would like if you could please provide an update on the latest with this.

MR. ABBOTT: In terms of these series of recommendations, of course, they were all sort of addressed to the individual health authorities but we have coordinated and are looking at how they are implementing.

In terms of the first recommendation, for instance, Eastern Health has fully implemented the recommendation, both Central and Western have partially implemented – and we can speak to some of that – and Labrador-Grenfell has yet to begin implementation.

The indicators that were identified are all relevant, and depending, again, how they've been set, and we are collecting data – or the health authorities are collecting data – and reporting to us on those. Central Health, for instance, expects to be fully compliant by the fall of 2018, and Western Health by late fall of this year.

I think what the Auditor General has identified in this area is an important piece of work to help us manage our hospital costs. They are the most – it's sort of the highest cost in the country. We have now means to look at how we can manage the beds better.

We have over 1,500 beds in our system and, depending on how we manage those, will determine how patients get in, move through our system and, obviously, are released. We are operating at a very high level of capacity right throughout our system. As a matter of fact, higher than we should ideally, and that's why it's important that we manage the beds and the people in those beds much more closely.

Again, the Auditor General's report I think has been very helpful to the system in identifying a critical management issue for us.

MS. P. PARSONS: Could you just elaborate on the management policies and procedures with particular regard to discharge and admission, as well as (inaudible).

MR. ABBOTT: Well, ideally, on admission you should have a discharge plan. So a physician, working with the nursing staff, will say: Patient X, based on the conditions they're presenting with, based on the care plan, we should see that patient being released within three days, four days, five days.

That's not always done, and it needs to be. That's a best practice right across the country. Then you're managing against a potential date. So if a person comes in on Monday, we're assuming they're going to leave by Thursday based on the care, and if they're not, then why not? Has the patient gotten better or worse? Has the care plan changed or are we just not managing that patient as closely as we should? The physician, for instance, is available to write and support the discharge note or notice at the time.

So it's a lot of parts moving at the one time, but if we do this well, the patient is better served. If the bed frees up one day earlier, that means somebody else can come in to get in. So it really improves access if we do this right.

MS. P. PARSONS: Right. The common concerns we hear – over the years we've heard of patients being on a bed in a hallway.

MR. ABBOTT: Yeah.

MS. P. PARSONS: That's a common concern.

MR. ABBOTT: Yeah.

MS. P. PARSONS: How have we improved in that regard? At the same time, we hear the complaint that patients are being released too early –

MR. ABBOTT: Yeah.

MS. P. PARSONS: – when still needing care and still in critical condition.
MR. ABBOTT: Yeah.

On the first example you used in terms of beds in hallway, it's usually indicative of overcapacity in the hospital that day. That means generally the beds upstairs, shall we say, are full and there's no room. So they have to be managed through the emergency room.

Part of this whole exercise in looking at the management of the beds is to say: Are each of the beds that are in whatever service they're in, are the patients being appropriately cared for? Are they appropriately in those beds? Can they go home sooner? Should they be in them there in the first place? The discharge plan on admission helps manage that.

What we're seeing in some successes now through other initiatives is that we are starting to free up beds. So waiting in hallways is starting and, hopefully, will come down. Ideally, you'd want to eliminate it, but you'll never fully eliminate it because if you get a surge on any particular night or weekend or what have you, then you have to manage it as best you can for that period.

In terms of the discharge early – and we hear that from time to time – those decisions are made by the attending physician based on the care needs, the physical condition of their patient. They will make a determination on release. They will get advice from the nursing staff and others, but that's their call at the end of

the day. There is no particular – if it's after three days and they're not ready to leave after three days, then they stay.

Now, will the physician always get it right? Maybe not but, again, we measure that. That is a standard of care as well through our monitoring system, because if that patient comes back within a day or two or three, well, that means the initial care has not been appropriate. We have processes then to review that and review that decision so ideally it shouldn't happen the next time.

MS. P. PARSONS: Okay. I'm good for now.

Thank you.

CHAIR: Mr. Petten.

MR. PETTEN: Thank you very much.

Just reviewing the AG's report, there are a lot of common themes that come out that – and I know that you just addressed a lot of it in having a discharge plan or the overall planning from when you are first admitted in the hospital. I know Pam referenced to the waiting times in the ER.

The number, 69 per cent of discharges happening between noon and 6 p.m. – 61 to 69 per cent – I think everyone here can attest if you ever were in the hospital, had a family member in hospital, if you never get discharged by Friday afternoon, you're in for the weekend.

MR. ABBOTT: Yes.

MR. PETTEN: If there was nothing done by 4 in the evening, you could be rest assured you had to wait until the next day. It usually was that the physician wasn't around to sign your discharge papers or someone needed to write a prescription. There are a lot of variations to it.

Looking through the AG's report, that theme went right through when we look at our Acute Care Bed Management – I guess the general question is: What is the plan? Do you change physicians? It's really a scheduling thing in hospitals because a lot of physicians are in the ER or in the operating room, they're performing clinics, they don't do the rounds until 5 in the evening.

Personally speaking, I think that is one big issue when you look at our acute beds being – the discharge. There are a lot of other things involved but, to me, that's one of the biggest issues from personal experience. I think we can all attest, they don't make the rounds until 5 or 6 in the evening or near evening.

Is there any plan to …?

MR. ABBOTT: Well, as part of looking at this particular issue, yes, the physicians have to be totally engaged in how they also change practice to support better utilization of the beds that, in fact, their patients are in and their subsequent patients will be in.

This is not new. Over a number of years, the health authorities have tried different methods to make sure that the discharge is done ideally before noon and ideally right over the seven days. If you look at what's happening in the best performing hospitals across the country, you will see that's in fact what they do.

We know what needs to be done, we know how to do it, but the piece – and you alluded to it – is getting the physicians to sort of change their practice, to be supportive. That requires the VPs of medicine to better engage with them and with the nursing and allow, in some cases, nurses to discharge if it's – if I can use the term – routine. So we need to delegate some of that authority back to nurses and what have you to allow them to discharge when the care plan suggests that everything is on course.

There's a lot of work that still needs to be done on that particular piece. That's probably one of the more difficult pieces that we're struggling with.

MR. PETTEN: Do you have a percentage of beds that are being occupied now by long-term care patients awaiting beds?

MR. ABBOTT: Yes, we do.

Denise Tubrett has …

MS. TUBRETT: It's about 20 per cent on any given day that there are individuals in an acute care bed that is discharged and waiting for an alternative service level, one of which could be long-term care.

MR. PETTEN: You say they're discharged. If they're in that acute care bed, do the doctors still make rounds to those individuals or are they more in the care of nursing staff? How does that work? I'm just looking at resources.

MR. ABBOTT: Yeah, that would be primarily under then the daily care of the nurse. The physician would, as required, then would attend but not on a regular basis because they've been basically discharged.

MR. PETTEN: When you look at those long-term care residents or patients or what have you, they're sporadically all throughout the hospital. There's no real – there could be a long-term care patient in with three people who had surgery or what have you.

MR. ABBOTT: Yeah.

MR. PETTEN: There's no actual area in any of hospitals, they just take whatever bed is available; is that correct?

MR. ABBOTT: It does vary. So out in Central, for instance, they have moved to bringing those patients together.

MS. TUBRETT: And Western.

MR. ABBOTT: Western as well, as Denise is letting me know.

In St. John's, they're more dispersed, and again they've tried different models here. But that being said, St. John's is probably having the most success in recent time of moving those patients out to either long-term care because capacity has increased, or getting some actually to return home while they're waiting for long-term care.

MR. PETTEN: One other question on this – I know my time expired. You have dementia patients who tend to – I know our acute care beds are taken up with a lot of – 20 per cent is used. Dementia patients, unfortunately sometimes, tend to land wherever. A lot of times it's probably more of a less desirable location. Granted, they're getting their meals and their care, but where they are put – I don't know if my colleagues can attest; I can attest to it. As an elected official, I deal with it a lot of times with families who have grave concerns with their loved one when they're waiting to get into – they can't come home.

MR. ABBOTT: Yeah.

MR. PETTEN: They can't look after them at home, but there's no long-term care facility available so they're waiting for a placement.

MR. ABBOTT: Yes.

MR. PETTEN: I've dealt with this first-hand. Families have come to me; I've dealt with them, and it's been a very stressful time. But they tend to be wherever a bed is available – it may not be where me or you would want to be, but they're put there. It is almost the least, if you look at your A level bed to your D level.

MR. ABBOTT: Yes.

MR. PETTEN: I've heard from other people as well; I've dealt with it myself. That seems to be the norm. So they get their three squares and wherever they can put them. Someone else I guess more vocal or – I don't know what you'd call it – more opinionated or more able would probably not end up there.

