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Department of Health and Community Services

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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
Julia Mullaley, CPA, CA, Auditor General
Sandra Russell, Deputy Auditor General

Department of Health and Community Services
John Abbott, Deputy Minister
Heather Hanrahan, Assistant Deputy Minister, Regional Services
Michael Harvey, Assistant Deputy Minister, Planning and Performance Monitoring
Cameron Campbell, Director, Primary Health Care

Also Present
John Finn, MHA

The Committee met at 9:30 a.m. in the House of Assembly Chamber.

CHAIR (Brazil): Okay, ladies and gentlemen – Ms. Rogers, if we could get started. We have Hansard doing the recordings for us.

I want to welcome everybody to the Public Accounts Committee hearing with Health and Community Services on a number of topics, but the primary discussion at the beginning of the hearing will around the road ambulance recommendations put forth in the AG's report.

I'd like to welcome everybody to this session which is taking place July 18, 2018 in the House of Assembly. I would like to ask the Members of the Committee if they would introduce themselves and then we'll ask the Auditor General's staff and the staff from the Department of Health and Community Services also to introduce themselves, then we need to swear in a couple of individuals who haven't been sworn in, in previous hearings.

I'll start with Mr. Reid, an introduction of who you are and your district, please.

MR. REID: Scott Reid, MHA for St. George's – Humber.

MR. KING: Neil King, and I work for the good people of the historic District of Bonavista.

SOME HON. MEMBERS: Hear, hear!

MR. KING: I am stealing your line, Gerry.

MS. ROGERS: You stole my line. That's good. It means I am having an influence; I like that.

MS. P. PARSONS: Pam Parsons, the District of Harbour Grace – Port de Grave.

MS. ROGERS: Gerry Rogers, and I work for the good people of St. John's Centre, and anybody else who call me.

MR. FINN: John Finn, Stephenville – Port au Port.

MR. PETTEN: Barry Petten, MHA for CBS.

CHAIR: I'm David Brazil, Chair of Public Accounts and Member for the District of Conception Bay East – Bell Island.

I'll ask the Auditor General.

MS. MULLALEY: Julia Mullaley, Auditor General.

MS. RUSSELL: Sandra Russell, Deputy Auditor General.

CHAIR: Oh, and I go to the ADM – or the DM, sorry.

MR. ABBOTT: It's John Abbott, Deputy Minister of the Department of Health and Community Services.

MS. HANRAHAN: Heather Hanrahan, ADM, Regional Services.

MR. HARVEY: Michael Harvey, ADM, Policy Planning and Performance Monitoring.

MR. CAMPBELL: Cameron Campbell, Director of Primary Health Care.

CHAIR: Welcome to everybody. We have three individuals that need to be sworn in: Ms. Mullaley, Mr. Harvey and Mr. Campbell.

I'm going to ask our Deputy Clerk if she'd do the swearing in, please.

Swearing of Witnesses

Ms. Mullaley
Mr. Harvey
Mr. Campbell

CHAIR: Thank you, Elizabeth.

Now I'll explain the formal process that we'll use here. I'll ask the deputy minister to first do a synopsis or an overview of particularly the road ambulance recommendations or the findings and the response from the department as to the action plans that are in play. Then I'll start with Mr. Reid, giving each Member 10 minutes to ask questions relevant to that particular topic. They don't have to use the whole 10 minutes as we go through it.

If a Member feels the questions have been answered that they had, they can skip. Then afterwards, if the road ambulance process has been completed and the Committee are happy with the findings or at least the information that's been requested, we can move to any other issues around the AG's report for the Department of Health and Community Services.

So I'll ask Mr. Abbott to start for us, please.

MR. ABBOTT: Thank you, Mr. Brazil.

Since the release of the Auditor General's report on the Road Ambulance Services in November 2016, work has been ongoing to implement the recommendations. The department, along with the regional health authorities, recognize the importance of optimizing the ambulance program. We have made significant strides in improving the monitoring of ambulance operations, ambulance professional skill development, internal communications and policy and procedure development.

To address recent concerns over ambulance staffing and response times, Western Health, on behalf of the four health authorities, engaged Grant Thornton to carry out a staffing and payroll review of the 48 private and community ambulance operators. The report was made public. The review's findings raised concerns over insufficient staffing of ambulances and the operators' use of funds provided by government.

As a result, the department is continuing to contract with Grant Thornton to carry out forensic audits of several operations. The firm has also been contracted to establish a monthly staffing and payroll reporting system to ensure operators are meeting their contractual commitments.

Eastern Health has constructed and moved into a new ambulance dispatch centre. The Eastern Health authority is in the process of customizing, testing and training dispatchers on computer dispatch software. Once the centre is fully operational in October of this fall, Eastern Health will have the most up-to-date technology to dispatch and monitor its ambulance operations.

The department continues to develop options for the establishment of a central medical dispatch centre for the province that would allow for a province-wide ambulance dispatch system and oversight. The department and the four regional health authorities are reviewing a proposal to acquire electronic patient care records, referred to as an ePCR system, as part of a larger acquisition of new defibrillator monitors for road ambulances. The ePCR system will not only improve quality assurance for patient care, but will also track ambulance staffing.

The department has hired an advanced care paramedic within the department to aid us in better defining appropriate attendant skill levels and to begin planning for the introduction of advanced care paramedics in rural regions of the province. The department and the four RHA paramedicine departments have formalized a communications process to ensure the department's performance objective and information needs are communicated to the RHAs –

CHAIR: Excuse me –

MR. ABBOTT: Yes.

MS. ROGERS: (Inaudible.)

MR. ABBOTT: Oh, I'm sorry. Yes.

MS. ROGERS: Great. It's such good information; I don't want to miss it.

MR. ABBOTT: Okay. I can provide this later for sure.

The department and the RHA paramedicine departments have formalized a communications process to ensure the department's performance objective and information needs are communicated to the RHAs and through the Provincial Medical Oversight office. The department and the four RHAs have revised the ambulance program policies and procedures and standards manual, and the revisions will be implemented as part of the new service agreement with the operators.

Finally, on the 12 recommendations from the Auditor General, one has been fully implemented to date, 10 are partially

implemented and one has not been implemented to date. That's our summary right now, Sir.

CHAIR: Okay.

Thank you, Mr. Abbott. I appreciate that.

I'll go right to Mr. Reid and we can start with your questioning.

MR. REID: Okay.

Thank you for your update and the information there. I have some questions as I go along. Some are sort of general to get some more information so that I better understand how the system works and things like that. It's more of a general sort of knowledge that I want to get about how it works and, as we go on, we may get into more specific sort of things.

But in terms of the training for ambulance operators, that was one of the things that came up in the AG's report, can you tell me a little bit about the training requirements, where the training is done, who offers the training, those sort of things, how extensive it is and how we compare with other provinces in terms of training?

MR. ABBOTT: Okay. I'm just going to lead on that, Mr. Reid, and then maybe I'll ask Cameron Campbell to also add to that.

One of the things, as a general sort of overview comment, is we realize that we need to enhance training right across the board. So we have the ambulance attendants, as it were, and we have the paramedics and the advanced paramedics. Our intent is to expand training for paramedics so that there are more ambulances right across the province. So we're engaging both public and private training facilities to, in fact, do that and to up our skills.

One of the things we have done is bringing an advanced paramedic into the department to help us define those training needs with more certainty. We're also engaging with the paramedics and the attendants in terms of how we should move towards regulation of that occupation. Again, that will help us increase and improve standards, and part of that would be to expand training.

Right now, the operators are really responsible whether they are private, community or hospital-based. Operators are responsible for making sure the training is provided and/or the attendants are, in fact, trained. We've seen that as a bit of a challenge for them and we recognize that, but at the same time the public's expectation is those who are on our ambulances are meeting the basic skill sets that are needed.

With that, I'm going to ask Cameron if there's anything specific he wants to add.

MR. CAMPBELL: Sure.

John had touched on the fact that we've brought some advanced care paramedics to the department that are working with us, and with a group across the regional health authority where we've first targeted that, to look at how we would go about spreading the advanced care paramedic model across the province. It's currently concentrated in a couple of areas, primarily, in and around the St. John's area. Of course, advanced care paramedics are able to work at a higher scope of practice. We're looking at how we spread that in the rural areas where it could be quite a valuable care tool for people.

I think as well, kind of speaking specific to your question around where does training happen and how does that compare to other areas of the country, locally we train what we call EMRs, or emergency medical responders, and primary care paramedics. Primary care paramedics are trained at the college level. That happens both in our public and private college systems. The EMRs, or emergency medical responders, is a shorter training stint. Those are the individuals who are referred to as our ambulance attendants. They are not paramedics and do have a much smaller scope and are often utilized in areas where it can be hard to retain primary care paramedics.

Recently, the department has been working with the community paramedicine operators association. They've paired up with a company called Training Works to look at how we upscale existing EMRs that are working primarily in our rural communities so that they have the opportunity to become primary care paramedics, while still working and ideally

doing that remotely. That's one of the major initiatives that's been moving forward, and we're certainly paying a lot of attention to, because of the ability there to potentially upscale a number of our current attendants.

We've also been working as of late with our Provincial Medical Oversight office, which is housed within Eastern Health, to update the process of registration for paramedics. In particular, linking back to the AG's report, we're looking at how we ensure that we have adequate continuing education and ensuring that we update the number of hours required to maintain licensure in the province. I think that's an important step to make sure that we are increasing the level of oversight and ensuring that appropriate education is available and required for those currently working in the profession.

I'd also note that in terms of how we compare across the country, our paramedics have to complete what we call a COPR exam which is an exam that's organized at a national level. It allows for labour mobility across provinces, but it also ensures that we have paramedics that are on par with those in other regions of the country.

MR. REID: In terms of the recent study that came out, the Grant Thornton study, that focuses mostly on sort of financial accounting matters and how the money is spent. So in the future you plan to do more of an assessment of what training people have to get a better – is that the plan moving forward?

MR. ABBOTT: So going forward, the Grant Thornton report lays out a number of recommendations and, on top of that, we will be negotiating with the operators in terms of, again, how we how we skill up and make sure that those who are on the ambulances are meeting the standards and then we make sure that we have the supports in place to do that.

So that's all to happen relatively shortly because the agreements expire in September and we have to engage them very shortly around that.

MR. REID: Yeah, so that's an opportunity there in terms of the contracts and when they expire.

MR. ABBOTT: Yes.

MR. REID: In terms of requiring additional training and having a plan as to how to achieve it.

MR. ABBOTT: Yes, and we're doing that, both using that as that opportunity to really bring more attention to it, but also, as Cameron Campbell said, to continue to plan and put the supports in place. We've been talking to the regulator as well in terms of how to move forward to bring our EMRs and our paramedics into a regulatory regime so that we can enforce the standards as well.

MR. REID: Yeah.

You mentioned the professional association. In some cases, I think the professional associations for some other medical professions play a large in developing the training and developing the certification.

Is that the case with the association for people –?

MR. ABBOTT: Yes, they're fully engaged. Again, they're evolving as an association. There's new leadership, so again we're back at the table with them to help them to help their members.

Part of the challenge is not all those that are in the practice, shall we say, are seeing the benefit of more training, regulation and those kinds of things. It's a learning process, as well, for everybody.

MR. REID: Yeah.

The report, I think, showed that a lot of the – in terms of the way people were paid, they weren't paid the required amount, I think 32 per cent or something like that in Grant Thornton.

MR. ABBOTT: Yes.

MR. REID: Is that related to training? These people weren't able to find someone who didn't have the training to justify a certain pay level? Or why is that?

MR. ABBOTT: Not in and of itself. I think part of this is there was a negotiated agreement; monies were put in to really help the operators attract and retain the attendants and paramedics.

The question then or the issue, obviously, that Grant Thornton has found is that some of that money has not gone where it should have.

MR. REID: Yeah.

MR. ABBOTT: We realized we have to do more work on that. Part of it is an administrative function within each of those operations.

There have been some complaints made by different individuals and that's helped us focus where we should get Grant Thornton and others to focus their efforts. But in and of itself, we would disconnect the two.

MR. REID: Yeah.

Okay, I think my 10 minutes are close to being up there.

CHAIR: Okay. Thank you, Mr. Reid.

I'll move to Mr. Petten now, if you want to ask some questions to the witnesses, please.

MR. PETTEN: I might be repetitive because I'm having a lot of trouble hearing most of the questions. I don't have an earpiece either.

MS. ROGERS: (Inaudible.)

MR. PETTEN: I don't even think I have one there, actually.

In 2015 the province had 769 registered ambulance attendants. What is that number today?

MR. CAMPBELL: Right now it would be just shy of 800. I'd have to confirm the exact number because it does change on a day-to-day basis.

MR. PETTEN: Right, so that's pretty close to being that same ballpark.