My question is, I know these people are waiting to get out into long-term care and they are taking up an acute care bed, no matter what their issue is, but is there any consideration given to the fact of their personal situation? With dementia, it's pretty sad disease. Is there any priority given to make sure that they are probably in a more stable environment?

MR. ABBOTT: If I understand, it's in terms of while they're waiting for placement in a long-term care, so they may be somewhere in the hospital setting. I can't speak to anything specific on that. The particular challenge, if I can put it that way for those with dementia, Alzheimer's, who are in the hospital waiting for placement, there are only so many beds that we would have in a nursing home that can take and

care appropriately for that. And there you're seeing some quote, unquote backlog.

MR. PETTEN: Yes.

MR. ABBOTT: Now, how they're managed in the hospital setting, again, they are patients and they are supposed to obviously get the appropriate care. I'm not aware of any particular cases that have come to our attention that speak to what you've observed. So that's something we can certainly follow up with in terms of – as I understand, one of the key points there is for those dementia patients in what we call the ALC bed, the alternate level, do we have some additional nursing provisions to make sure that their care is appropriate.

MS. WADDLETON: I can speak to that.

MR. ABBOTT: Okay.

MS. WADDLETON: So when the individual is in an acute care bed waiting to go to a long-term care bed, oftentimes the hospital will look at their needs. If they're a dementia patient, then they will look at constant care, so putting clinical staff with them or nursing staff, probably a PCA, something like that, to protect them while they're in the acute care bed.

They'll get as much care as they need to keep them safe and keep them well while they wait for an acute care bed. In some cases, it's additional staffing that may be assigned to the individual.

CHAIR: Excuse me, Mr. Petten, I'm going to move on to Mr. King and then we can come back to you.

MR. PETTEN: Sure.

CHAIR: Mr. King.

MR. KING: Thank you very much again, to compliment you on the work for such a short time frame. I know this came out in November. So to see the level of detail that you guys have put into this – well, mostly the health authorities at this point.

One major question I have is with acute care management; where does technology come into play so with data management and you track everything and you get better outcomes – are you guys looking at technology or utilizing any technology at this point?

MR. ABBOTT: Well, in terms of capturing the data, yes. Really, the conversations we're having now is how technology can help monitor residents and patients as they leave the hospital; if they do go home, how we can monitor and support them through remote monitoring and those kinds of things.

We are looking at how some of our systems, if we brought a lot of the information together in terms of one health system or information system, we can better deploy our resources. Taking a case of somebody who comes to the emergency – and the minister announced on Monday the Chronic Disease Action Plan – within that, we see a lot of opportunity to use technology to help patients support themselves in the community or through support by their health authority.

That's the kind of conversations we're having. There are a lot of applications now being developed for just that – some that are being developed locally. We're seeing, I suspect, over the next three to five years, quite significant investment in technology to help us deliver a lot of these services.

MR. KING: Yeah, because technology and trend analysis would be ideal, certainly, for tracking the outcomes of this.

MR. ABBOTT: Yeah. We have a lot of that in place in decisions and supports to allow that. The thing is it's really incumbent of us to use that data then, to start informing our program changes that we need to make.

MR. KING: That's all I have.

Thank you.

CHAIR: Ms. Rogers.

MS. ROGERS: Thank you very much.

When we look at some of – I know this is such a complex thing and it's been age old. We've been dealing with this problem for years. I don't

know if it seems to be getting better at all or what, I'm not sure; or if, in fact, there's even a greater demand on the system because of our shifting demographics.

The response from the department spoke of establishing working groups from the four regional health authorities so we can optimize acute care management and working to strengthen existing policies and procedures, so the working groups were established. Can you tell me: Is it one working group? When was it established? Has there been any reporting from it at all yet?

MR. ABBOTT: Mr. Chair, Heather Hanrahan from our department has joined us. I'll ask Heather to speak to that.

MS. ROGERS: Great. Thanks.

MS. HANRAHAN: There is one provincial working group that the department leads. We have myself and another individual on the working group and then there's one senior representative from each regional health authority. So we've gone through all the findings and the recommendations.

The RHAs have shared any indicators, any policy work, anything they've done that's current and recent, with each other as a way to, I think, get the work done faster and to get the work done in a more provincial and consistent fashion.

MS. ROGERS: Heather, when did that start, that working group?

MS. HANRAHAN: I'm going to say December.

MS. ROGERS: Okay, great. That was fast to get that up and going.

MS. HANRAHAN: Yeah.

MS. ROGERS: Will that working group look at factors like home care, the availability of home care, all the number of issues that impact whether or not folks can leave a hospital or go to other alternative levels of care facilities? What are some of the mitigating factors that keep people in acute care beds?

MS. HANRAHAN: So there's a major initiative, I guess, within the department in terms of Home First and trying to have the maximized supports that we can have in the community. I guess our working group here will pick away at these recommendations and findings until we feel that they are complete and things are in order as they should be.

MS. ROGERS: Okay, thank you.

Is there still a dedicated admission discharge manager in each hospital? I know a number of positions have been cut. But do we still have that, a dedicated admission discharge manager in each hospital?

MS. HANRAHAN: Yes, there would be somebody who would have that responsibility in each health authority.

MS. ROGERS: Okay, and that would be a manager?

MS. HANRAHAN: Correct.

MS. ROGERS: Okay, great. Thank you.

Some of the work where we see there's been some delays around discharge records, medication reconciliation, to name a few of them, would any of those be as a result of under staffing or too few staff doing too much?

I can see you smiling there, John, because I raised this issue a number of times. but I'm just wondering because I don't think we have staff not working hard. I think staff are working very, very hard and the demand on our health care system seems to be growing. Are any of the problems that we're facing a result of that?

MR. ABBOTT: Yeah, the pieces you've identified are mostly in an electronic format, in any event.

MS. ROGERS: Okay.

MR. ABBOTT: It is a case of bringing those files together within the hospital setting. We have the Meditech system, which has the record for all interventions and required interventions on one file. If things get missed – and that does happen – it may be a case of rushing or

overlooking some things but, again, we are resourced to make sure that care plan and the needs are fully addressed.

MS. ROGERS: Okay.

Why are some of the issues we are dealing with so – they've been going on for so long, even the issues that seem simple, like not discharging before noon, which seems simple from a layperson. Why are they so ingrained? Why have we not been able to at least solve some of them?

I know there is some positive work being done, but what's keeping us from achieving where we want to go and where we – again, this conversation has been happening for years. What's your assessment of that?

MR. ABBOTT: If you look at our health authorities and certainly in the hospitals within those, as I said, we are very well resourced, and well-resourced relative to other systems across this country, so it isn't a resource issue. It really does boil down to how we manage each of those programs in each of those facilities. If you look at some of the excellent work we do in terms of cardiac and cancer care, then we need to replicate that.

Ms. Rogers, you appreciate when you look at the mental health and addictions, we know a lot of what needs to happen, we have resources. There may be, in some cases, in that particular area where we obviously need to add, but we know what needs to be done.

All our staff are trained, our physicians are all accredited. All our systems are accredited and we have resources here. So it is a management issue, at least from my perspective. The conversations we're having with the health authorities and each of the professions is how we can better manage the resources we have to get the better outcomes.

That's certainly a theme the minister has been focused on since he's come into the portfolio is to really focus. That means challenging the department and in turn challenging the health authorities and proprietors that we can and should be doing better here because we have all the tools at our disposal.

So there really isn't one thing you can point to that says it's missing, but when you try to tease it out you realize – and to your point, a lot of these are not new issues by any stretch. So it's incumbent upon us now really to turn the tide, to make sure we manage this and much, much more effectively.

I think holding the administrators, both in the department and in the health authorities, to account is I think more than appropriate.

CHAIR (Brazil): Ms. Rogers, I'm going to go to Mr. Finn.

Mr. Finn, any questions?

MR. FINN: Thank you, Mr. Chair, and thanks for the thorough information.

You've answered most of, I guess, some of what I've been able to flip through in my short time here, but with respect to discharge – and I can understand some of the challenges there, but I'm curious. With the discharge planning and some of that relating to the physician, is some of the gaps there because individuals once discharged don't have a family physician? Is that …?

MR. ABBOTT: That could be, from time to time, a factor in when you are doing your discharge to whom do you discharge –

MR. FINN: To whom are you putting in (inaudible)?

MR. ABBOTT: – and if there's a follow-up care. That will come from time to time. We have, obviously, our community health nursing system that really then will step in to manage that, and we have nurse practitioners now more so in the community to do that. Other than that, then that patient would end up coming back through emergency or if there are some day clinics at a particular hospital site for follow-up care. It's not ideal, but that would be the backup in those cases.

MR. FINN: Okay.

One of the findings here and it states: three of the four hospitals examined under the Regional Authorities did not require medication reconciliations be performed.