At the time when the AG report – Eastern Health operated an ambulance service in St. John's and Carbonear and provided oversight for another 15 private operators and six community care operators. The AG report examined the skill levels, response times and oversight of the RHA and other ambulance services.

Would you say the department has made sufficient progress in each of these areas?

MR. ABBOTT: Mr. Petten, I would say we are making significant progress but we know there are still gaps that we are needing to address, and that's been the focus literally since the AG's report has been out. As late as, literally, this week we are continuing to focus on improving the quality of the services, making sure we have more paramedics on our ambulances, that they are meeting the training standards required by the program and working closely with the oversight office to make sure that they are supported and have the skills there to move that whole service forward.

We think, certainly, central dispatch is going to be a critical part of that so we know where the ambulances are, who are on those ambulances both in terms of staff and obviously in terms of patients, and that we provide really sort of a national-class service for the residents.

That's where we are and we'll be continuing to discuss those issues with the various associations, as well as in the department with the health authorities, obviously, making sure we can get the funding to meet the needs that we're finding as we go forward.

MR. PETTEN: Recently, I know it was in the news, the Southern Shore region, Bay Bulls to Bauline region, their issue was response times for ambulance service in their region and apparently a new ambulance operator was approved. So has that worked out yet? Again, about response times, is that issue still ongoing or is there any resolution?

MR. ABBOTT: We've been having discussions, obviously, with the proponent and with Eastern Health. Our data would suggest that the response times are not the issue that's been made public. That's why we are reviewing all of that data to make sure, in fact, that the services are meeting the needs. It has not been, for us or through Eastern Health, the issue that has been out in the public at this point.

MR. PETTEN: So, just to be clear, the department questions those response times that have been made public, the numbers that the public spoke of.

MR. ABBOTT: Yeah.

PETTEN: You don't agree with those numbers?

MR. ABBOTT: Well, we're reviewing them. They brought that data forward. Again, it wasn't coinciding with the data we had, so we were obviously going to review that. We obviously owe that to the communities involved to do that.

MR. PETTEN: Okay.

Also in the report the Canadian industry, the best practice for training – and I don't know if this question was already asked by my colleague, Scott, there. Has the department skill level standard been raised to match the Canadian industry best practice?

MR. ABBOTT: That's where we want to go. We're working with the operators and with those staffing them to, in fact, move there. As Cameron Campbell said, in terms of the paramedics, they are tested and licensed based on national certification and testing. We would want to bring all our attendants, their skill level, up as well.

MR. PETTEN: Okay.

And the same then, will the same thing will be expected of the private operators as well? It's not –

MR. ABBOTT: Oh yes, absolutely.

We don't make a distinction between community, private and those operated by the RHAs directly, so we want to make sure the whole system is meeting national service levels.

MR. PETTEN: But that's where the gap appeared to happen because from our base hospital it seemed to be running – their record is much improved, St. John's and Carbonear, as opposed to our private and community operations there. That's where the big gap seemed to – it seemed to be almost a three-tier system when you look at …

MR. ABBOTT: Yeah and some have described it that way. We're trying to make sure it's as level as we can. The hospital-based services, it's easier to attract skill, the paramedics. They are directly funded, obviously, by government. They have the latest technology and we need to bring everybody up to that level.

MR. PETTEN: Also, in the AG report they found that Eastern Health's own operators in St. John's are not meeting the response time benchmarks. Has this issue been dealt with or is it being dealt with or is it approved?

MR. ABBOTT: Again, that's going to be just an ongoing issue that we have to address with Eastern Health or any of the operators, is to meet the response times. Part of that, again without getting too technical, is sort of the immediate response time which we call the chute time. The time the call comes in to the time the ambulance is on the road should be 10 minutes max and then the question is 10 minutes or longer to get, obviously, to the point where the pickup, shall we say, takes place and we monitor those response times. We have the technology now to know where each ambulance is and their response times. We monitor those very closely.

So if you recall last year, there was a significant issue up in Labrador, in the Happy Valley-Goose Bay area, and the operator was having trouble, repeatedly, meeting both the chute time and then the response times. So through that review, we determined that operator was not going to be able to provide the service we felt was needed. So we then had the health authority take over that service so that, in fact, we could meet those response times.

That's how we monitor each of the services across the province. If there's an issue or complaint made, we'll investigate. We'll work with the operators, whether it's the hospital – because, again, the same thing applies. We've reviewed all of their operations as well. We don't have double or triple standards here. We try to have one for the province. But, as you can appreciate, a rural area, it's going to take a little bit longer to actually get to the scene than in an urban centre. But urban centres are matched against other urban centres across the country so that the level of service is comparable.

MR. PETTEN: Okay.

The AG also found that the department wasn't providing effective oversight. Has there been

any changes made within the department now to improve upon that or –?

MR. ABBOTT: Well, we have, in terms of – the simple answer is yes. We've provided more support, resources to that. We have our director here, Mr. Cameron Campbell, to oversee that work. We have brought in, as I said, an advanced care paramedic to work with us on training. We have ongoing and regular meetings now with each of the RHAs and ongoing meetings and discussions with each of the operators and certainly their associations.

So we are monitoring much closer the activity out in each of the regions and the lines of communications have certainly been improved so that we can get – and technology has allowed us to know where the ambulances are. So we are able to, in real time, know where the ambulances are and that certainly helped us in terms of any discussions we've had with both the public when complaints come forward, certainly with the RHAs and then the operators themselves as to meeting the standards expected of them.

MR. PETTEN: Okay.

CHAIR: Thank you, Mr. Petten.

I'm going to go to Mr. King next.

MR. KING: Mr. Abbott, you talked about, when you did your introduction, you had a number of the recommendations implemented partially and not. Can you go through which are done, which are partially, which are not and the reasons why?

MR. ABBOTT: Okay.

The first recommendation was: "The Department of Health and Community Services should evaluate its basis for road ambulance attendant skill level policy, which is below Canadian industry best practice, and determine whether it is sufficient to ensure quality care."

We feel right now that's partially implemented. Since we reported last year – and I'll give the update as of March 2018 and then this month, so it will give you some sequence of activity – we continue to work with the training institutions and industry in an effort to address the primary care paramedic supply issues.

The department and representatives from the RHAs and industry are developing a strategy to place advanced care paramedics in rural regions of the province. As late as this month, as I've said, we've seconded an advanced care paramedic from Eastern Health to work with the department to better define appropriate attendant skill levels, and aid us in planning for the potential placement of advanced care paramedics to rural areas of the province. That work will continue. We don't have a specific end point at this point.

In terms of the second recommendation, that the Eastern regional health authority should ensure that the road ambulance services provided by private and community-based operators for the region meets the skill levels required by the department – and it continues on – based on where we were in March from when we last reported, the department and the four RHAs have developed a strategy to address best efforts, issues and are waiting for the new service agreements to discuss a change in the best efforts clause with the ambulance industry.

We are currently planning for – again, we replaced some of the ambulance operator service agreements that expire in September and we intend to address this issue in these new agreements. That's in terms of the operators making sure that they have those that are skilled to meet when there is a shortage.

The third recommendation: The department should ensure that its policies and procedures and the Ambulance Operations Standards Manual are up to date, are being enforced, et cetera. Again, they updated in March. The proposed changes to the policy and procedures manual have both operational and financial impact on ambulance operations, which have to be discussed with them. We'll be discussing that through the renegotiation of the service agreements. We are also waiting to move forward on those with them. We've been developing the changes, internally, but we now have to sit down and negotiate some of those with the operators.

The issue before us – and we approached Cabinet on this – is that we feel that we really need to have new emergency service legislation for the province and that these operating standards, in fact, then become either statutory or regulatory and that they're really not a negotiated item, as we do in other areas. So Cabinet has approved us moving forward with drafting legislation. We will be doing consultations this summer and into the fall to develop that legislation.

The next recommendation was that we should evaluate its basis for dispatcher training and determine whether it's sufficient to ensure quality care. That one has not been implemented and we are waiting on the results of Eastern Health's central dispatch and how we can learn from that and move that service right across the province.

We felt it would be, sort of – I wouldn't say wasted effort, but we felt that once we knew what we were doing in terms of central dispatch because we want them focused on the training for those dispatchers than for looking at this dispersed across the province.

The next recommendation is the department should set ambulance response time targets, giving consideration to Canadian industry best practice for response times. Again, partially implemented, and I sort of referred to that in some of my previous answers.

We have now automated vehicle locator system in each of the ambulances so we, in fact, know where each one is at any point in time, when it's either parked or on the road. This has allowed us to gain better information and it's used by the paramedicine staff and ambulance operators to track and audit ambulance operations so we know then what response times are and then we can monitor those.

As a result of that, we've been able to figure out if there needs to be any change in both location and response times.

MR. KING: Sorry, just a quick question on that one: Is that on private ambulances as well?

MR. ABBOTT: Yes.

MR. KING: And to be cognizant of the time –

MR. ABBOTT: Yes.

MR. KING: – just go through the Health and Community Services. I know there are a lot of recommendations.

MR. ABBOTT: Yes, the next one in terms of the department ensuring it is providing effective oversight of the road ambulance program; as mentioned, we believe that is fully implemented based on some of the responses I've given earlier.

The next one: The department should ensure that contracts with the private and community operators are negotiated and renewed in a timely manner. Again, we are at the point now and we will be sitting down with the operators very shortly to look at the future of those agreements, and we're looking at the options for how to renegotiate those. We think there's sufficient funding in the system to allow us to move and make the changes we need to see happen.

The next one is the department should monitor the road ambulance program to ensure intended results are achieved. Again, that's ongoing work so we say it's partially implemented. And the Grant Thornton report was a major piece of work we did this year to really get a better handle on what is happening out there in terms of the system, who is delivery what and who is getting paid for what.

The next –

MR. KING: Oh, that's why those – I was just looking through the Health and Community Services, what you folks have been doing –

MR. ABBOTT: Okay.

MR. KING: – I know each health authority would be based on what you guys would dictate to them.

MR. ABBOTT: Yeah.

MR. KING: Just getting back to the third recommendation here about Health and Community Services ensure that policies and

procedures and the Ambulance Operations Standards Manual –

MR. ABBOTT: Yeah.

MR. KING: You talked about emergency service legislation in consultations. What type of consultations will you guys be looking at?

MR. ABBOTT: Again, we'll be going out to the communities across the province. We'll be meeting with, obviously, the operators and their associations. We'll be meeting with municipal leaders and the public if they're so inclined, so interested. We will then be pulling all of that together and going forward in the fall to Cabinet.

MR. KING: Thank you, Mr. Abbott.

CHAIR: Ms. Rogers.

MS. ROGERS: Thank you very much.

This may seem like an odd question, but if we were to sit down and have a beer, John –

MR. ABBOTT: Who pays?

MS. ROGERS: I'll pay.

MR. ABBOTT: Okay.

MS. ROGERS: I'll pick up the tab for that.

If you were to just tell me in a nutshell – these are the real challenges for our ambulance services in the province – to sort of give us a global picture of what's working, what's not working and what are the challenges. What we're doing is we're looking at some of the very specific issues, but if we get sort of a global picture of what you're really up against.

MR. ABBOTT: I think from the department – and as we look at these issues on a regular basis and as we sit down and address the challenges – for us we think we, collectively, can still better manage the ambulance service in the province. We look at what's happening across the country and we see no reason why we can't have similar standards and quality.

It's getting acceptance by all players, the operators, the staff and government, to agree that, one, we want to improve the quality of the service. In doing that, we need to provide better management; we believe a central dispatch so that we, whether it's on a regional or provincial basis, can improve response times. Then, within that, we need to make sure we have, on the ambulances, the appropriate professionals to provide the standard of care.

If that is done properly, obviously, the quality of care and survival rates, particularly in severe incidents, is improved. It allows those paramedics to work to their full scope of practice, and they become active as opposed to passive in terms of supplying care.

We know all those elements and we now just need to bring those together. We believe there's sufficient funding in the system to allow us to do that. Again, on the whole, we get complaints but we don't get a lot. I think both community and private operators are doing a very good job in responding. We have, as I said, those chute times. They have to meet those 90 per cent of the time and they generally are.

When we do see a problem, I think the department, with the RHAs, are then in a position to move because we understand the business and we know what is acceptable and what isn't. I think the government wants to make sure wherever there's a gap that we're going to fill that in. On a go-forward basis, we'll sit down with the operators to work through, then, the detail as to how that gets done.

MS. ROGERS: What you've talked about is really where we'd like to see the service elevated to, but what are some of the challenges of getting there? When I look at it, the dispersion of our people, the geographic situation where population is widely dispersed, seniors, money – one of the things we hear about is from people out in rural areas, in either community or private operations, is the disparity of work-life balance and payment for staff, people who are staffing the ambulances. What are some of the challenges to get to where you really want to go?

MR. ABBOTT: Looking at the dispersed population – so, again, the call on the system is not significant. In some cases, an ambulance may not move for a day or two, so retaining and

attracting skilled paramedics for that service is going to be challenge, both – well, in the first instance will somebody want to work on that service and, then, will they stay, and will they be able to work to their full scope of practice and remain proficient in that. That's going to be – as we speak and going forward – our biggest challenge. We want to skill up. Then, in doing that, it's going to be – that's our biggest challenge.

The money, we say, is there and will be there to meet that. We can do better. We can be more efficient around some of the services so that we can make sure their response times are a bit better and the dollars are better spent. Technology is there and we need to apply that and use that regularly.

If I was to flip it around, I think the expectation of, say, our urban centres, whether it's the greater Northeast Avalon, which is a metropolis, and the standard of service and expectation there is high and we have to meet that. So we have to be comparable to whether it's Halifax or Moncton or what have you in both the quality of care and response times and things like that. They're probably under as much pressure, if not more, than some of our rural operations.

The other aspect is around the operators, generally, and certainly the community operators. Many of those are still relying on volunteers.

MS. ROGERS: Yes.

MR. ABBOTT: We know that in rural Newfoundland that's going to be a challenge based on just availability of volunteers. So we're going to have to look and monitor that very closely. The default then is either a private operator and/or a RHA-run service will be the result.

So we'll be looking at that closely, but that's going to be the biggest challenge, I think, for the community operators. We know they're very active and embedded in their communities, in their regions and we support that, but we have to make sure they can also provide the service that people expect.

MS. ROGERS: What about an aging demographic, how does that affect the operation of ambulance services?

MR. ABBOTT: Today, or in the short-medium term, we're not seeing that from the supply side, but it's the demand on the system and that's why we want to see paramedics and advanced care paramedics in the service because then they can support seniors in their homes, in the communities, in their personal care homes so that we don't have to bring those citizens into the acute care system when they can be serviced at home.

We are working now on the West Coast in having an advanced care paramedic program embedded in the community so that, in fact, the so-called ambulance service is actually going to provide care in the community.

MS. ROGERS: That's great.

Cameron was talking about upscaling and training. So how do you see that being done particularly in rural areas? My understanding – I don't know if these numbers are correct or not – Eastern Health employees get about $26 or $27 an hour. They're on call 12 hours a day. Private operators get about $21 an hour. They're on call 24 hours a day, a number of days in a row.

How do we address the disparity that we see, for the workers themselves, in rural and urban? If we want to upscale – I love this idea of again using that full scope of practice – how do you operationalize that when we see such a disparity in payments and hours? How do you make that attractive? How do you make that possible without it just being on the backs of the individual workers?

MR. ABBOTT: Well, part of what we do is we scan right across the province and certainly across the country to make sure we are going to be competitive in what we pay.

MS. ROGERS: Uh-huh.

MR. ABBOTT: That's a given and we work then through the negotiations with the operators to make sure that what we negotiate – and this is the whole basis of the Grant Thornton report, is we negotiated agreements, we put money in to

address the exact issues that you're referring to, but we found that some of those monies weren't going to where they should go.

MS. ROGERS: Okay.

MR. ABBOTT: So that's really the basis of the Grant Thornton report. That's why I think we feel confident and we say look, we think there's money in the system to allow and to bring both the salaries up and, in doing that, we also want to make sure we bring the skill levels up. If we have to pay more, we're prepared to pay more to meet – and that there aren't the gaps that you refer to.

We believe as a department, and I think within talking to the paramedics and others themselves, that professionalizing that service, professionalizing the work they do as a regulated occupation is something that we support. That way the standards can be enforced and it doesn't become optional. Operator A can say yes; the operator B says maybe. No, everybody has to operate at the one level.

So that's the course we're on. As well, we just had a meeting this past week with the licensing authority to talk about that and how we get to the next step. That's going to require some development with the paramedics and the EMRs to make sure we can get them to that stage, whether it'll be within a year or two but that's where we'll make the biggest difference, we think, going forward.

MS. ROGERS: Great.

My time is out. I have more questions, but I guess I'll have to wait.

CHAIR: Okay, when you come back.

Ms. Parsons.

MS. P. PARSONS: Good morning.

My question is in regard to the response time benchmarks. As outlined in the Auditor General's report, the Eastern Regional Health Authority has established a 10-minute ambulance response time benchmark for its own ambulance operations in the metro St. John's area. However, it has not established a response time benchmark for its Carbonear operations.

This is of particular regard and interest with the people I represent in the District of Harbour Grace – Port de Grave.

MR. ABBOTT: Yes.

MS. P. PARSONS: Also, the Department of Health and Community Services and the Eastern Regional Health Authority have not set any ambulance response time targets for ambulance services outside of the metro St. John's region.

I guess, why is that and what is the latest and the status with regard to, I would say, fixing this or improving this?

MR. ABBOTT: Okay, just one second.

I'm going to ask Cameron Campbell to respond to that.

MS. P. PARSONS: Okay.

MR. CAMPBELL: We have looked nationally at what benchmark targets do exist and whether or not there's an ability to apply those. So I think there are kind of two key parts to the question here: One is that in order for us to even monitor our benchmarks, we knew that we needed to have technology in place that would allow that to occur. So up until the point of this review, we would not have had any of the automatic GPS-based systems that would actually allow us to monitor any benchmarks that are set, with the exception of Eastern Health actually being an initial earlier doctor of that technology, which has allowed them – particularly in the urban setting – to try to establish those targets.

We can say at this point what we have done is put in place a system across the province – and we spoke about this earlier – around automatic vehicle locator. That allows us to start to trend and track what our timing is currently. I think, to be fair, before we get to a point where we're willing to set a benchmark, we need to make sure that's not arbitrary and that it does fall within the realm of what is realistic within the current configuration of the system.

Over the last year or so, we've begun to collect that data. In addition, Eastern Health has led the way in now establishing its own central dispatch. The department has been working quite closely with them. As part of that, we are putting in place what is called a computerated dispatch system.

That will serve all of the Eastern Health current assets, including those outside of St. John's and the Carbonear ambulances. That computerated dispatch system is designed to automatically provide the best possible routes, but also select the ambulances that make the most sense, and to keep our ambulances in a state of – what we call – dynamitic positioning where when an ambulance is responding to one call maybe on the eastern side of a zone, those on the western side of that zone would begin to shift over to make sure that we still retain ultimate coverage across the region.

I think back to the question around the benchmarks in particular, it has certainly been more challenging for us to determine how we would go about setting response benchmarks in rural and remote areas of the province. And in some ways, we are not comparable to many areas of the country because of our very dispersed population. If we look at other areas, the road networks are not nearly as long and the distance between homes are not nearly as long. We will have to account for that and I would think that may change our actual response times going forward.

What we can control at this point is that piece around our chute times, which is making sure that when a call comes in that ambulance is leaving as soon as possible. The deputy, John, had referenced that we currently aim for a 10-minute chute time within 90 per cent of the time.

MS. P. PARSONS: Okay.

It has been made known to me of an incident, in particular, a year ago, February past. It was obviously the winter and road conditions perhaps played a factor in this. A call was made. The patient died, unfortunately, not because of – I don't think the response time in this case, but it was made known that the response time, by the time the ambulance got there, was significantly long. That was a major concern by family.

It happened in the community of Spaniard's Bay and Ridge Road in particular. I would think this would be covered by Moore's Ambulance Service there. Just to make that known to you.

Also, I want to move now with regard to the contract. Moore's contract is said to be operating on the 2008-2012 contract. Is this a fact? Why is this happening? When can employees in this particular area expect that the contract will be signed in the 2014-17 contract? What can you tell us about that?

MR. ABBOTT: The contract is with the lawyers now to finalize; we've gone back and forth. We've been hoping that this could be resolved any day and it's taken a bit longer between the lawyers for both government and the operator. We think we have pretty well all the terms sorted out but yet to be signed.

MS. P. PARSONS: Yet to be signed. Okay.

Also, employees have raised concern about the retro pay.

MR. ABBOTT: Yes.

MS. P. PARSONS: I guess that would be all part of that. I often get asked that question to look into this on behalf of them. When can – a ballpark – employees expect to receive that retro pay?

MR. ABBOTT: I think we're familiar with those cases and we're monitoring that. Once things are signed, then we can make sure those funds are paid out.

MS. P. PARSONS: Okay.

In closing now, as you're aware of course, there was a $5-million announcement recently down at Carbonear hospital. Probably about a month ago – well, in June there and that's to include a new ambulatory service to be operated out of Carbonear General Hospital.

So can you just shed some light on that and just give some details on exactly what that means?

MR. CAMPBELL: If I'm not mistaken, you're referring to the infrastructure that would be updated at the Carbonear site?

MS. P. PARSONS: Right.

MR. CAMPBELL: So I don't have a whole lot of detail on that, but I do understand that part of that infrastructure funding was to update the ambulance bays that would be located at the hospital to bring them into a more modern stage. It's part of a broader infrastructure redevelopment that has an impact on the emergency department there. So it's one of many sites where we've been continuing to do that over the last number of years.

So when we've been making those updates at sites, we're making sure that, if there is an ambulance base there, it is appropriately placed, it's close to the emergency department and that allows us to do a couple of different things, including to better utilize our paramedicine staff. So if they're not waiting to respond to a call, they could be inside of the hospital helping to provide care services as well.

MS. P. PARSONS: So we can expect, of course, for services to be enhanced and improved, obviously based on this. Right? Okay, thank you.

That's all for me for now.

CHAIR: Mr. Finn.

What we'll do after Mr. Finn, we'll take a short 10-minute break, if anybody needs to go to the washroom or make a phone call.

Mr. Finn.

MR. FINN: Excellent. Thank you.

Good morning, folks, my colleagues – I guess the benefit of going last – have done an excellent job in terms of being very thorough, as you have with your responses. So I just have one question and you just hit on it, Mr. Abbott, and this was around the piece on the West Coast with some training and trying to have the paramedics provide more services in the community.

I've had conversations with the minister previously and, I believe, yourself. So it's certainly something very exciting. So in addition to having made significant progress, I believe, on your recommendations, I'm just really curious about that one particular piece.

MR. ABBOTT: Well, we're anticipating an announcement on that shortly and, again, it grew out of the community coming forward to say we think we can do this. Working with the Western Health Authority and the department, the pieces have come together to allow the ambulance/paramedic service then to engage in providing further services in the community.

It's based on what has been happening across the country, in Nova Scotia, in particular, and we've been monitoring that. I'm not going to say we're using this as a pilot in the sense of what we want to do is learn from this and then how we expand that across the province.

It's certainly suited for this province in terms of the rural nature, the isolated nature and where we have an ambulance service, it can then add to the primary care service in that region. The paramedics, if we have them work to their full scope of practice, then they can be as qualified then to provide initial response and care.

To Ms. Rogers's point, for seniors in the community, they then can go in and help – get diagnosed and be first responders in providing service, and through technology, going back to the dispatch to the hospital to say with the state of this particular patient, what else can we do to maintain this patient in her home and/or community.

We also want to bring that in to our personal care homes. We are seeing that we have seniors who are leaving the personal care home to come by ambulance to an emergency room only to be told: Yeah, here, and now you can go back. We're saying we want to bring that service in to the personal care home sector as well. We're going to learn from what we do out on the West Coast and then apply that across the province. But the fact that the community wants to do that has been the critical part here. We haven't imposed it.

MR. FINN: Excellent, looking forward to it.

That's all for me. Thank you very much.

CHAIR: Okay, if we want to take a quick 10-minute break. Then, if we head back here at 10:45, it would be good. It's a bit different on your phones; I think it's three or four minutes, so say 10:50 by your phone. We're all on 10:38 now. We're good?

Recess

CHAIR: Okay, ladies and gentleman, we're going to reconvene again.

I'm going to go to Mr. Reid to continue the question process.

MR. REID: We'll start again.

I'm going to continue with some questions on the road ambulance. Again, I have a few general questions. Part of it is to get some background and to get a sense of where the department is going in the future and where you see the problems.

I'm just wondering about the urban-rural challenges in each of these areas. You mentioned the pilot project on the West Coast, how that could work and what information that might provide. I'm just wondering: Has the department looked at other possibilities in rural areas, especially co-operating with fire departments or things like that, in terms of road ambulance service. Are those models used in other provinces and other jurisdictions? Is the department exploring options in that regard?

MR. ABBOTT: What we are looking at is, from a principle review is, obviously, how we can improve the service, make it more effective and be more cost effective in doing that. An example of what we're looking at, and it started basically on the West Coast, is we're providing the same ambulance and attendants on the ambulance if it was – quote – an emergency or if it was inter-facility transfers, those kinds of things.

We are reviewing, with the health authorities, what is most appropriate there. Western Health had started that a little over a year ago and has found that they can provide more responsive service, a more cost-effective service by changing the nature of the ambulance in responding to those different types of calls. One is an emergency call, fair enough; the other is a call made between a facility, say, in Corner Brook, Western Memorial, and up in one of our facilities on the West Coast if we're moving patients between facilities.