I'm thinking specifically because they didn't require the medication or reconciliation be performed, it doesn't mean it wasn't actually being done –

MR. ABBOTT: No.

MR. FINN: – but I guess to me that would just raise a lot of questions because then we're circling folks who leave the hospital back into emerge.

MR. ABBOTT: Right, yes.

We think that, one, because the health authorities are now reporting back on implementing that particular recommendation, but now with our pharmacy network fully in place, then we have found a mechanism with our electronic health records system that now we pull all that data together up for that particular patient. So this becomes much easier to do.

MR. FINN: Sure.

MR. ABBOTT: They just have to make sure they monitor that report.

MR. FINN: Okay, excellent.

Thank you.

CHAIR: Mr. Petten, another question or questions?

MR. PETTEN: Yeah, I just wanted one follow up from my questioning from earlier; I never got to finish asking it. The point I'm trying to get at is we have all these acute care beds, demand is on, people waiting to get in for the surgeries and that. We have long-term care patients that are taking these beds up.

I want to go back to the – I guess they're waiting to go into long-term care and they have their faculties about them, they're just occupying a bed. As long as they're being taken care of it's not a huge issue.

My point on dementia, people with Alzheimer's and forms of dementia – and I've seen this myself; my mom was in hospital in December. The next bedroom over at St. Clare's, the next room to her was a dementia patient. She was there, she had a bed, but there seemed to be very little controls.

It's twofold is what I'm trying to get at. You have some places where you have a dementia patient in where everyone is functioning. It's a very unsafe position for both people because they're at the mercy of whomever. Then there are patients that are in just for regular surgery who have to tolerate what comes with that. Like I said before, it's a sad disease.

Again, to me, what I've observed and what seems to be when I read this report, there's no real plan when it comes to it. That's an issue. Like what was just said, 20 per cent of the beds are occupied by various forms of people waiting to get in long-term care. While we're dealing with that – until facilities are available where that number decreases hopefully to zero at one time – that seems to be done in a very ad hoc fashion. It's like wherever the bed is, they'll end up going there.

I've heard nothing here today and I've probably seen nothing that tells me otherwise, especially when you're looking at – probably what I was trying to get at is there should be better planning when it comes to certain residents that are waiting to get in long-term care facilities because it's more than dementia. There are variations as you progress in life that we all have to face at one time or another. There doesn't seem to be any real planning from the hospital health authority point of view, other than the fact we have a bed for you.

MR. ABBOTT: Yeah.

Again, depending on the individual circumstance, because what we are seeing, which is sort of the gap that we're facing, we will have patients at home – before they get to the hospital – they are being managed by their family, maybe with some home support, but get to the point that really they cannot be managed and the family has run out of energy, resources that, from time to time, obviously, will bring their family member to the emergency and say there's been an incident and we can no longer have our mother and whatever come back home. Then the hospital is obligated, obviously, to receive and treat. So then they have to find a bed for that individual. If it's dementia or

Alzheimer's, it's generally, depending on the patient's condition, will probably be isolated in a room because the hospital will say that they been managed there because, i.e., it won't disrupt the two- or four-bed ward.

What we are attempting to do, and as was announced in the budget, through a truly Home First, is that we can identify these potential patients that are residents now at home who are high risk, who do have dementia, may have Alzheimer's, develop a care plan for them so that there isn't a surprise when they show up, because they shouldn't go to emergency in the first instance.

If they cannot be cared for at home, they should bypass the hospital system and go right into the nursing home. So that's the approach and planning we are currently doing. Because you do identify a big issue that each of the health authorities are trying to address. What we at the department are now doing is sort of viewing that as one of the key priorities for us for this year. We brought all the senior leadership, whether it's public nursing, home care, home support, all of those disciplines, we've brought them together for two days to map this out so that we can actually move the patients, one, that are in, out – home, if need be, to long-term care right away. We are seeing a positive impact already that are starting to free up the beds, because people are in hospital that should not be.

With a few extra dollars in terms of adding to either their home support hours or home care hours or the nursing hours, we're able to leave them definitely in their home where they want to be, and that's a more cost effective and certainly more acceptable way of doing that.

If this pans out the way we are planning it, we are seeing there will be a significant reduction in beds for that particular population. So either those beds can close or they're used for the two- or three-day requirements if somebody has to come in for routine surgery, those kinds of things, then we can move them through much faster.

So I think you're going to see, over the next couple of years, significant change, certainly in the Eastern region, because that's where most of these issues are playing out – here, Gander, Grand Falls and Corner Brook. So we're quite encouraged by what we're seeing already on that front.

MR. PETTEN: Thank you.

CHAIR: Mr. Bragg.

MR. BRAGG: No, I'm good.

CHAIR: Ms. Rogers.

MS. ROGERS: Thank you very much.

I was surprised, John, to hear you talk about – the Home First is great and that's a great plan and great to push towards, and you were saying with some extra dollars or hours to help people stay in their homes. Yet, what we're hearing, in fact, is people who are telling us that some of their home care hours, particularly homemaking and home-keeping hours have been eliminated, which is making it harder for them to stay in their homes.

MR. ABBOTT: Yeah. So if I can split that for the moment.

MS. ROGERS: Yeah.

MR. ABBOTT: The homemaking ones, again, we looked at what was happening across the country, looked at, obviously, in terms of our overall budget situation, and determination was made that we could do that and it would not impact on people staying in their own home, around that particular aspect.

But when it comes to the more nursing and related – I shouldn't say nursing – but when it comes to other home supports and nursing, we are now looking at what are the appropriate assessments to be done; how we need to change those. We are currently looking at some training programs for our nurses and social workers to look at how we assess and that we will be coming forward basically to say, look, we want you to assess against the hours of care that are needed and then we will fund that accordingly.

MS. ROGERS: So there may be some movement on the issue of some housekeeping hours?

MR. ABBOTT: No, we won't be changing that aspect, but it will be the other supports that they need to stay in place. We believe if it's one or two hours of homemaking a day, depending on what's assessed, that will be sufficient; but if they need other supports, which is the other two or three or four or five hours a day, we are looking at that in a much more consistent manner and to allow people to stay at home.

The Home First is really looking at, one, our review of the home support program says we need to do that. Secondly, our focus on Home First for patients with a whole lot of complex needs, we can't confine them to three hours a day or four hours a day necessarily; but if it takes four hours this week, five hours next week and some other supports, OT, PT, what have you, we will put that in place.

We certainly want to focus on palliative residents. If they want to stay home, we want them to stay at home. We know we have to change how we do that and the hours that are required there. So we're changing that. We had an arbitrary rule of 28 days. Now, who knows when you've been diagnosed as a palliative care patient – our rules said basically 28 days and that's it. We said that obviously makes no sense.

Once you've been diagnosed, then we can put in whatever the appropriate services are in place. Money has been put in the budget to do that, the policy direction has been set and now we're trying to operationalize that. The federal money that's coming in will help support that as well.

Again, we see that as a bit of a game changer in how we deal with the program going forward. There are going to be some bumps in the road we know. We're dealing with the home care agencies. They have to change how they do business as well, but they seem to be fully engaged with us on making the changes.

MS. ROGERS: Just for a point of clarification, I know I seem like a dog with a bone on this one, but the issue of some of the homemaking hours. Are those gone entirely or what?

MR. ABBOTT: Well, again, we are assessing every resident as to their ultimate, you know, what they need.

MS. ROGERS: Yeah.

MR. ABBOTT: The policy direction in the budget before last, that reduced those hours, that still stands. But we are doing it at the same time; we are going case by case. If there are exceptions to that, we'll deal with those.

CHAIR: Ms. Rogers, do you have much left on this heading, only because …

MS. ROGERS: Just one comment.

CHAIR: Okay.

MS. ROGERS: Again, it's been such a long-standing, serious issue and I'm so glad that you are so committed to look at it. I wish you every luck because it has been so intransigent. Is that the right word for this at this point?

MR. ABBOTT: Yeah.

MS. ROGERS: I just want to thank you very, very much. Good luck with this.

CHAIR: Okay.

Before we leave that heading, I'll ask the AG if there's any particular comment or not. You're good on it?

Okay, if we can break for lunch and resume at 1:15 p.m. sharp, appreciate it. We're making progress.

Thank you very much.

Recess

CHAIR: Okay, ladies and gentleman, we're going to reconvene the Public Accounts hearing this afternoon with the Department of Health and Community Services and the health authorities.

So we've moved to the fifth heading, Personal Care Home Regulation, and we'll start the process with any questions starting with Mr. Bragg.

MR. BRAGG: Okay, if we're all ready. Hope we had a great lunch, a nice light lunch.

So I'm just wondering, where are we with the operating standards for personal care homes. Has there been any movement on that? Is there any listing or …?

MR. ABBOTT: Okay. If I may, just for a second, and then to answer your direct question – in the Auditor General's report he had provided 16 recommendations specific to our department; six targeted to the regional health authorities and eight to the government service centres or Service NL. I just wanted to let you know of the eight recommendations between the department and the RHAs are dealing with, six have been fully implemented and two are partially implemented.

So with respect then to your question on the standards, right now we have a draft of the standards that are complete, we are currently reviewing those in the department and we expect to have those signed off and out to the system this fall.

MR. BRAGG: Okay.

We talked about nutrition earlier this morning, not in personal care homes. Is that being looked at too, or are we just looking at the overall appearance and, I guess, the qualifications of the employees and those sorts of things?

MR. ABBOTT: No, it would be the full gamut.

MR. BRAGG: It would be the full gamut of everything, right?

MR. ABBOTT: Yes.

MR. BRAGG: Okay. So when that's available, I'm assuming there will be reports online?

MR. ABBOTT: We're going to move it in that direction.

MR. BRAGG: Yes.

MR. ABBOTT: The government overall is moving there. We have yet to develop our plan as to what and when we'll be putting online. These will be, but I can't tell you when.

MR. BRAGG: Are you guys aware of any right now that are probably operating at a level that would be considered inferior?

MR. ABBOTT: What I can say is there is certainly one home that is under sort of a conditional licence and that we are working with that operator at present.

MR. BRAGG: Okay, thank you.

All right, I'll move on.

CHAIR: Are you good?

MR. BRAGG: Yes.

CHAIR: Okay.

Mr. Petten.

MR. PETTEN: Thank you very much.

Personal care homes, ironically, I have 13 in my district. A lot of what we talked about this morning with the nutrition, I guess really Acute Care Bed Management too, acute care beds, it all kind of goes hand in hand with our personal care homes because they're part of the bigger system of our long-term care strategy to various levels.

The question I have is, there are various levels of care – out of the 13 in my district, each one of them could be rated on a different level. Yet under the regional health authority, under Eastern Health, they're all considered to be Level 1 or Level 2. They're all rated for various residents. What I'm questioning is what quality assurance mechanisms do the departments or RHAs have in place to make sure that you're getting – you're going in a home that's providing Level 1 care and they should be relatively of the same standard.

I hate to say it but, unfortunately, they're not. I know you say you have one unconditional licence. What checks and balances – who's really policing to make sure you have the proper nutrition, the proper environment, pretty well right across the board? Because there is a distinct difference in the level of care – I probably shouldn't say the level of care but the

combinations, the level of service provided to various – it depends on which home you go in.

MR. ABBOTT: Yes, and particularly in your district in Conception Bay South with the community care homes that really came out of the Waterford program. They're required and there are certain standards that have been set for them, and we fund them accordingly.

Each of the RHAs then have the program and a director and managers that are responsible with professional staff, whether it is the social workers that would visit, the community nurse, that if there are issues and deficiencies, what have you, that they are to report those as part of their monitoring. But we know that there are weakness in our system. So part of the review we're doing now in developing the standards, again, also developing and monitoring framework is that we move to increase the quality.

In terms of the care requirements, they are assessed by whether it's the social worker or nurse as to the required care and the home's ability to provide that care and manage the resident. What we are actually doing in the personal care home – to your initial comment, they are a significant player in the long-term care sector or the community and long-term care sector. We are looking to see where we can expand how they deliver service; can they take patients who may have a higher level of need but can be accommodated in a personal care home.

Over the past year or so, we have had an enhanced subsidies to allow that. At the same time, we are supporting the personal care homes to provide them with more resources for those residents who now need to transition into long-term care. They've been assessed to move, but in the case where there isn't a bed, we recognize that we also have to provide more resources to that personal care home to allow them to take care of that resident while we're waiting.

We have a standing committee in place with the personal care home operators and we work with them. There have been some challenges within that sector and we're trying to work through the issues with them.

MR. PETTEN: Okay.

CHAIR: Okay, Ms. Parsons, moving on the personal –

MS. P. PARSONS: (Inaudible) I can come back.

CHAIR: Okay, good enough.

Ms. Rogers.

MS. ROGERS: Yes.

Somebody who I'm working with insisted that I bring the *Report of the Commission of Enquiry into the Chafe's Nursing Home Fire, December 26, 1976*. We all know what a tragedy that was and that was also because of safety standards and how very, very difficult that is.

MR. ABBOTT: Yeah.

MS. ROGERS: In that inquiry there was a quote: We have placed our trust in government to ensure that these homes are controlled and supervised so that there's an acceptable standard of safety and care. And it would appear from the evidence that has come to light during this inquiry that this trust has been somewhat misplaced.

I'm sure that we have really learned from that tragedy – that was 40 years ago – but we still have some issues that arise because of standards and whether they're adhered to or enforced and how is that. Again, I really understand and can appreciate – although my knowledge is somewhat limited on the extreme – the growing need for different kinds of care, whether it's seniors or people with disabilities, and how do we meet those in this particular economic climate and also with our shifting demographics.

The Auditor General recommended a comprehensive review of personal care home operating standards and the regional health authority monitoring standards every two years. So the department's response is that these items are almost complete, these two items?

MR. ABBOTT: Yes.

MS. ROGERS: So when will you expect them to be complete? I'm not sure who answered that in a previous –

MR. ABBOTT: Yes, Ms. Rogers, we intend to have those released this fall.

MS. ROGERS: Will those be public documents?

MR. ABBOTT: Oh yes.

MS. ROGERS: Okay, great. So we will be able to get copies of those.

Now, the issue of inspections of our personal care homes, we now release the results of inspections in food establishments –

MR. ABBOTT: Yes.

MS. ROGERS: Will the department make public results of all inspections of personal care homes?

MR. ABBOTT: With the standards and putting in and monitoring framework, that's our intention to do that.

MS. ROGERS: Okay.

MR. ABBOTT: We have to coordinate what we do with the government service centres because they do the physical fire life safety monitoring and reporting. But that's the direction we intend to go.

MS. ROGERS: Do you see any possible objections to that, any push back at all? Is there anything that you think would prevent that from happening?

MR. ABBOTT: Not that we're seeing. I mean, there may be somebody in the industry that may not be as welcoming of that, but we are consulting, obviously, with the sector. As a policy direction we are moving towards that public reporting.

MS. ROGERS: Okay, great.

And the Auditor General also recommended that all four RHAs implement, I don't want to say surprise inspections but –

AN HON. MEMBER: Unannounced.

MS. ROGERS: Unannounced inspections, and the department's response was that Eastern Health will continue to do so. Will all the other regional health authorities do that as well?

MR. ABBOTT: I think we're going to have more conversations with them on the specifics of that and how that is done. But putting that aside for the moment, each of the RHAs have staff visiting in those homes constantly, regularly, announced, unannounced; either because it's as a community health nurse going in to do their visit with their patients and other social workers and what have you. What we want to do is that they will have a formal reporting. Any time they go in for whatever reason –

MS. ROGERS: Okay.

MR. ABBOTT: – there is a report and recorded. It's part of their normal activities. If they notice anything that should be brought to the attention of their managers of record, then that will then be recorded, so that I think will go a long way in addressing that.

Part of that is also I think, looking at it from a risk point of view, which homes are probably having challenges around care issues or food issues or life-safety issues and making sure we, one, visit them and monitor them more closely and obviously more unannounced.

MS. ROGERS: Right.

MR. ABBOTT: So in the case I mentioned that we are sort of addressing right now, we are doing regularly, unannounced inspections to make sure that they are meeting the terms of those conditions.

MS. ROGERS: Yeah.

Yet, those situations, whether it be an OT or a nurse or whatever, they have a specific task when they go in.

MR. ABBOTT: Yes.

MS. ROGERS: So they wouldn't be looking at a global thing.

MR. ABBOTT: No, but they would have sort of a template that they can report against. When

they are there, yes, they are there for their regular business and oh, by the way, this is what else we noted.

MS. ROGERS: Yeah, but you'll also be looking at doing the unannounced more global inspections.

MR. ABBOTT: Yes.

MS. ROGERS: Great. Thank you.

CHAIR: Ms. Rogers, I'm going to move to Mr. King.

Thank you.

MR. KING: I don't have a whole lot on this one actually. It seems to be pretty much up to date. There are a few that are partially implemented and one not implemented and that goes back to January of this year.

MR. ABBOTT: Yeah.

MR. KING: Can you give me an update on those? I think it would be 3, 5 and 6 on the first page.

MR. ABBOTT: So if I can just quickly, in Recommendations 1 and 2, they are partially implemented in terms of the operating standards will be out this fall. Reporting results to the public, we are working actively on that and may begin reporting as early as in the next week or two.

MR. KING: Okay.

MR. ABBOTT: So we're focused on that for the data we have.