We can schedule those and what have you. We've looked at that. We're then seeing how other health authorities can do that because it takes pressure off in the true emergency and the ambulance service, so that then we can be more responsive and have better wait times.

That's an example of where we're looking at. The other thing is around central dispatch. Eastern Health now is just putting their centre down in the Miller Centre because they had some space that they could use in that facility. That will be operational in October. I think we will learn from there the central dispatch for all of their assets and how we can get better information, better response times and better coordination.

We have the automated vehicle locator now on all – again, that's relatively new – our ambulances; get better data on how we manage those. The intent there is that data then can go into a central dispatch to know if you are actually returning from a call – and, particularly, we have a lot of calls that are ambulances coming from rural into urban. We have ambulances coming from the Bonavista Peninsula in to St. John's or from the Southern Avalon coming in to St. John's. They're going back. If there's a call, can they be redeployed?

It would make sense, have faster response times and, certainly, better utilization of their vehicles. It then becomes more cost effective. So we're looking at all of those possibilities as we move forward. The industry is, I think, supportive of that. We just need to make sure we have more conversations in how we do that and how they get compensated appropriately.

MR. REID: In terms of the rural-urban issues, are there more challenges in terms of rural areas of the province in terms of keeping trained people in those areas? One of the recommendations relate to monitoring the system and things like that. Do you have a sense of how things are going in rural?

MR. ABBOTT: Yeah, I mean it is a challenge, as I said earlier, about recruiting and retaining the emergency ambulance attendants and, in particular, when we want to move up to paramedics. Dare I say that's a challenge in all our health services; the further we're away from a regional centre, then the more difficult that is becoming for us.

It's the attraction part of that and then it's just the availability, in the first instance, of young people really wanting – are they there and do they want to come in to this service. It's incumbent upon us to make it as attractive as possible. We think having it as a regulated profession will give them more sense of professional identity and support as they go into this.

It's going to be an ongoing challenge for us, there's no doubt about that. We see that in other services. In other areas we're putting bursaries, we're putting return to service agreements, those kinds of things. We haven't done that in this particular area yet, but I can see that's going to be something we may have to turn our attention to as well.

On distance, obviously, in the response times and things like that, we're providing the physical vehicle and the equipment. That's the easy part. The training that's going to be required, we're committed to, but it's going to be the recruitment – it's just the HR issues that we face in health care, generally, are going to probably play out quite significantly in the ambulance side of things.

So that's why we want to come up with new models to make it more attractive. Again, as we're doing on the West Coast, on the Port au Port Peninsula, is that we can make that more wholesome, sort of, experience as a paramedic, and not only are you going to be on the ambulance, you are also going to go into people's homes to help them provide care. That, we think, will be part of the solution.

MR. REID: Yeah, and you mentioned legislation and how that relates to professionalization and the, sort of, statutory requirements. So there's no legislation now in terms of –

MR. ABBOTT: No.

MR. REID: – that establish those things?

MR. ABBOTT: No.

So we're really the only province, I think, that hasn't gone down that road. We've talked about it for some time. So this spring we did go to Cabinet to say: We think time is – we're overdue on this. That was accepted and we're out consulting.

I guess the benefit of being the last in here is that we can look at best practices right across the country, which we're doing, to support the legislation when it comes forward.

MR. REID: Yes.

Okay, I think that's all I have on the ambulance stuff. I may have something else later on.

CHAIR: Okay, perfect.

Mr. Petten.

MR. PETTEN: Thank you.

Back to the skill level. I know the AG found the department skill level policy was outdated. I know we've talked about various improvements being made and things being worked on. I guess my question is more of a broader question from the common sense point of view that we all live in this province, we know the dynamics we deal with.

I said it earlier when I spoke first – and I want to go back to it – the three-tier system. I'm not saying there's a three-tier system, maybe there is, but it's a job to deny that there appears to be a different level of service. My community operates under private ambulances, but I'm fully familiar with the community system as well.

If I go to the Health Sciences Centre, ambulance operations at the Health Sciences Centre are first class compared to what I've seen. That's not diminishing the other private and community care – or community. But it's obvious to anyone – the common sense point of view when you look at it – there is a stark difference in the professionalism and the equipment they have.

Everything about the operation is totally different

I'm going to ask a really broad question: How does the department deal – I know it's nice to say in theory and it sounds good publicly to say we offer the same service to a rural community to the urban centre. That would play well. Being in politics, I get that totally.

In reality, how does the department – how can you tackle that issue? Training the proper number of paramedics, skill levels, you name it, the geography, everything, to bring this to an acceptable service for all involved – because I don't think we'll ever meet across the board standard, as hard as we may try. I don't know if you have any commentary on that.

MR. ABBOTT: If you look at the options – and, obviously, we've had lots of conversations in the department to the questions you ask. In the way the service has evolved, it really started, in many cases, in the community; it wasn't a top-down kind of a service. The community responded. That's why we have the community operators and there are volunteers.

We will ensure they have the equipment they need, but then staffing and training. Unless it becomes – and until it becomes – mandatory, you're going to see variations. So we would like to move to making sure the skill sets that are mandatory – you won't be able to operate an ambulance unless you have the right people on the ambulance and that are fully skilled to the level.

We want to make sure there are paramedics, ideally, on each of the ambulances. That's going to take some time but that will raise the standard. That's where you will see the difference because the technology now – we have to know where the vehicles are, how quickly they respond and make sure we have electronic patient records, all of that tied in.

Until we get a mandate and get to that level – so legislation will help us, regulating the profession will help us. That will be the key drivers to get that equilibrium across the province.

If you look at the dedication and the commitment in the community side – and, certainly, even on the private side – we have a lot to work with in moving forward. As the population changes within the province we'll probably see more concentration and more pressure on our urban services, certainly on the Northeast Avalon, out in Grand Falls and Gander and Corner Brook and Happy Valley-Goose Bay, to make sure that those services are probably even at a – I'll call that an urban standard. Fundamentally, it's response times and the quality and skill of the people on the ambulance. Those we have a fair bit of control over.

MR. PETTEN: In keeping with that, rules can be in place for whatever and in government there are lots of rules. But enforcement is probably just as important as the rule.

How do you police this? How do you ensure those community ambulance operations and private are up to scratch? Do you have regular inspections? I know you make things mandatory, but unless you see something happening sometimes you'll never know it occurred.

MR. ABBOTT: Again, the health authorities are pivotal to that because they have a role to oversee each of those ambulance operators and the contracts and service they provide. We rely on them to do that, again, I think when we get to making sure we have the legislative standards.

Right now we negotiate these elements. I'll say, you violated – no, I didn't, and you get into that kind of conversation. But if we have legislation and regulations, which are definitive, then either you did or you didn't and there's no discussion around that. I think that will be very helpful to all of us, both us as overseers of the service and then for those who are actually delivering.

We work closely with the health authorities, and through the associations, for the operators to make sure we are moving the standard forward and that the quality of the service is moving forward. We do get complaints around response times. If we do get an issue, generally, in terms of a complaint, it's around the response times.

Right now, at least we have the systems in place to track the ambulance, where it was and where it wasn't, so it's not debatable anymore. That has improved our ability to respond to when

there are problems. Ms. Parsons mentioned an example. We're able to go back and track and have that discussion. If there's an issue with that operator, as we found out in Happy Valley-Goose Bay, then working with the health authority we are able to go in, intercede and either fix it or we have to replace you.

The minister has been very firm on that. With that resolution, we're able to then improve all the services going forward. Part of that is making sure our oversight is – we, in fact, do our part. That's what we're certainly committed to doing.

MR. PETTEN: Thank you.

One other point to that, too, is in rural Newfoundland sometimes you're increasing the rules and regulations, you're tightening, you restrict. We call it cracking down, enforcing, making sure things are keeping a proper standard. Sometimes the pool will shrink for qualified or interested people that are in that small geographic area that's willing or capable of carrying out the service as mandated by the department. I guess that will be something that will be a challenge.

MR. ABBOTT: Yeah, there are definitely those considerations. We definitely want to work with the operators that are there, but they have to have both the willingness and capacity to improve what they're doing. If they can't or they won't, then we obviously have to have a separate conversation of how we deal with that.

Again, using the Happy Valley-Goose Bay scenario, we had conversations but we felt we had to move. I think we will do that and you will see some changes going forward – nothing specific at this point – where larger operators may take over smaller operators, or the health authority may have to take over some operators or operations if they can't meet their requirements.

We've got that from a contingency point of view. Now, of course, the sector is becoming unionized. Fair enough. Then if there's withdrawal of services and those kinds of things, we have to have backup plans and contingencies there. We're always trying to keep an eye on what is happening on the ground. We have a very good information basis to help manage any of the scenarios that are likely to happen over the next five to 10 years.

MR. PETTEN: I have a final one before my time wraps up.

The AG referenced the patient care reports. A lot weren't completed. There was some post – after the patient was transported. They were altered after the fact. Has the department figured out what happened there? Are there any mitigating things put in place to prevent this from being a regular thing?

MR. ABBOTT: Well, what we find if we're using manual systems, then we're going to run into those problems. They're not acceptable but they're a fact of what is happening. We will be now moving to automated reporting. That then will take out that challenge or that gap in service. Then it becomes automatic, the reports are logged in electronically and they follow the patient into the hospital.

As we move in with our electronic medical record system and other electronic systems, then it will be all integrated. That will be one less challenge going forward. The bottom line here – and I think some of them I answered – technology is really helping us and will help us with a lot of these operational issues that we've had in the past.

MR. PETTEN: Thanks.

CHAIR: Thank you, Mr. Petten.

Mr. King.

MR. KING: Thank you for the detailed overview here this morning. Great questions by my colleagues; it's pretty much covered off everything that I've had marked down.

Thank you.

CHAIR: Thank you.

Ms. Rogers.

MS. ROGERS: Great. Thank you very much.

Central dispatch in Eastern Health, we're going to see that fully operational by October?

MR. ABBOTT: Yes.

MS. ROGERS: When will we see a central dispatch that will cover the province?

MR. ABBOTT: We're looking at a couple of options there. Right now, we are going to see how Eastern Health's plays out. We're going to monitor that very closely and then one of the options is whether or not we can bring that system or equivalent across the province. Then it would be either a public-operated system either out of Eastern Health or however we manage that.

Some jurisdictions have a private provider for a central dispatch, so we've had discussions there. That's an option. Or we can continue to rely on a mixed system here, both public and private. Some of the private operators obviously have their own dispatch and we can work more closely with them. I think the Eastern Health piece will help us determine, over the next number of months, which way we should go.

MS. ROGERS: Do you mean that if – oh, it is 11:11 – Central Health's experience, then you would have more than one central dispatch then? Eastern Health will have theirs and then are you –

MR. ABBOTT: Yes. So we're looking at Eastern Health having theirs. Do we expand that model and that system then across the province?

MS. ROGERS: Yes.

MR. ABBOTT: That's one option. The other is do we have – quote, unquote – three or four for each of the health authorities having their own. Do we go contract with a private operator to have it province wide, which is done in Nova Scotia and New Brunswick, or do we just built on with the private operators in the province right now that have their own – quote, unquote – dispatch? Do we try to enhance that and tie it into, say, each of the health authorities?

We're trying to figure out which of those options we think makes the most sense for us going forward.

MS. ROGERS: You would even explore a private operator province wide.

MR. ABBOTT: Yes.

MS. ROGERS: Then they would take over Eastern Health as well.

MR. ABBOTT: Yes.

MS. ROGERS: Are you in negotiations or discussions about that now?

MR. ABBOTT: No, we just did some fact-finding, based on we knew what was happening in those two provinces, but that's as far as we've gone on that.

MS. ROGERS: Okay.

Do you have a timeline for that, John, in terms of …?

MR. ABBOTT: We were hoping to have something by now. Because Eastern Health was working with their model, we've slowed down a provincial one until we see how theirs works, how they plan to deliver, and then can we leverage that for the rest of the province rather than have to reinvent a new system.

MS. ROGERS: So you don't really have –

MR. ABBOTT: No, and we think what they have – in terms of the infrastructure they put in place, it probably can meet with some additional staffing for the province as a whole.

MS. ROGERS: Have you looked at what are the benefits or challenges with a private versus public dispatch system?

MR. ABBOTT: One is just the experience, really, was what we saw in New Brunswick and Nova Scotia. Medavie provides the service there, so they have the experience. It's certainly state of the art.

That was one of the options. If we could contract through a public proposal process, somebody could come in and put that in place literally right away, as opposed to us building it piece by piece. That was really the attractiveness of looking at that particular option.

MS. ROGERS: Okay.

The automated vehicle tracking system, is that province wide?

MR. ABBOTT: Yes.

MS. ROGERS: Okay.
So you have new data, then, on response times?

MR. ABBOTT: Yes.

MS. ROGERS: Can we have that?

MR. ABBOTT: Yeah, we can look at any particular period and …

MS. ROGERS: Great.

MR. ABBOTT: Yes.

MS. ROGERS: Okay, because I think that's something that has really been identified, like the Fitch report and that. It would be great to see what you folks have solved with that.

MR. ABBOTT: If I may, then we can have a conversation with your office as to what period you would be interested in or …

MS. ROGERS: How long has it been effect?

MR. ABBOTT: Cameron?

MR. CAMPBELL: It came into effect about a year ago. Although some of the data would have been not so clean in the very beginning, in terms of needing to narrow down a specific request; one issue that we would still have. There is a fair bit of work involved in looking at specific response times.

We need to then pair that with 911 data. Then, of course, there are still some gaps in cases where a private or community operator is contacted directly. So it makes it difficult for us to know what the contact time was versus the movement of the vehicle.

MS. ROGERS: Right.

MR. CAMPBELL: We have all of the movement data. It's just when you're looking at a certain period how do you then pair that up with your 911 or your call data.

MS. ROGERS: Yeah.

I would think it wouldn't be just my office, I would think the Public Accounts Committee would really like to see what has happened again, because that's been identified as such an issue with the Fitch report and then what we hear anecdotally as well.

I would think that to be able to get some of that information – what have you found yourselves now? Have you got a bit of a picture? Since you've been able to do some of that tracking, has it told you anything?

MR. ABBOTT: The general finding is that we are being responsive within what we've targeted as reasonable response times. So we're looking at a 30-minute max kind of thing for most regions in terms of where the ambulances are located. There are variations in some regions just because of geography.

We haven't seen any significant issues outside the issues that arose in Happy Valley-Goose Bay. Then to have conversations with specific operators when we see and hear, or a complaint of a specific delayed response as it were, we'll look at that. Now we have the data. Again, it's done in real time and we can monitor that as we speak.

What we'll do is we'll develop a report for the Committee and table that here.

MS. ROGERS: Okay.

Thank you very much. That would be great.

With the Grant Thornton audit, some operators have reviewed the latest audit and are telling us there are many mistakes with numbers off, the issue of not being able to replace staff because of the requirement for different levels of training. They find there's a major problem with some of the calculations.

I'm just wondering, have you been getting that kind of feedback from operators where they feel it really hasn't accurately reflected the challenges they have been dealing with?

MR. ABBOTT: I mean we have heard some criticism. As a matter of fact, probably not as much as we probably thought we might because, again, the report finds significant issues around use of funds, payment and what have you. That's why we ask an independent auditor to do that because that's their business. Each of the operators are then free to have that conversation with the auditor and correct, if there are things to be corrected. At the end of the day, we have to stand behind whatever that auditor finds and then go from there.

Part of that is just going to be some conversations. We're being careful going to the next stage, based on the recommendations of the auditor where we need to do further audits. The numbers are significant where there's a variation of 25 per cent, which is, you could argue, a high threshold. Because of some of the reasons, we know it's not a perfect system there. We will then do further audits of those operators and see what needs to happen on those.

That's the basis of the audit. Not everybody would agree, but as we say, the facts are the facts as we know them. They had done a fair bit of time – we thought this audit would take a couple of months; it's taken longer than that for some of those reasons. Some of the operators did not keep good records. They weren't as compliant in the first instance, those kinds of things. So they really had to work hard to get in to get access to that data.

MS. ROGERS: I wonder if I could ask for leave.

CHAIR: Oh yeah, go ahead.

MS. ROGERS: I only have two more questions left on this, on ambulance.

CHAIR: That's fine.

Mr. Finn, yeah, and Ms. Parsons.

MS. ROGERS: Some operators are telling us – and I don't know how accurate this is – that the minister said he's not renewing their contracts, there's no meeting scheduled to start the negotiations and many operators and their staff are kind of unsure of their future. I'm just wondering what the department is doing to quell those fears?

MR. ABBOTT: We will be continuing to provide road ambulance service after September. The audit piece was – because it was slightly delayed (inaudible) results. We wanted to wait for that before we went to the next stage with them. We will be conversing with them very shortly as to what the next stage of the negotiations will be for those agreements.

MS. ROGERS: Okay. So you are going to meet with them and –?

MR. ABBOTT: Yeah. We don't see, obviously, in a short period that there's going to be any significant change here, but we need to work through that now with this report in hand.

MS. ROGERS: My last question. I know there have been some real challenges around folks who may have a mental health crisis who need transportation to a facility. How is that going? What has been done about some of those issues?

MR. ABBOTT: We are working with the health authorities to make sure how we respond to any emergency is done in a more appropriate and sensitive fashion. This area we haven't really explored a lot yet and it's something we know we need to do. That's something we have on our work to do further on that, working with the paramedics and the operators to make sure that those issues are fully recognized and addressed, as you put it.

MS. ROGERS: Yeah, and because I know the RCMP in some rural areas have said they're not going to do that transportation.

MR. ABBOTT: Yeah, we have not had that. Again, we're working with the RNC and the RCMP on that.

For them, it is training and making sure the right people are in those situations. It's not perfect, certainly, as we know it, but as we've seen with the mobile response with the RNC, they have stepped up significantly. They've set a higher bar for the province and we, the RCMP, the ambulance operators and everybody else will have to move in that direction.

MS. ROGERS: Okay.

Thank you very much.

CHAIR: Thank you, Ms. Rogers.

Ms. Parsons.

MS. P. PARSONS: No, that's everything for me.

Thank you.

CHAIR: Perfect.

Mr. Finn.

MR. FINN: Yeah, just one actually.

Mr. Abbott, you mentioned once or twice that you felt there were sufficient funds in the department for some of the implementation of a variety of the recommendations. With respect to the Grant Thornton report, were there any cost savings realized or any areas where you could –?

MR. ABBOTT: Well, I'm taking the report at face value, and based on that, if you – because they just looked at one quarter. If you pro-rated that across the system on an annualized basis, there's over $2 million to be addressed. That's a significant amount of money within that program. That gives us some comfort to say all right, we need to figure out how we redeploy those dollars. But we do need to sit down with the operators to figure out how we do that.

It's going to be a potentially heated type of conversation because that money that was intended for a very specific purpose hasn't happened. We need to know why and we need to know why on an individual operator basis how they're going to change that going forward.

MR. FINN: Okay, excellent.

Thank you.

CHAIR: I'll go through again to see if there are any further questions.

Mr. Reid.

MR. REID: On the road ambulance –

CHAIR: Road ambulance, yes.

MR. REID: (Inaudible) the Fitch ambulance review, there were recommendations related – medium- and long-term recommendations. I'm not familiar with that report. I think it was done a number of years ago.

MR. ABBOTT: Yes.

MR. REID: What were these recommendations and where are you in terms of those?

MR. ABBOTT: It was done under the previous administration. It was really looking at the road ambulance program in its entirety. There were a series of recommendations but it really focused on how to improve quality, skills training, central dispatch and those kinds of things, things that the Auditor General has also hit on in the report.

MR. REID: Yeah.

MR. ABBOTT: We have taken that report and are working with industry to make sure we can implement those as quickly as possible; central dispatch was certainly a significant one, the need for legislation and those kinds of things. We're looking in tandem with the Auditor General's recommendations to implement those.

It was a very well-done report and I don't think anybody had any fault with it. Part of it then was making sure we got consensus with the all the operators as we start to move forward with implementing those recommendations.

MR. REID: Yeah.

When was that report, just so I can locate –?

MR. ABBOTT: 2013.

CHAIR: 2013.

MR. REID: 2013, okay.

MR. ABBOTT: Yeah, because that's five years.

MR. REID: I should have a look at that because it still seems to be some of the same issues, maybe, that you're dealing with now.

MR. ABBOTT: Yes.

MR. REID: Okay, that's it for me.

CHAIR: Thank you.

Mr. Petten, anything further?

MR. PETTEN: No, I'm good. Thanks.

CHAIR: You're good?

Mr. King, you're good?

Ms. Rogers, you're good?

MS. ROGERS: (Inaudible.)

CHAIR: Ms. Parsons and Mr. Finn.

I'll just have a few concluding remarks on that one. I do thank and appreciate everybody. It's been a very thorough discussion.

It did, from my perspective and, obviously, the Committee will have more discussions later on about – appeasing is probably not the right word, but at least relieving some of the concerns we had. That's why we called for a second hearing on this one.

In comparison to some of the other responses that we had received from the department, there was less of an uptake on ensuring that compliance was adhered to in this case, and I do realize for a number of factors: you have a three-tiered or three-approach system here when it comes to road ambulances and how you provide the service; you have regional health authorities who may do things differently and you have a different hierarchy or bureaucracy that has to be followed; and different geographic challenges, no doubt. Knowing that the Grant Thornton was one part of a report that was in play may have played a part in waiting to see where that is and what impact it may have on certain things there.

The discussion here from my perspective – and I think from the response from the Committee – seems to alleviate some of the concerns we have. No doubt we'll have an opportunity, after we review discussions and we start to formulate our report for the fall, we may have some recommendations around how you move that forward.

One of the big concerns by all on the Committee was time frames because, obviously, your ambulance service is your primary first responder call that anybody relies on. Particularly, how do you provide those services in remote and rural areas? How do you provide an adequate service in heavy-demand areas like the Northeast Avalon and urban centres?

I do give credit, you've outlined at least a plan is in play to make that work and there are going to be contingents that may have to change along the way. Obviously, the biggest concern that we've had over a period of time is always asking if it's resourced properly. I know even from Grant Thornton, being able to look at the finances is one side of it, the training is the second side and the implementation process is the third component.

I'm happy to say from my perspective that there's a plan in each one of those. Some may take a bit longer than others; some might actually literally have to change the process of moving resources to make it happen. It may have to change being a little bit more creative on the model that gets implemented in a particular area. I do appreciate that and representing a district that's urban from Paradise, Portugal Cove-St. Philip's and then having the challenges on the ambulance service on Bell Island, I can appreciate the uniqueness. So do my colleagues here who come from rural and represent rural and remote and city-oriented districts that there are different challenges there.

I will say, and I apologize in advance, I say it tongue-in-cheek, but I have to ask you a question I asked eight years ago in Public Accounts to a deputy minister from a different department but in a similar circumstance. At the time it was with the Department of Education. We had different school boards and I asked would it be easier, more fluent and more consistent if there was one authority that oversaw the whole process from a department point of view.

Being a former bureaucrat here in the building, I know sometimes when you're trying to juggle how one works where, and you've got 10

components coming at you versus having to deal with regional health authorities – and I'm not putting you on the spot –

MR. ABBOTT: No.

CHAIR: – but I do recognize the challenges, and we did in Education at the time. I'm hopeful that the new plan in education has to be fluent and has been working with the one school district because we seem to have an even flow of access to particular services in various regions, even with some of the challenges.

So I'll just throw that out to you. You don't have to answer, but I would appreciate if you'd just say, or just your concept, it would be easier if there was one or a set policy that was umbrella for everybody.

MR. ABBOTT: Well, I think for us in the department and we've accepted – we have the four health authorities and for the reasons they were set up I think they're still valid. As I say, trying to respond to a health issue or whatever in Labrador from St. John's –

CHAIR: Becomes a challenge.

MR. ABBOTT: – is a big, big challenge.

So that health authority, as an example, are able to deal with their issues, I think, quite effectively. What we are doing as a department is that we want to ensure that we have provincial standards and legislation to back that up if need be, but certainly provincial standards and policies that then are to be consistently applied across the province no matter where you are, reflecting that there are going to be some contacts there. Obviously, road ambulance in Labrador is going to be slightly different than road ambulance on the Northeast Avalon.

That's really where we are, whether it's ambulance service, cardiac, speech language, we want to make sure we have provincial policies and that we're not just relying on four individual sets of policies, or even more, around the province. So the same with ambulance, we've really focused on making sure we have consistent policies across the province and then on a go-forward basis with the legislation and new agreements, I think we'll get closer to that ideal.

CHAIR: Good.

So do you feel you've got good co-operation between the four regional health authorities when it comes to road ambulance particularly?

MR. ABBOTT: Yes, absolutely.

CHAIR: Okay.

They bought into rectifying, improving and finding the models that work and supporting it?

MR. ABBOTT: Yes.

CHAIR: Perfect. Okay.

The norm at the end of part of a session before – and we want to continue in to some of the health ones. I'll get a little time frame here and we'll have a little chat about that in a second.

I would like to ask the Auditor General, after sitting here – and I know it's a report to your predecessor, but you're very in depth into this report after discussions that we've had in meetings. From what you've heard, do you feel that they're adequately approaching and addressing the recommendations to your review in a year or so, that you'll be confident that they're compliant to a point where they've improved exactly what the standard of ambulance services should be for the people of the province?