Recommendations 3, 4, 5, 6, 7 and 8 are implemented.

MR. KING: Okay.

Just one more question, a lot of this has been fully implemented over the last two years. So for the fully implemented recommendations from the health authorities, are you finding a noticeable difference in the improvement of following the regulations? Or have you had an opportunity to do the follow-up?

MR. ABBOTT: The standards when they were written and then where we were, I think what would happen is we sort of put the standards there and we followed them but we weren't monitoring against them as –

MR. KING: Okay.

MR. ABBOTT: – closely as we should. I don't think there was any issue when we talked to the RHAs in how we do that. Again, the staff and the directors and managers are constantly meeting with the operators, visiting and those things, so there's a process in place to do that.

Now, we've formalized that to make sure that it's done on a regular basis according to the standards and we now can report out with more confidence.

MR. KING: Okay, thank you.

CHAIR: Mr. Petten.

MR. PETTEN: No, I'm good.

CHAIR: Mr. Finn.

MR. FINN: I am just curious on the reporting of the results, which you said you were partially through. It says the department will begin to post – this is Recommendation 2 – the licence status. Are you going to get into any more specifics around that – I guess back to Gerry's point, what information other than just a licence has been –?

MR. ABBOTT: So we'll start with that and once we have the standards done and our monitoring framework in place, then we'll provide more comprehensive reports on are they meeting those standards and where they're deficient. Then that will allow you to interpret why the licence was fully met or conditional.

MR. FINN: Right. Because some of them were referring to fire life safety –

MR. ABBOTT: Yes.

MR. FINN: – and some of those nuances. It's one thing I guess to log online and see that personal care home ABC is licensed, but it's another thing to know that it's licensed yet there was a noncompliance with this, this or that.

MR. ABBOTT: That's where we want to get.

MR. FINN: Right. Okay, excellent, that's all. It looks like great progress on all those fronts.

CHAIR: Thank you.

Ms. Rogers.

MS. ROGERS: Just to pick up there where John left off, John. The Auditor General recommends that three of the RHAs, Eastern, Central and Labrador-Grenfell, should only license personal care homes when they comply with the personal care home operational standards.

MR. ABBOTT: Yes.

MS. ROGERS: That's a self-evident recommendation. So why do you think there were personal care homes licensed when they did not comply? What was the reasoning –?

MR. ABBOTT: We've had that discussion internally from time to time. When an operator, whether it's, in this case, a personal care home or whether it's an ambulance operator or what have you, when they are deviating from the accepted standard, then we look at the context in which that is happening.

If it's a case of yes, there's a fire extinguisher not working, that's one thing –

MS. ROGERS: Yes.

MR. ABBOTT: If it's there is no sprinkler system working, that's a different issue. But then you get into is there a plan in place to address that, that is satisfactory and poses no risk to the resident. Then, thirdly, we then have to have a contingency – in any event, can we move the residents? So, in some cases, there is – my term here, not the department's term – sort of a bit of a compromise to be worked out –

MS. ROGERS: Yes.

MR. ABBOTT: – because, in some cases, there is no option to relocate the residents. So we have to work with the operator and, in those cases, then we're in doing regular monitoring and inspections and follow-up so that the risk is minimized, not obviously eliminated, until the deficiency is addressed.

It's not ideal from our perspective, but it's the reality in which I guess our system has to operate.

MS. ROGERS: I can't remember now going through the documents. Are there still existing personal care home that do have some non-compliance?

MR. ABBOTT: Yes.

MS. ROGERS: And do we know what they are? Is it possible to get that information?

MR. ABBOTT: We have those that would – and as I said, there's one that is sort of very current that we're currently working here in the Eastern region, but that is available, yes.

MS. ROGERS: So we can get copies of that?

MR. ABBOTT: Yes.

MS. ROGERS: Okay, great. Thank you very much.

The Auditor General again recommended that Eastern Health, Central and Western RHAs ensure that personal care home staff meets the minimum hiring requirements as required. I think you spoke a little bit to this.

MR. ABBOTT: Yes.

MS. ROGERS: This report now is two years old.

MR. ABBOTT: Yes.

MS. ROGERS: The department's response is that Eastern Health is doing this. What about the other RHAs and how do we know this?

MR. ABBOTT: We're obviously having conversations with each of those and they're fully apprised of this.

Two things here; one is in terms of which requirement they need to meet. As an example, if you're hiring a new employee, if they have been tested for tuberculous – and we do that –

but if the need for that individual is now on a Friday and they haven't got that test done because it's scheduled for next week, could or should we hire that person?

I think the answer is I think we will. We'll take that risk as long as there's a follow-up. Do they have first aid, those things? So it's looking at each of those criterion and say well, what is the risk in the event of; but the goal is, obviously, to not only meet those minimum requirements, but to increase those, particularly as the residents are older now, they're frailer and they're having more complex health conditions so we know we need to increase that issue.

The reality we're facing in some areas, not all, is staffing shortage, availability of.

MS. ROGERS: I was just going to ask you that, yeah.

MR. ABBOTT: Many times the operators are left scrambling to find anybody – dare I say – to fill in. That's where we have to be careful because we may be compromising, yet on the wrong thing. So we are working with those operators for them to have some contingencies as to their recruitment plans. But if it comes to a point they can't, then that's another conversation that needs to take place because at the end of the day it's the residents – their needs have to be fully addressed. If the operator cannot do that in a sustained way, then the licence would have to be removed. There are no two ways about that.

MS. ROGERS: I imagine as well, as you spoke earlier, that the personal care homes that you're looking at having people with higher level of needs, needing higher level of care, and I was going to ask you about that – I imagine that staffing is a challenge and I would imagine it's because of demographics, but it's also because of level of pay.

MR. ABBOTT: Yeah. That will be a factor and we're cognizant of that. If that, at the end of the day, is the issue then we obviously have those conversations and we continue to adjust, based on provincial need, wage levels and local wage, as needed, in these programs. So we constantly adjust around home support and any of those community-based programs.

Again, it has been less an issue of pay. It's just simple availability of individuals that are willing to do this work. It's difficult and hard work, there's no doubt about that.

MS. ROGERS: Yes.

What's being done to try and address that? Because it is a growing problem, isn't it?

MR. ABBOTT: Yes. Again, the operators are ultimately responsible for the recruitment, so we work with them. We're working obviously with the private and public colleges to make sure those are trained to move in this work and we do a lot of work in our HR, human resource planning, in the health system so we know where the needs are, where the capacity is in the training system to meet that.

We are making sure we have sufficient subsidies provided that allows the operator to hire appropriately and at the appropriate wage levels. So it is within health, and there is one in two other areas where the staffing is going to be a bit of a problem, and there's no immediate fix for some of these operators.

MS. ROGERS: Just finish this one –

CHAIR: Ms. Rogers, I'm just going to move to Mr. Bragg to see if he has any other questions.

MR. BRAGG: (Inaudible) about the personal care home that caught fire and burned, I think, right to the ground last year out in Central. Did we learn anything from that? Because I'm thinking like emergency plans and where to put all the residents; most of them have closed up their houses or the family has sold their house. What would be the contingency plan there?

MR. ABBOTT: There are contingency plans each operator would have. Then in the short term, obviously, is there an adjacent home or facility that they would be back into a hospital, nursing home or a related community facility? Obviously, talking to the family for those that can return home for a short period of time. In this case, it worked out well. The community came together, the adjacent communities, and we were able to literally that evening and into the next morning have everybody located. Obviously, this is the long-term thing, it's the

only home on the Baie Verte Peninsula, so we were able to place everybody for a longer term.

The challenge then for those is that it's not necessarily immediately that they're going to go back within a month or even a year. We're not sure yet. I believe the operator may be rebuilding, but I don't know.

The lesson learned is we just build on that. Each of our health authorities have fairly good emergency planning systems in place that we rely on. We monitor those and if there was a resource shortage, dollars, whatever, we'll make that available. But, in this case, they were able to accomplish and accommodate all of that within the region in literally less than 24 hours.

MR. BRAGG: Okay, thank you.

One other quick question: Capacity for these buildings, are they at full capacity for a guess – I do not know if you would have –

MR. ABBOTT: No. It varies across the region.

MS. TUBRETT: 16 per cent vacancy.

MR. ABBOTT: Yes (inaudible). So around 16, according to Denise's numbers here, vacancies within that. It varies by region; Central, actually, the vacancy is a bit higher.

MR. BRAGG: Okay, perfect, thank you.

No more questions for me, Sir.

CHAIR: Mr. Petten, anything further?

MR. PETTEN: No.

CHAIR: You're good?

Ms. Parsons.

MS. P. PARSONS: I think we covered everything that I had concerns for, yes.

CHAIR: Ms. Rogers.

MS. ROGERS: Back to the staffing issue, I was in conversation with someone from labour who was saying that the majority of people providing home care or this type of personal care are women in their 50s and some middle-to-late 50s and that soon they won't be working and doing this kind of work. So it really is –

MR. ABBOTT: Yes, it is how to make this more attractive opportunity for young people, but that's true for this and home support where –

MS. ROGERS: Yes.

MR. ABBOTT: – some of the home care agencies would find, certainly in the more rural areas of the province, in trying to meet the need because our seniors are staying in place; people are moving out.

MS. ROGERS: Yeah.

MR. ABBOTT: So that's going to be an issue that we will have for some time to come. As I said, we are working with the operators and the trainers to make sure, to the degree possible, to have people in place.

So like physicians in rural areas, we do have times when there's a shortage. We work diligently trying to find a solution with the community. So far, we've been able to do that, but when we project out – again, it is trying to make sure we can support people basically in the rural communities. It's not easy.

MS. ROGERS: This is not one that can be solved by automation.

MR. ABBOTT: No, that's right.

MS. ROGERS: Okay.

The Auditor General did identify 16 critical fire and life safety deficiencies identified in seven of the 30 personal care homes reviewed, yet the Auditor General could not verify if these critical issues were dealt with quickly. Several of the same issues were identified in previous year's inspection as well.

So what's been done since this report to ensure that this is still not the case, that serious issues are dealt with properly and to be able to verify that, properly, quickly?

MR. ABBOTT: Ms. Rogers, because it's with the Government Service Centres in Service NL,

I don't know if I can answer that to the degree that you would like. We have checked with them prior to coming here today.

MS. ROGERS: Yes.

MR. ABBOTT: We've been informed that those recommendations have been fully implemented by them.

MS. ROGERS: Okay, thank you.

The interesting letter to the editor in *The Telegram* was in August 2016 from a person who had personal experience with personal health care homes and was critical of many of the same problems identified by the Auditor General. One of the issues was that the inspection process for re-licensing a personal care home did not include questioning the residents or their families regarding their satisfaction with the quality of care.

MR. ABBOTT: I think one of the things we will be doing on a go-forward basis, as throughout all our health care services, is doing more client-resident-family satisfaction surveys.

MS. ROGERS: Great. Okay.

MR. ABBOTT: Because that's one of the common standards around quality, and that's recognized.

MS. ROGERS: Yes.

MR. ABBOTT: So that will be in our plan going forward.

MS. ROGERS: We'll see that as a regular course of action.

MR. ABBOTT: Yeah.

MS. ROGERS: Great. Thank you.

Also, has any consideration been given – so if you are in fact doing inspections, if inspections are being done, to include resident and family input in the actual inspection?

MR. ABBOTT: I do not know if the previous question and this are connected here –

MS. ROGERS: Yes.

MR. ABBOTT: In terms of an appropriate survey, we would ask them their observations or issues around are they satisfied with a, b, c, the physical condition –

MS. ROGERS: Right.

MR. ABBOTT: – however we phrase that, but I don't know – two things: for the areas that we're responsible for, family counts as to whether it was long-term care, if that is the case, and their input is certainly requested and encouraged. But in terms of actually participating in – depending if I understand your question correctly – the process of inspections or monitoring, I wouldn't necessarily see that at least from where we were.

I, again, don't want to speak for Service NL, but I wouldn't necessarily anticipate that they would be doing that either.

MS. ROGERS: I guess if there are any formulized inspections of any aspect to actively then – not that they would do that –

MR. ABBOTT: Yes.

MS. ROGERS: – but to actively reach out to residents or families as part of that process.

MR. ABBOTT: I think the important part here is what we find, they find, say, collectively that there is a public report that the residents and their families are fully apprised of the results of those reports so that then if there are obviously issues, or as you are selecting where you want to go or your family member, then you have that information.

MS. ROGERS: Okay, but you are also going to survey?

MR. ABBOTT: Yes.

MS. ROGERS: Okay, great.

Complaints process, is there a formalized complaints process? How does that work?

MR. ABBOTT: Again, if there is a complaint process, it will be within the RHA and then they would record and monitor that. We, at the

department, on occasion would get a complaint directly from a family member or a resident, but usually a family member on their behalf. We would address that with the RHA. The requirement is then that they would follow up with the family and/or the operator, or both, depending on the nature of the complaint, and then report back to the minister.

MS. ROGERS: Okay.

Do you see what kind of role the Seniors' Advocate might have in this area, not just in complaints but in the whole issue of personal care homes?

MR. ABBOTT: I guess our assumption is that given that we are the department that deals largely with the seniors' issues in terms of care and through the full gamut of care issues that we will have a lot of engagement with the advocate. Again, the advocate's role will be more systematic issues but these all bubble up at times and you have a systemic issue there that we will be working closely, as we do with the Citizens' Representative from time to time. He's making his reports based on what is happening in the health care and we work and respond to that.

What we find, actually that's a very useful process because it takes the subjectivity out of it and it's fact based and it's an independent observer and recorder of the facts. We encourage many residents and families when they're not satisfied and they're not satisfied with our answer, we encourage them to go to the Citizens' Representative office because then we think they will get a fair hearing. Then it helps us with improving our processes where they need to, rather than us trying to defend some things that probably are indefensible.

MS. ROGERS: Okay, I'm fine.

Thank you very much.

MR. ABBOTT: Yes.

CHAIR: Thank you.

Everybody good? Mr. AG, you're good?

MR. PADDON: I'm good.

CHAIR: Okay, good.

Thank you, Mr. Abbott, and your officials.

Now we'll move to our last heading under Health and Community Services and Eastern Health which is the Road Ambulance Services. I want to welcome Mr. Wayne Young who is the regional provincial specialist in this area. You've been sworn in, so it's all official.

I'll turn it over to Mr. Bragg to ask any questions, please.

MR. BRAGG: Okay, thank you.

I have three questions. I guess I'll start off with the training. It seems like the further you are – and I looked at the map and this is only eastern, so I'm assuming from Clarenville east that this report was done, but it is probably reflective for the rest of the province. It seemed like the further you are away from the Avalon region, St. John's region, the more lenient you are to the actual training of the ambulance attendants.

Is there a reason for that? Is it a job with staffing or …?

MR. ABBOTT: If I may, before I answer your specific question, just to give you an update on the recommendations. The Auditor General provided 12 recommendations; eight that were specific to our department and four specific to Eastern Health. Of those 12, 11 are partially implemented and one we have not started implementing. I think the simple answer to the question is one of capacity in each of the health authorities and then within the operator community to take this on.

We're, as a department, and certainly in the direction we have from the minister, is that we need to really focus on this aspect of the road ambulance service. We need to engage the training system because there's a capacity issue there. We can only train so many. I think – Wayne, if I'm correct – if we met exactly what the AG is sort of suggesting or implying, which we agree with, it would probably take us seven years or something to get where we need to go. We know that's not sustainable in terms of what we need to achieve here.

So we are looking at some self-regulation for paramedicine so that they can up their game. We need to provide more training capacity within the province, and then at a certain point – hopefully sooner than later – with the operators, in terms of our service level agreements with them, that they will have to meet that higher level of training before we will fund them.

That's, again, easier to say because that means a lot of change is going to happen and the operators are going to have to step up their game as well.

MR. BRAGG: In the community groups, would that be volunteers? I think I saw (inaudible) –

MR. ABBOTT: Well, volunteers on that – so if you're in the ambulance, if you're paid or a volunteer, you're going to have to meet a certain standard. We, relative to other provinces, have a lower level standard of care. We are providing the emergency service, as needed, but the ability then for the attendant to actually provide care is minimized because they are not paramedics. We need paramedics on all of these ambulances if we want to provide the standard of care that people expect and we believe needs to be delivered.

So it's a lot of change that has to happen in very short order.

MR. BRAGG: Okay, thank you.

The other question I have is relating to response times, and I guess I'll tie this in with – I'm not really familiar with the 911 system, if the Avalon always had it or it was just the greater St. John's area. The new 911 system province-wide, does that speed up the ambulance response time, or does it somewhat slow it down?

MR. ABBOTT: Again, there's a change in what each region or your community is used to. So if you're calling an ambulance, you can call 911, and in St. John's that's accepted. You could call the hospital directly or you can call the operator directly. Depending on who you call, when you call – so if you're calling 911 and then they have to triage that and send it over to the operators, there's obviously a gap in time, and depending on how sophisticated your system is. So we are learning, outside of the greater St. John's area, how to do that better, but it's still not perfect. Our response times then, once the call is in, if it's to 911, the 911 to the operator, the operator then, whoever is on dispatch receives the call, within 10 minutes that ambulance is supposed to be leaving for the scene.

That's sort of what we measure and we have all the statistics on that for each service across the province, and we monitor that closely.