MS. MULLALEY: I guess I certainly can comment that I'm encouraged to hear the progress that's happened over the last few years. I'm certainly encouraged of some of the initiatives that are underway.

From our office's perspective, we monitor reports three years after the issuance. This particular report would have been issued in the 2016 time frame, so we will actually do some formal monitoring next year to the House of Assembly and the public on a further status update on that. I think that will also beneficial because I think many of the initiatives we heard here today will be further implemented in that regard. I think that will be an appropriate time

frame then to update the House of Assembly and the public on progress.

CHAIR: Okay. Perfect. Thank you.

Mr. Abbott, I just ask that if we have some follow-up questions down the road when the Committee gets together, that we can send an email to you and you can respond with information. I know, as Ms. Rogers had noted, some information, but if you could share any information that you shared with either one of the Committee Members, you share it general, to everybody. You can either send it to myself or Elizabeth and we'll ensure that it gets part of people's packages.

As you know in hearings, we're taking notes and that, but there may be something that we may think we have an alarm out. You may have already answered it and got the detail, or it may be something that we neglected to ask that may be pertinent to when we put together our recommendations. We do ask that if you share with one Member of the Committee, you share with all.

MR. ABBOTT: Sure.

CHAIR: Because then that's pertinent to our discussions when we complete our report for the fall.

I thank you on this part of it. As we noted, we wanted to take advantage while we had you guys here, rather than call other hearings in this. This was one that warranted it because of the fact that compliance wasn't at the level that we had thought it was.

We had agreed as a Committee that we'd probably spend an hour or so – and we'll probably have to take a break for lunch at 12 p.m., for a quick break, and then we'd come back. My plan would be that we'd have everybody out of here between 1:30 and 2 p.m.

I know everybody has busy schedules as part of that, but there are some general ones there, I know, going back over what was in the AG's report. Particularly, I have a couple later on, on the personal home care. A lot of information you had shared with us and we had the debate and the discussion last year. But as part of just follow-ups, rather than us have to go through a whole hearing process again, we may be able to knock that off today and not have to worry about this and have it in our report of the fall.

I'll start with Mr. Reid. We're going to continue. Around five to 12 we'll break for lunch for half an hour, and then we'll come back and try to conclude. So I do ask – there may be a couple there. We don't want to get generally into the same thing we did last year, but because there's been a lapse of a year, there may be a couple of things that have popped up; I know a couple on some of the policy changes in personal care home approaches there.

There may be something that we can knock-off, have done, and then when we do our report we'll have a more fluent, thorough report for the House of Assembly in September. I think we're all happy with that.

Dose that work for your time frames?

MR. ABBOTT: Yes.

CHAIR: Yes, we'll plan to get everybody out between 1:30 and 2 p.m. for sure. We'll give you a break for half an hour at lunchtime at 12 to go make a call, get something to eat, these types of things.

I'll start with Mr. Reid, if you have a few health-related questions.

MR. REID: Yeah.

Are we going to start with any particular area or just general?

CHAIR: No, no, if that's okay with Mr. Abbott.

MR. ABBOTT: Sure.

MR. REID: Yes, okay.

CHAIR: All the ones relevant to the AG's report that you responded to eight months ago.

MR. REID: Okay, I'll just ask a general question first about the nutrition in long-term care facilities. There were some issues raised about that in the AG's report. I'm just

wondering how the implementation of those recommendations are going?

MR. ABBOTT: As you know, the AG provided 10 recommendations; two specific to the department and the remaining eight to the regional health authorities.

In terms of the two that apply to the department directly, they've been partially implemented. I can just speak to those in a moment here. One second.

In terms of "The Department should conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador," we have a working group from the health authorities, as well as ourselves, to review and revise the standards. That's ongoing.

To date, approximately 90 per cent of the standards have been drafted. To get the full implementation, the working group needs to complete the remaining standards, begin a review process with the stakeholders and gain approval of the manual. That's sort of standard process. When we do that kind of work we want to ensure in this case, obviously, the health authorities, the nursing homes and others are fully engaged in the final approval. Our plan right now is to have all this work done, completed and implemented this fall. That's where we are on that particular one.

Then Recommendation 10: "The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data," et cetera. The department has identified financial and statistical indicators. We've done that work. We're in the process of validating those with the regional health authorities. Again, we are consulting with them and the Centre for Health Information on the benchmarks.

Through our system we have different operations, different delivery models, size of facilities, et cetera. So we have to take that into consideration. We're comparing those against national comparators where we can find them. There are not as many there as one would think.

We hope to have that work fully implemented by the end of the summer. In essence, give it another month or so and we should have that work completed. The RHAs – for those that I'm aware of – are in the same mode in terms of implementing or partially implementing the recommendations specific to them. I have some updates on those as well.

MR. REID: Yeah.

Okay, I think that's good for me for now.

CHAIR: Okay.

MR. ABBOTT: If I may, just on that.

MR. REID: Yeah.

MR. ABBOTT: What this AG report has highlighted is an area that really was sort of under the radar; we were talking about it. It's really brought heightened attention by the department and the health authority. So it's been very helpful, us honing in on that particular area.

There are industry standards, there are comparators that we know we should be and could be using. That's been very helpful in focusing the work.

CHAIR: Okay.

Mr. Petten.

MR. PETTEN: Thank you.

The AG's report on the personal care home regulations; I know myself and my colleague, actually too, for Ferryland, have a fair number of personal care homes in our districts. I know I do, as well as himself – community care homes.

I've come back to this report, actually, when I've had questions and talked to the different home care operators. It appears to be inconsistent, and I know Keith is finding it in his district as well. It's gone from we're working with you and there's a bit of give and take – and they're not slack, but they were used to a certain level. Now we've gone from one end of the spectrum to the other. They're finding themselves going to non-compliance or getting sanctioned or getting warnings for almost any infraction out there.

We've gone from probably being a bit too easy on these homes, for want of a better word, to now – it's gone from one extreme to the other. This is home owners in two different districts altogether, two unrelated groups. We've gotten the same message.

My question is being that I know the department, obviously, tightened up on a lot of this with the regulations and I have no problem with that, but how much has the department done in consulting with these home owners? A lot of the home owners find they're getting very little consultation. They're being told there are changes coming, these are the expectations, we need this and we expect this. Then someone is coming in, walking in unexpectedly – which is fine, a surprise inspection – and they're getting wrote up.

I had one home, one person and they had a resident. They had everything prepared and the resident was on their way. In mid-transport it was cancelled due to some infraction. They pushed back, kicked up and questioned it and at the end of the day it turned out to be a non-issue and it was solved. They feel they're constantly under siege now as opposed to before, they probably weren't under siege enough, if you know what I'm saying, but trying to find that balance.

Is there a concerted effort? I know there must be but has the department given any consideration to probably being more collaborative with the home owners to try to bring them in to compliance and to bring them to the new age. I understand. There are 13 in my district and there are all levels from there to there. I agree with improving but I'd like to see more of a …

MR. ABBOTT: I hear you. So just a couple of things, if I may.

In terms of inspections and then conditional licensing; there are two components of, I'll call, an inspection. Service NL will go in to look at the physical premises and preparation of food, those things. That falls within their mandate based on current legislation and regulations. Then they can issue a report and a conditional licence, or pull a licence if it's not safe. Then we have the health authorities that go in obviously to monitor care in the facilities and depending on what they find, can provide conditions on the licence.

It's not done lightly and it is done based on standards, protocols and best practices, what have you, that the operators are fully knowledgeable about. Harking back to our conversation earlier about road ambulance, once we go to the regulatory side, and if a standard is set, then they must meet that standard. They are funded to meet that standard.

In terms then of consultation, we have a working committee with the personal care home operators. We meet on a regular basis. We are reviewing, currently, the new operating standards and we are going page by page with the operators to make sure they understand and can support those changes.

The working relationship with the home operators has generally been good. There have been issues at times where things might not have gone as well as both parties would have liked but, certainly, under the current minister we are working quite closely and meeting on a regular basis, including myself, as needed and the minister also, as needed.

We think the working relationship is quite good, but as the standards change and the expectation – and the expectation of residents is changing – then the operators are sometimes finding that a bit of a challenge. The market has changed and what have you. For them to – quote, unquote – keep up, will require them to invest and invest in the training and what have you.

That's where we're finding, at times – and it's not happening on a regular basis but there are, and I suspect I could probably guess who some of those operators might be – that they're having a difficulty to keep in with the change in business practice and expectation. There's really nothing we can do, other than have more conversations with them.

We know, in particular, the small home operators – say with 25 beds or less as a case in point – some of them have been around for quite a while. We are working and have committed to working with them on their finances and what have you, because in certain locations they need to be there. We need them there because they're

the only operator in a large geographic area. We will work and are working closely with them as well.

That's sort of where we are on that as we speak. There is a table for them to bring any and all issues and our doors are definitely open to hearing those.

MR. PETTEN: I guess it goes back to with those – because I do have a pretty good knowledge. I know all the operators; I know a lot of their issues. They've been around for a long time.

MR. ABBOTT: Yeah.

MR. PETTEN: I know a lot of those homes were operating under some form of a committee as opposed to individuals. There was a committee, a personal care and community care home group that dealt with the department or their RHA on different issues.

MR. ABBOTT: Yes.

MR. PETTEN: I'll go back again to say that there seems to be a lot of confusion. I know that the department are probably trying to work with these home owners. This confusion doesn't seem to be – I'm just wondering is there a better way the department could address this issue? It's not like one issue here or there, I've gotten it pretty well from right across the board and I know Keith has in his district as well. He met with groups in the last week.

No one is saying we're opposed to change. It's just the expectations and they're overwhelmed. The expectations have gone from there to there and they feel they have no support. I know I've talked to several home owners and they feel helpless. I mean one I was trying to – I'm waiting to hear back, actually. I tried to set up some sort of meeting with the department to go in and have a face-to-face because they were struggling. There was a lot of stress on them, a lot of financial responsibility because most of the homes in my district are the 20-25 beds or less.

MR. ABBOTT: Yeah.

MR. PETTEN: They're the small operators that have been around forever. I'm speaking on behalf of a lot of people in my district and these are real concerns – and Keith's district as well and I'm sure others.

You may not realize because they're dealing with the RHA, but this is a lot of stress to those home owners. They're not opposed to doing change, but they want more help and more guidance in helping them attain the proper change. It's a lot of investment for these small homes. It's a lot of financial to keep up with the criteria, but it's their livelihood as well. They obviously don't just run the homes, they work there. It's part of who they are. They're family operations that have gone on for a long time.

MR. ABBOTT: Yes, and I think, Mr. Petten, certainly with some of the homes that are in your district, they operate slightly different in that they really work under the RHA, the Eastern Health Community Supports Program, usually for persons with mental health and other challenges.

We have been just talking recently around how we to need to re-engage with those operators with the focus on how we support the residents in there and, consequently, the operators to meet that. We're committed to engage further with them and with Eastern Health.

We may need to have a separate conversation with you and some of those operators if their voice isn't being heard to the degree you've enunciated that. But we have flagged that in the department as a specific issue as late as this past week that we need to do along the lines that you've set.

MR. PETTEN: Okay.

Thank you very much.

CHAIR: Okay, just looking now that it is 11:52, if we could break for lunch just to give people an opportunity to get lunch and make some calls. Then we'll come back at 12:30 and spend an hour. It gives each to the five who haven't – their 10-minute opportunity to ask a few questions. Then we can be out of here by 1:30 or so.

Is that good for everybody?

Okay, back here at 12:30 sharp, please.

We're out in the Speaker's Boardroom. Yeah, we are. We can have a chat on a few things.

Recess

CHAIR: Okay, I want to welcome everybody back, and as we committed to, we'll try to conclude this within the hour. We've asked people to – any questions that are outstanding or something new that's changed, particularly around health care, while we have the officials here that we could have a little discussion around that.

Okay. Mr. King, you're next.

MR. KING: Okay. The only question I have is related to communities, environmental care facilities (inaudible). Around this time last year when we met we had just rolled out the new system for food. I forget the name of the –

WITNESS: Steamplicity.

MR. KING: Steamplicity; I just want to know how that's working out. Has it improved food quality, and are patients happy?

MR. ABBOTT: It's been operational now for – give or take – four to six months, fully operational in Eastern Health. The initial response has been positive. The quality of the food is better, timeliness and what have you. They're monitoring and will be reporting to us on those issues as we go forward. We'll be sort of monitoring that approach and whether or not then we should obviously roll that out to other hospitals down the road.

MR. KING: Yeah.

MR. ABBOTT: It is early days. The promise is of a better system, so we're now going to monitor for that.

MR. KING: Yeah. From what I've heard of it, it's been very positively received. Is this in long-term care facilities here locally as well?

MR. ABBOTT: No, just in the hospital.

MR. KING: In the hospital, okay. You're evaluating it right now and you're looking at possibly moving it out, too.