MR. BRAGG: I was just curious, if you get complaints where people are used to calling the local number and now they call 911, they call back there and people are saying now, where I used to wait 10 minutes, I wait 40 minutes.

MR. ABBOTT: Yes.

MR. BRAGG: You're not hearing that are you?

MR. ABBOTT: No. We've heard examples of that.

MR. BRAGG: Yes.

MR. ABBOTT: When we do hear that, we do go back to find out who called whom when and try to measure that. If there's a problem in that community or region, then we're honing in on that to make sure that the residents know exactly who they should be calling.

MR. BRAGG: If you look at your ambulance system overall, would you rate the best situation where anybody should go forward with like an ambulance from the hospital, ambulance from a volunteer group, or from a private company?

MR. ABBOTT: I don't know in terms of which one it is – are they meeting with standards that you're setting? Do they have an efficient, high-quality dispatch? Do they have good vehicles and do they have trained paramedics on that vehicle? They are sort of the three elements. If you got that right, then you have a good service.

Both in terms of the AG report but also the other work that the department has done in terms of Fitch report, which has been referenced; they did a comprehensive review of our ambulance service here in the province. They've laid out a series of recommendations that if we follow those according to their recommendations, we

will have a high-quality ambulance service throughout the province.

We are starting the implementation of that report in tandem when looking at these recommendations because they do go hand in glove. The first focus for us now is on central dispatch. We have to have all ambulances coming out of basically one system so we know exactly where all ambulances are, what they're doing and how they're doing it. And right now, we're able to monitor where they are, but we're still running multiple services and we have exclusive areas and things like that. All of that has to change if we want to improve the service.

MR. BRAGG: One final question, Mr. Chair, and that has to do with the condition of the ambulances, overall condition.

MR. ABBOTT: Yeah.

MR. BRAGG: Except for Service NL, are there any other checks and balances to make sure the ambulances are up to code?

MR. ABBOTT: Well, there are different inspection systems. One of the things that we do not have here in this province, we do not have one piece of legislation that covers all aspects of the ambulance service from the time your licensed to have it, to monitor the vehicles, to monitor who's on the vehicles. So we are working on drafting legislation, hopefully this fall, if not, next year, to put in-house so we can bring all of those pieces together.

MR. BRAGG: Thank you.

That's it for me, Mr. Chair.

CHAIR: Okay.

Mr. Petten.

MR. PETTEN: Thank you very much.

On this issue, one broad question I'd ask: Is the funding adequate for the road ambulance program? You hear anecdotally and we've heard over protests and complaints.

MR. ABBOTT: Yeah.

MR. PETTEN: It seems to originate back to some policy but a lot of funding issues.

MR. ABBOTT: Mr. Petten, I don't see it that way and certainly at the department. Again, we are meeting the needs of each of the ambulance services and operators across the province and we negotiate on that. We've added significant new dollars under the current agreement.

For the hospital-based services, we work with them on their budget needs, but we are also challenging how they can be more efficient to do things more effectively. So as an example, in Western Health last year, and now we're moving into Central Health and hopefully into Eastern Health in the near future, is when we are doing non-medical transports. So why do you use the same service and attendants for that service, when you are responding to an emergency? They're two completely different services. They have now moved to change that. That frees up resources and saves dollars that they can put back into the ambulance program.

Depending on how you measure this, but at the department we believe we have an overcapacity of ambulances in this province. We can reduce the number of ambulances and use that money to put it into training, increasing the skill level and, obviously, payment within the system and also support having a central dispatch system throughout the province. But that means certain decisions would have to be made as to which ambulances and which communities would have to change.

Again, the bigger costs are certainly in the urban centres and their response times are closely examined. We expect – when we talked this morning about value for money – to make sure we get that in those services.

From time to time, we do get complaints there isn't sufficient capacity on a particular hour in a particular day, particularly in the St. John's area, but they have systems in place to address that. They can call on the regional fire department and others and other ambulances to support them, if need be.

It's really measuring the risk at any point in time. As the population changes and the

communities change, we have to respond with the appropriate ambulance service.

MR. PETTEN: Okay.

I had another question that was medical transport so you went two for one on that.

MR. ABBOTT: Yeah.

MR. PETTEN: That was a question I've always wondered about because you're taking resources from areas and you see it all the time, they're just transporting from one community into the hospital and they have their staff onboard. They're taking away the vital service, what's needed most. There has to be a way around it.

MR. ABBOTT: Yeah.

MR. PETTEN: So I appreciate that.

That's all I have for now, Mr. Chair.

CHAIR: Thank you, Mr. Petten.

Ms. Parsons.

MS. P. PARSONS: Thank you.

The question I have – it's a concern that's been brought forward to me by a constituent who is a paramedic in the District of Harbour Grace – Port de Grave and working for a private or community-based ambulance. The concern brought forward is that there's a difference in the overtime pay and the training. What is the level of standard versus the public-private? Are they paid relatively the same wages? Do they receive the same OT?

MR. ABBOTT: Wayne, I don't know if you want to respond to that.

MR. YOUNG: There is a difference in how various services compensate their employees. Essentially, it comes down to the contractor and the company that they work for. We say you have to have ambulances available, but how they compensate their employees – they are a contract company that we move forward with.

The challenge that many of them face is there's a significant difference. I mean everyone in the province deserves ambulance response, but we have operators that will do many calls in the run of a day and we have many operators who do very few calls in the run of a week. To be able to match staffing and employee compensation is a challenge that the operators have, but that is essentially – you know, they are contractors.

MS. P. PARSONS: Okay.

With regard to response times – and a recommendation from the last report in 2016 with electronic data-gathering technology which is yet to be determined – where are we on that? Have these devices been placed in the public vehicles where they can be monitored with regard to response times?

MR. ABBOTT: (Inaudible.)

MS. P. PARSONS: So that's done?

MR. ABBOTT: And we have started now tracking that information. We intend to use that then when want to develop more in terms of response times. But really from a quality point of view, are they responding on time; who's on the vehicle, because we are paying for each element. And then we'll use that information now when we sit down and re-negotiate the contracts with the operators beginning this fall.

MS. P. PARSONS: This would apply to obviously community based, privately owned as well?

MR. ABBOTT: Yes.

MS. P. PARSONS: Okay.

Just one last question for me – yeah, I guess a question. There was an incident, as we can recall back several years ago, where a patient was being transported and had managed to escape on the Trans-Canada Highway and unfortunately was hit by an oncoming vehicle.

It was a fatality. What have we done as a result of that incident to prevent these further incidents? This, to my understanding, was a patient with mental health issues. What has been done since then?

MR. ABBOTT: No, I'm not familiar with the case.

Wayne, do you …?

MR. YOUNG: There has been a fair bit of conversation with the paramedicine experts and the mental health staff on the transport of patients who are under consideration for that. We try, where we can, not to move them at night as we do, and we try and take all precautions that we can. But it's also very much within the act and within everything else what are the considerations for the patients themselves in the evaluation that's done – it's been a challenge.

MS. P. PARSONS: As a result of incidents like this one, I guess ambulance paramedics and whatnot, and even operators; do they have sort of like a kind of speciality training when dealing with patients with mental health? As we know, a lot of these calls are to do with mental health issues and crisis.

MR. ABBOTT: So again, that would be part of the training, but to your point is as this becomes more prevalent, we have to ensure that. We'll be building that in as we're doing now with dealing with naloxone and things like that.

As these issues emerge, we're sitting down with Eastern Health with the provincial oversight for the ambulance service to develop protocols and then work with the operators and their staff to put those in place. But it does require the co-operation of each of the operators. Outside of the hospital basis, they're all privately or community owned and we have to engage each of those and get them onside.

MS. P. PARSONS: Thank you.

CHAIR: You're good?

Okay, Ms. Rogers.

MS. ROGERS: Thank you.

The Fitch report now is four years old. That report called for a complete overhaul of our province's ambulance system. Looking at, too, when we look at the three issues – a single agency to administer and oversee the program, a central dispatch system, a self-regulation of ambulance professionals – is it fair to say that a number of the Auditor General's deficiencies that he found are because the review's recommendations haven't been followed through?

MR. ABBOTT: I wouldn't put it the way you've raised it there.

MS. ROGERS: Sure.

MR. ABBOTT: But I think they are reinforcing those findings and that we now have in front of the minister a series of recommendations to, in fact, start implementing the Fitch report which, again, is consistent with the Auditor General's findings and his recommendations and how you now basically modernize our ambulance services going forward.

MS. ROGERS: Again, in those recommendations, they're four years old and still are so very relevant because we haven't followed through on those.

MR. ABBOTT: Yeah. Now, I wouldn't –

MS. ROGERS: Why haven't we?

MR. ABBOTT: I want to be careful. Different aspects are being implemented.

MS. ROGERS: Fair enough, yes.