MR. ABBOTT: Yes.

MR. KING: Okay.

Thank you.

CHAIR: You're good?

MR. KING: Yeah.

CHAIR: Thank you, Sir.

Ms. Rogers.

MS. ROGERS: I'd like to ask a few questions about acute care bed management. It's still such a big problem, hey.

Can you give us an update on the state of the art of what's happening? There are so many recommendations here for different regional health authorities. I know there are working groups, program team looking at the lean process, improvements, patient flow, task force priorities.

Can you just give us an update on what's happening with acute care bed management?

MR. ABBOTT: In terms of the 16 recommendations – and they apply obviously across all the health authorities – 10 of those have been fully implemented and six are partially.

We have a working group in place. They've taken these recommendations quite seriously. We know we have beds that are underutilized or – quote, unquote – over utilized in the sense that there are people in them, patients in them that really should be discharged earlier, discharged home or discharged to long-term care or personal care or what have you. We've been looking at that.

I just want to give you – I won't say it's an anecdote because it's, in fact, the case. In recent months in Central Health, we've had 17 cases where people have been in long-term care and we were able to move them actually back home.

MS. ROGERS: Oh, great.

MR. ABBOTT: All of this sort of ties in, when we look at what we call the alternate level of care beds, as people who clinically can be discharged but have nowhere in the first instance to go. They will obviously remain in the hospital bed. We're really focused on bringing those occupancy levels down considerably.

We have adopted a Home First approach, which basically looks at those, and said: What do we need to do? What supports to we need to put in place in addition to our existing programs and policies? We have home support, we have this, we have that, but is it working for that particular client? It is an individualized approach at the end of the day. We're finding a lot of success with that and we've only really been rolling that out over, literally, the past year.

That's been the focus. That will help us with the management of the acute-care beds. The working committee involves the department that's overseeing that with the four health authorities. They have a work plan that's in place and we are striving to meet and implement all of these recommendations. Given the nature of the work involved, they're meeting on a monthly basis to drive that work.

MS. ROGERS: Is that just Eastern Health or is that province wide.

MR. ABBOTT: No, that's the province as a whole.

They're taken and they're going through each of those recommendations, as well as looking at some other issues that need to be addressed as we go forward.

One thing that will be addressed in recommendations is what's the policy or plans to support any of the changes we need to make. We're developing the performance indicators to make sure they make sense and monitor those. There's a lot of good national data that we can use. We're applying those to the Newfoundland and Labrador context.

We are looking at, obviously, early discharge planning. So when you come to the hospital there's to be, at that point, a discharge plan already developed for you. Based on your case and your acutely, et cetera, it should take three days, four days, five days, what have you. A discharge plan is put in place and then you're monitored against that. That's to help manage the patient as well as the resources.

There's a whole series of those initiatives that the RHAs are working on and monitoring for that, comparing results against the benchmarks and then making the changes that are necessary. Obviously, it requires the full co-operation of the nursing staff and the physicians that are involved in the care, but sometimes it's simply down to making sure that when a patient leaves the bed, that the support staff that are put in place are available to make sure that bed and that room is cleaned appropriately to admit somebody shortly thereafter.

We hear of backlogs in the emergency room to get up to the floors. Again, that all ties in to that. If you look at the number of beds we have on a per capita basis, relative to the other jurisdictions we're again on the high side. Part of it is geography but part of that is that we need to utilize those beds a lot better.

MS. ROGERS: The work plan, is that a public document?

MR. ABBOTT: It's just a document that's used by the committee itself.

MS. ROGERS: Is that available to us?

MR. ABBOTT: I think that can be made available, yes.

MS. ROGERS: Oh, that would be great.

Thank you very much.

What are some of the blocks and barriers, because I think there's still – is there? Has it changed in terms of the amount of people who are medically discharged, but still in acute-care beds, the data around that? Has that changed the numbers?

MR. ABBOTT: It is improving.

MS. ROGERS: Yeah.

MR. ABBOTT: It's still higher than we would like, but we needed to have a response to that. The Home First approach; we knew the issue, we knew what some of the solutions were, but we weren't making the changes because we were dealing with established policies and processes.

What we've done now is set teams up in each of the health authorities so that it will not only have somebody from the Community Supports Program but from the nursing program, the OT and what have you, to say for this particular patient, for him or her to now go home, we need to make sure we have these things in place. Now they have a process to address those. It's a collaborative team approach there. Again, a very simple concept but it wasn't happening.

MS. ROGERS: Yeah.

MR. ABBOTT: Now we have put that in place. We've allocated some additional dollars to fill in the gaps. The federal money from last year's Accord was targeted to support that.

MS. ROGERS: What do you see as some of the main blocks, barriers and challenges to get people out of those beds?

MR. ABBOTT: Part of it will be, maybe, needing some more additional home support hours upfront. From a process point of view we were waiting to do the financial assessment before we allocate the hours. We're saying that can be done in tandem. The need is there, put the service in place and we'll address the financial assessment so, again, an example.

But I think providing home nursing hours, if needed, and adding those where it's needed, making sure there's either OT or PT services in place, connecting back to the family physician and those kinds of things – so, as I said, it's case-specific and each case has had a different solution.

MS. ROGERS: John, where are we with the financial assessments in terms of eligibility, ceilings and what we ask people to pay in relation to the rest of the country?

MR. ABBOTT: Yes, again, our Home Support Program, in terms of the level of subsidy we provide, is probably one of the more generous in the country. We have looked at that, but, again, how we can improve because there are still people who are not getting access.

We have gone recently to Cabinet to look at some changes and they have been approved and will be announced in short order; again, to get at some of the barriers that we see there, particularly for the liquid assets issue and then adults with disabilities who are working. We recognize there are sort of two areas that we can improve on and we can make it more administratively – we can simplify the process.

The income ceilings, I know we're not in a position to change those because we're not in the overall fiscal situation to change those at present.

MS. ROGERS: But in a number of provinces there is no means test. People don't pay out of pocket for home care, right?

MR. ABBOTT: Yes, but we won't be changing that certainly in the foreseeable future.

MS. ROGERS: Okay.

Are we still facing wait-lists for long-term care beds?

MR. ABBOTT: We do have wait-lists waiting for beds. Again, we've added capacity. We just opened up the beds in Carbonear; that will relieve pressure. We've expanded –

MS. ROGERS: Is that full now – Carbonear?

MR. ABBOTT: Yes, it should be, or if not we're just phasing that in over a couple of weeks' time. We've expanded – again, through Home First some home support hours were needed, so that's taken some of the pressure off. The numbers haven't increased significantly. I should say they've actually improved and we monitor those on a monthly basis.

CHAIR: Okay.

Ms. Rogers, I'm going to go to Mr. Finn.

MR. FINN: Actually, I'm fine now. I was curious about the acute-care bed management. I

know there are a few nuances there and I think you've addressed what Ms. Rogers was referring to. Obviously, we want to get people out of the beds and into long-term care or back home with a level of care. I know that's a constant challenge, so that's really all I had, Mr. Chair.

Thank you.

CHAIR: Okay, thank you.

Mr. Reid, anything further?

MR. REID: Yes, I just had a couple of questions. I guess I'll ask them both at the same time. One is related to the Newfoundland and Labrador Prescription Drug Program and I just want to get a sense of how that's working out and if there are any changes in practice. Are there any savings based on the implementation of the program?

MR. ABBOTT: Sure.

The provincial Prescription Drug Program, we have roughly 130,000 people registered for that program. In any one year we may have between 105,000 and 110,000 people who actually use the program. It's administered out of our Stephenville office. Administratively it's, I think, fairly simple in terms of access.

We continue to add new drugs to the formulary based on Health Canada and the Canadian Agency for Drugs and Technologies assessment and then we negotiate a pricing agreement with, say, the generics or others. We're relatively fairly current on that.

The biggest challenge we have right now administratively is the special authorization. Some drugs need that to be authorized by our pharmacists in the department. Because of increased demand and some staffing issues, we're having a few challenges there, but we think we're close to catching up on that.

The income ceilings are such, in the way the program is structured, that there are more people looking for assistance than we can provide access. We are optimistic that the national discussions on pharmacare with the federal government will be a solution to that particular problem.

The other challenge is – and all governments are facing and anybody in the business – that the new drugs and therapies that are coming on are quite expensive. It's not uncommon now to hear that based on a new therapy developed by a pharmaceutical company that's gone through the approval processes that you're talking at $400,000, $500,000, $600,000, $700,000, $800,000 per patient.

That's going to be the biggest challenge we face going forward, just from a cost point of view. That's why we think the pharmacare discussions are going to be very instrumental in allowing us and all other provinces to deal with that. Technology and science are really going to be our biggest challenge going forward.

CHAIR: Are you good?

MR. REID: Yeah, that's good.

CHAIR: Okay.

Mr. Petten, follow-up questions?

MR. PETTEN: I don't have much else either. I'm just kind of curious overall with the AG report – we want a chart of what's been implemented partially, fully and not implemented at all on all the recommendations. I know that the Prescription Drug Program, according to us, most of the recommendations are 100 per cent done, but where are we with the other ones?

I know that acute-care bed management, nutrition in long-term care and salaried physicians we're probably a little over half fully implemented – the recommendations. What is the goal of the department to reach – where do you figure it will be to max out in completion percentages or where are you with those things?

MR. ABBOTT: If I may, just as a whole, we are working diligently on all the recommendations for all those areas and we anticipate – for those that are remaining to be fully implemented, like in terms of the physician's one, for example, over the next number of months we should have those in place, the same with acute-care management. So we've got working committees and processes in place to get us there. We don't feel substantively

that we're very far off in meeting the intent and spirit of those recommendations.

Now, there's one in the Drug Program in terms of a technical piece that we can't put that in place. It's cost prohibitive and it really is not going to solve the problem. It's not for the sake of looking at that seriously and in terms of trying to get close to what the recommendation was trying to get at.

Where it is at all feasible, we are striving to get these recommendations in place.

MR. PETTEN: Okay.

That's all I have to ask, Mr. Chair.

CHAIR: Okay.

Mr. King.

MR. KING: I'm good.

CHAIR: You're good?

Ms. Rogers.

MS. ROGERS: Yes.

Back to acute-care bed management, because I know it is very complex – what are the recommendations? Is that work ongoing to ensure that policies are in place throughout all areas to support acute-care bed management? Can we see those policies? Would it be possible to see those policies?

MR. ABBOTT: Yes.

MS. ROGERS: And I know it's all very, very complicated and I know that a number of facilities do have people in acute-care beds that need to move on but that it's difficult.

And so we see that Labrador-Grenfell Health has not implemented yet, in this last report that we had an update – "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."

The last update we had was that Labrador-Grenfell Health has not implemented this to date but are arranging for a group to commence this work within the next several weeks. Has that happened?

MR. ABBOTT: Yes.

MS. ROGERS: Okay, great.

MR. ABBOTT: Of those indicators, they have five in place and four they're working on. We also now have a new CEO in place who will be driving that change.

MS. ROGERS: And that's happening in all the regional health authorities, is it?

MR. ABBOTT: Yes.

MS. ROGERS: Okay.

MR. ABBOTT: Heather's telling me that all the others are fully implemented.

MS. ROGERS: Okay, great. Great.

For the provincial Prescription Drug Program, the ceilings for eligibility, have they changed at all? If not, how long has it been since they've changed?

MR. ABBOTT: Those, Ms. Rogers, were put in, roughly in, I think, 2006.

MS. ROGERS: Okay.

MR. ABBOTT: And we, I don't think, have changed those for that period.

MS. ROGERS: Yes, because I'll tell you why – 2006. I hear from so many people, particularly seniors, whose income, OAS and GIS, has really not changed; yet, their cost of living has skyrocketed, particularly rent. And how many seniors come to us saying: I can't afford my drugs – who may not be right at, you know, they may just be above the eligibility rate.

I'm hearing also from doctors. I'm hearing from people in emergency departments about people coming, particularly again seniors, who are not taking their meds. It's anecdotal, but it's real.

MR. ABBOTT: Mm-hmm.

MS. ROGERS: Or cutting their meds in half, taking them only every second day, which I think probably ends up being a cost down the road to our health care system. It's a problem.

MR. ABBOTT: Yes. I think certainly the department and the government recognizes that. Right now, because of our government's fiscal situation, not really able to move to expand as much as I think people would like. But that's part of the argument and rationale moving towards national pharmacare so that there is a level playing field right across the country, and access to the expensive drugs as well. That's where I think we're pushing with Ottawa to move this forward.

MS. ROGERS: I don't want to argue with you, except I believe that probably the cost down the road is greater if people are not able to take their medication as prescribed.

MR. ABBOTT: Mm-hmm.

MS. ROGERS: Have we really come to the point in our history where we can't afford, until we get pharmacare, to ensure that people have the medication they need to stay well and keep them out of hospital, keep them well and not sicker.