MR. ABBOTT: But the larger system-wide ones – and I would say because of timing of elections and government change and those things, it's probably slowed down the progress. I know the department was on this road and had to sort of just wait until the government was able to address it with the other priorities it's dealing with. But as I say now, the minister has a series of recommendations that he will be dealing with going forward and we've spent a fair bit of time with briefing him and working with him on these issues.

We think – and we've talked to the operators. Again, there's a lot of change here, so as much as we would like to say let's have it done by X date, there's going to be a fair bit of negotiation with them and it requires an infusion of dollars. Given the government's overall fiscal situation,

we've had to do some trade-off of dollars to find the money to put into this service.

MS. ROGERS: Is there any kind of guesstimate time frame around a central dispatch system?

MR. ABBOTT: Well, as the government has already committed in *The Way Forward* this is a priority. We have to have proposals out literally in the next couple of months, and ideally this year, to have that in place. So that's sort of the time frame we're working on.

MS. ROGERS: So the proposals, like the request for proposals, would be going out in a few months.

MR. ABBOTT: Yes.

MS. ROGERS: Okay.

There was an RFP that went out September 2015 and called for design and implementation plan, and the closing date for that October 2015. But we're going to see this happening again.

MR. ABBOTT: I'm sorry; I was just asking Denise here.

MS. ROGERS: Yeah.

MR. ABBOTT: That proposal that you referred to was again before I joined the department.

MS. ROGERS: Yes.

MR. ABBOTT: That was to hire a consultant to help us design.

MS. ROGERS: That's right.

MR. ABBOTT: Which they have done. They have submitted a report. Now we are taking the ideas presented there and that will allow us now, assuming government agrees, to go out with a request for proposals to put a central dispatch system in the province.

MS. ROGERS: Okay, so not just for design again, but to actually implement the design that was …

MR. ABBOTT: Yeah.

MS. ROGERS: I can't remember, has that design been made public, the report from that proposal? And will it be?

MR. ABBOTT: Yeah, I don't think there's any reason why we'd – now, it may be caught up in our Cabinet process, but we will check on that.

MS. ROGERS: Okay.

If it's available, can we have a copy of that?

MR. ABBOTT: Yes.

MS. ROGERS: Okay, great. Thank you.

That's encouraging. That brings us one step further.

MR. ABBOTT: Yeah.

MS. ROGERS: Closer.

Then in response to the Auditor General's recommendations on patient care reports the department noted the process would be much more efficient with implementation of electronic patient care reporting. Can we get a sense of where that might be?

MR. ABBOTT: Wayne, do you have any …?

MR. YOUNG: The electronic patient care reporting – which is essentially laptops in the ambulances – ties hand in glove to the central medical dispatch centre. Fitch, when they did their planning project, envisioned that electronic patient care reporting be a part of the central medical dispatch centre.

MS. ROGERS: Okay, so there's no point in having them if we don't have a central – right. Okay.

A question once again about the RFP for the central medical dispatch centre; the RFP might go out this fall. When is the anticipated – then, how long for the RFP and then the actual implementation?

MR. ABBOTT: Well, I would say from that you're probably talking 12 to 18 months. Again, depending which options we come with and who responds, there are those that are – and there's

some dispatching going on "centralizing" because we have summer operators because they run multiple services and large services in the province. Then there are those outside who have provincial systems that they could literally parachute in here.

We'll measure all of that once we get the responses and we'll be looking at, obviously, which will be the most cost effective to allow us to proceed.

MS. ROGERS: Okay.

Thank you very much.

CHAIR: Thank you.

Mr. King.

MR. KING: (Inaudible) questions here. Rural areas are always a challenge. I look at some cases which were brought to my attention where the one – because it's all through private contract. I know Fewers are the big name out our way.

You have a dispatcher getting called from home, and then he has to go get his buddy, which you drive past a house but you need to stop, too, to get his compatriot there and then you have to come back.

Has there been much through to providing a central location, say like Bonavista or somewhere they can stay, be dispatched from that location and you get there in a little quicker time?

MR. ABBOTT: Well, I think when we get to the central dispatch and the concept we have, then you start bringing all those issues out on the table.

MR. KING: Okay.

MR. ABBOTT: And you say, if you want the most efficient system and the most timely response, then you have to do things exactly as you're suggesting.

MR. KING: That's some feedback I've actually gotten from some paramedics. Having a central location makes more sense for them because they don't have to make that stop for their buddy, go back and then go from there.

One other thing that came to my attention very early on after I got elected is what's being taught – I believe the paramedic college is in Grand Falls or Lewisporte – I think that's a private college, but I'm not sure – what was being taught and what was being tested at the time because I think at the time we underwent new standardization. We went by something that Ontario went through or tested on. And what the attendants found was what they were being taught at their college wasn't the same thing they're taught on their exam. So has that been taken care of or something that you're aware of?

MR. ABBOTT: I'm going to ask Wayne if …

MR. YOUNG: It's Keyin College you're talking about in Grand Falls.

MR. KING: Yeah, I think so.

MR. YOUNG: They've had, to the best of my knowledge, very good pass rates.

MR. KING: Yeah.

MR. YOUNG: I know because I deal with them. They have made some modifications to their training program to help the students be, what they consider to be, better equipped to do the national exam, but it's not technical medical skills. It was how the questions were being asked and being phrased.

MR. KING: Yeah, I believe –

MR. YOUNG: I think the first time around, they had some experience that the students were taken a little off guard, but Keyin Tech has very good pass rates.

MR. KING: Yeah, and that was the attendant – he passed his exams, but there a little concern at the time because there a bit of transition time. Usually when you don't hear anything afterwards, everything seems to work out. So thank you for clarifying that question for me. It's something I've had in the back of my mind for some time.

That's all the questions I have. I want to thank the department for providing us such detailed answers and listening to our concerns. You seemed to do a very good job over the last two years getting things from where they were to where they are today.

CHAIR: Thank you.

Ms. Rogers, any further questions?

MS. ROGERS: I'm fine.

Again, thank you so very much for today. John, you've been stellar in providing all that information for us. Thank you to all your staff.

You certainly do have a challenge ahead of you. I feel we're probably all very much in good hands. Good luck and thank you.

CHAIR: Mr. Finn.

MR. FINN: I'm fine with the questions that have been asked by my other colleagues.

Thank you.

CHAIR: Gentlemen, as I think everybody has completed – and, again, I want to echo on behalf of all the Committee all the key things that have been outlined.

As the Chair, I always get to have the last word and normally ask questions that may or not have been answered or not answered to our satisfaction. I had 18 questions noted and all have been answered to my satisfaction and even in more detail than I would have thought.

I do have one question that I'll ask Wayne: Can you give me a little bit of a breakdown, or us a breakdown, on the classifications from primary, secondary ambulance services, just so we have an understanding of how that's determined.

MR. YOUNG: You're talking about a primary and a secondary ambulance?

CHAIR: Yeah, exactly in the particular community or region.

MR. YOUNG: John, do you …?

CHAIR: Or, John, would you …?

MR. ABBOTT: Go ahead.

MR. YOUNG: Okay.

What we've done is we have 83 ambulance bases in the province. Every multiple ambulance base has at least two ambulances that we contract 24-7 response. There are a number of single ambulance bases and that ambulance base, obviously, is contracted 24-7. Other additional ambulances at that base – so say there was an operator who had four ambulances, two would be considered primary and they are to staff them 24-7 with 10-minute response.

The other ambulances are what we class as secondary ambulances. While they are still available for emergency response, their primary task is inter-facility transport and go from there.

CHAIR: Yeah. That's just the clarification I wanted. That was my understanding but I wanted pure clarification as to where that is.

Other than any other questions, again, on behalf of the Committee I want to thank you guys. It was a great opportunity for us to get some clarification. We were impressed by the response that came back from the department, but there's always clarification. Sometimes you guys might use lingo from a bureaucratic point of view that, us, as mere politicians, may not understand. It's good to get clarification because we need to keep our constituents informed.

I want to thank the Auditor General and his staff also for being here. We look forward to seeing the Auditor General again tomorrow; we have two more sets of hearings tomorrow. You guys right now until we do a review in two or three years, you're off the hook. Anyway, thank you, guys. I thank the Committee. I want to thank Elizabeth ,too.

So we're good, guys, tomorrow 9 o'clock here, CSSD. And while I have the Committee here, we need to pass – you're good; you don't get to vote on these minutes – the minutes from our meeting of May 18, which we reviewed which hearings we were going to hold.

Moved by Mr. Bragg; seconded by Mr. Petten.

All those in favour signify by saying ‘aye.’

SOME HON. MEMBERS: Aye.

CHAIR: Opposed, ‘nay.’

Motion carried.

On motion, minutes adopted as circulated.

CHAIR: Thank you.

The Committee adjourned.