MR. ABBOTT: I hear and I understand that perspective for sure.

MS. ROGERS: Okay.

It's not on the recommendations and issues that were raised by the Auditor General, but I was wondering how is it going with the cut in the Adult Dental Program? What have been the unintended consequences of that?

I'm hearing from many, many doctors – and from different emergency rooms – the number of people that are presenting with infections and cellulitis due to poor dental care, even working people saying they can't afford dental care. They end up at emergency; they end up with expensive IV treatments.

Has there been any tracking of the rollout of the effects of cancelling that Adult Dental care program in terms of the additional expenses because people can't access proper dental care?

MR. ABBOTT: I don't have that data and we haven't been monitoring closely. Now, at any point in time we can track that data. We've been staying close to the dental world, through our director of dentistry with the department, to monitor – and we've just negotiated a new agreement with the dentists' association.

Again, because of cost in the first instance, the government had to backtrack on that particular part of our program. I don't think anybody said we won't move in that direction at some future point but, right now, we're in a holding pattern.

MS. ROGERS: Is there any intention to track it, to evaluate what the rollout has been of that?

MR. ABBOTT: As I said, that's something that is not active.

MS. ROGERS: Yeah.

MR. ABBOTT: If cases come forward and need attention, we will make sure we'll assist that individual as required. But we have not seen any wholesale evidence of that, but to be fair, we haven't been tracking closely either.

MS. ROGERS: Yeah. It's kind of interesting hearing from an emergency department to say it's increasing, increasing, increasing and the great cost just because of poor dental care.

The other thing again – it's outside of this – can I get a status on the bus pass situation that's now moved from AES to community health. I'm hearing multiple situations where people repeatedly have to go to the doctor to get notes in order to get a bus pass. Can you tell me what the policy is and where that's at?

MR. ABBOTT: The program is yet to be transferred.

MS. ROGERS: Oh, I see.

MR. ABBOTT: Yeah, it's almost any day now. I'm not in a position, really, to answer that. I know that it is an issue that is coming to the department, but we have not been engaged on that one yet.

MS. ROGERS: When people come to me and they can't get a bus pass, it's not Health that they are negotiating with, it's still AES?

MR. ABBOTT: Yes.

MS. ROGERS: Oh, okay.

MR. ABBOTT: Literally for the next couple of weeks and then …

MS. ROGERS: Okay.

I mean I'm sure you're concerned. Everybody is concerned the number of times people are going to doctors. Doctors are telling me as well the number of times people have to go to a doctor to get a note. Then the note is just not quite right, so they have to go to the doctor again and again, and the cost to our health care system.

MR. ABBOTT: Yeah.

I guess what we're seeing, and one of the rationales for moving the program over, is to address those kind of issues so we can align with our – because we have the data, the MCP data. When a client or patient presents, we can connect those stories right away and say, yeah, this is legit. We'll be looking at all those processes once they are within the Health and Community Services domain.

MS. ROGERS: Are you developing a new policy around it?

MR. ABBOTT: We will be.

MS. ROGERS: That's not developed yet, is it?

MR. ABBOTT: No, no.

MS. ROGERS: Okay.

Is it possible to get a copy of that policy once it's developed?

MR. ABBOTT: Absolutely.

MS. ROGERS: Great.

Thank you very much.

CHAIR: You're good, Ms. Rogers?

MS. ROGERS: I could ask a million questions.

CHAIR: We all could go for hours on health care. That's good.

Any other questions before I conclude with some questions? No? I appreciate that.

I have a few and some are statements.

Oh, yeah, go ahead, Ms. Rogers.

MS. ROGERS: There's issue of – I know that my colleague asked a question. Salaried physicians; can you just give us sort of a – because there were so many concerns that were raised, the fact that some people weren't working with a contract, and not being able to really implement the contract after someone has been working for a long time.

Can you just give us sort of a ballpark of the state of the art around so many of these issues that were raised and where we are with salaried physicians?

MR. ABBOTT: Yes.

MS. ROGERS: I was also surprised – no, that's fine, if you could just give us a sense.

MR. ABBOTT: Again, in light of the Auditor General's recommendations in that particular area, we've been working quite extensively with the health authorities to put the contracts in place, align our policies right across the province and look at how we manage and approve new positions. All of that is working.

The area that's still a bit of a challenge is getting physicians, who have been working in the system without a position description and a contract for an extended period, to see the value of doing that. But, certainly, anybody new that's coming in – and there's a lot of changeover – we are slowly but surely making sure we'll have full compliance.

We are still trying to work with all physicians to make sure they are clearly given a position description, they know what's expected of them and that the pay obviously follows that. We've re-established the Salaried Physicians Approval Committee. That's something that we've now

put in place over the past year. We're looking at locum coverage – all of those things – so that we get the best value for the dollar we're spending.

We're making sure we align the physicians that are needed in the communities where they are needed. There are some indicators we use, and the reference of one physician for roughly 1,500 citizens. In some cases we have a lot more than that, and some we have a lot less. When we're looking at requests for filling or replacing, we're bringing that data together.

Obviously, we've added nurse practitioners to the system.

MS. ROGERS: Yes.

MR. ABBOTT: They have to be considered in that equation as well. As we graduate more, we want to bring more into the system.

Again, we're looking at other practitioners – paramedics as well – for a role to play so that we have a full complement of fully trained professionals to deliver the care. All of that is playing out there. We've seen significant improvement in a relatively short period of time in how we're managing the salaried physician resources in the province.

MS. ROGERS: Meeting with family practice residents – many who are from the province and want to stay in the province – have talked about more of an interest to be salaried rather than fee for service.

MR. ABBOTT: Yeah.

MS. ROGERS: But then, also, the Newfoundland and Labrador Medical Association has talked about – is it co-capitation?

MR. ABBOTT: Yeah, sort of a blended model.

MS. ROGERS: The blended – yeah.

MR. ABBOTT: Yes.

MS. ROGERS: So where is the department –?

MR. ABBOTT: I think we will be starting negotiations in the near future with the Newfoundland and Labrador Medical Association. I think that will be certainly one of the topics for discussion. They put out a discussion paper just recently – or their 10-year plan –

MS. ROGERS: That's right.

MR. ABBOTT: – in how to move in that direction. We're in alignment with that approach; we just have to figure out together what is the best model and the payment model. Different jurisdictions have tried it; some with varying degrees of success. We have a finite series of dollars that we pay to the physicians and we see that we should be able to come up with new approaches within that budget.

MS. ROGERS: Okay.

My very last question: The issue of health care provision within our justice system.

MR. ABBOTT: Yes.

MS. ROGERS: Where is that at? What can we see?

MR. ABBOTT: We have our team in place; we have a team lead in place. We've started the discussions with the Department of Justice and Public Safety.

We are already providing services within several of the facilities across the province. We will be going into the penitentiary here in the city providing similar services, as we do in the community. We're working with Justice in how to accommodate that, both facility-wise and in terms of the relationship with corrections staff and their policies.

The minister was interviewed and quoted recently, within the year, that there will be the full transition. We're working towards that. I think it's certainly top of priority for me and several of our staff to move there and the Department of Justice is fully supportive of that. Again, we're talking different languages. Even though we're talking is it an inmate or a patient and getting the language sorted out when we sit down and talk about that.

MS. ROGERS: When you're saying that you're already providing some services, what would those be?

MR. ABBOTT: The single session; we're also providing counsellors out in Central and up in Labrador; and the psychiatry services in the Eastern region are provided out of Eastern Health.

MS. ROGERS: When you're saying single session, so folks who are incarcerated can avail of single session –?

MR. ABBOTT: Yes, so we want to move –

MS. ROGERS: That has started?

MR. ABBOTT: Yes, and we want to make that applied right across the system.

MS. ROGERS: Yeah.

MR. ABBOTT: There's a little bit of a challenge here in timing and resources, but we're committed to doing that.

MS. ROGERS: Is it someone from Eastern Health who is providing a service in the facility?

MR. ABBOTT: Yes, and we're going to be working to make sure there's somebody in place any day now; it's just a logistics matter.

MS. ROGERS: Okay, because I've just visited the facilities and nobody talked about that.

MR. ABBOTT: No.

MS. ROGERS: Okay, so it's like brand new, brand new.

MR. ABBOTT: Yes.

MS. ROGERS: Okay. That's good to know. That's good to hear.

I know that the minister has said within a year. Are you hoping to be able to do something about the psychiatric services sooner than a year or …?

MR. ABBOTT: One of the things we've committed to doing is doing a clinical review. We approached Eastern Health to do that, so that as we embark on that we take the latest best practices and apply them right from the start.

MS. ROGERS: Doing a clinical review of the current services?

MR. ABBOTT: Yes, and compare that to best practice. Then design what we think is the best approach, given our circumstance going in as we take over the service.

MS. ROGERS: Okay.

What do you see as some of the real blocks and barriers? Are there ones that …?

MR. ABBOTT: Again, at the end it's going to be a resource issue but we're committed to making the dollars available. Then we just need to obviously identify the clinicians that can come in and support our patients in the correctional facilities.

MS. ROGERS: Great. It's good news.

Thank you.

CHAIR: Thank you, Ms. Rogers.

I had one about the blended pay-for-services model. You've answered that and, obviously, I've been following what the Medical Association is proposing.

MR. ABBOTT: Yes.

CHAIR: There are some unique opportunities and probably some unique challenges within the whole system. I look forward to see how that unfolds in the negotiations.

While we're on the doctors, we hear on a weekly basis at least that doctors are coming and leaving for various reasons. Are we monitoring how many doctors? Have we added new physicians to the system over the last number of years?

MR. ABBOTT: Yes, we have. We were at the highest again that we've ever had. We had some vacancies right across the province in the specialities, and we monitor that daily and weekly. There are pockets where there's more concern than others. Certainly, when we see –

out in the Conception Bay North area there were several family physicians who had finished roughly at the same time for different reasons. We knew that was starting to happen so we went in to assess what services we need to put in place to accelerate the recruitment.

Part of it is a distribution issue and part of it is work-life balance issues for physicians now. How we practise today is different than how we practised five years ago, 10 years ago, so we have to factor all of that in our planning.

We are also undertaking a physician resource plan for the province. That will help us guide this for the next 10, 15, 20 years. That's the intent here. On the whole we are doing quite well, but there are some issues that have cropped up.

CHAIR: Do we have that data? Can we track –?

MR. ABBOTT: Yes.

CHAIR: I realize the demand areas, that there may be two doctors who leave in remote central areas, but you've probably added four doctors in an urban area because of the demand and numbers.

MR. ABBOTT: Yes.

CHAIR: If we could get a copy of the tracking.

MR. ABBOTT: Sure.

CHAIR: We've had a lot of conversations around physicians in different areas. How do you compensate to ensure there's a provided service? You're not going to be able to provide the same service to everybody. If we're recruiting doctors, how do you engage them to go to rural remote areas versus the urban centres? That would be a piece of information if you could share it with us, I think we'd all – there would be a value to that.

I have a concern that's coming up in my district and maybe it's across. It's purely health related but I don't know if it's the health authority as such. We've been noticing – I don't know if it's because of budgetary restraints or not – that social workers are doing very inclusive audits, for want of a better phrase, on their client services. We've had, I know in my district – and we've had a discussion about one particularly. Services for home care services, particularly, have been dramatically decreased based on what they call an audit reassessment.

In some cases, where it's becoming alarming to me in my district, we've had home care services cut for developmentally delayed special needs adults. The unfortunate thing – and we're talking minimal amount of home care; they were receiving 10 hours a week, two hours a day to help with preparation for meals and ensure that they showered that day and everything was safe in their home. When they lose that, they lose their allowances and they lose any other special supports and, in some cases, supports to go to a special needs program that was inclusive for a taxi cab or a bus pass, for example.

Those are my two concerns, keeping in mind – and I'll say this publicly – I was a bureaucrat for a number of years and I was with AES. The review process internally, I've always said, was a sham. I've never ever, of my 26 years, seen somebody overturn a co-worker's assessment internally. I didn't see it in AES; I didn't see it in Health. That's just the reality.

Then you take it to the next level – and I had this discussion with the supervisors and I've taken it to the next level about the discussion. The alarming comment made to me was that we've been over-servicing people. I challenge that because I said you're over-servicing with two hours a day for a special needs adult who was living with their mother who passed away and then her brother, who was younger than her, passed away. She's still developmentally delayed. That's not going to change. The environment doesn't change from there.

The supportive services that have been in play for nearly 20 years going to a particular program, that's a volunteer-run program, but her ability to go because the taxi is paid for. Keeping in mind she's at an age where I can see the next step. If these services continue to be cut, she will be in hospital. She'll be a ward of the state forever and a day at hundreds of thousands of dollars for the sake of if we're paying 10 hours at $150 a week. That ensures her safety and her well-being from a health point, not counting her mental well-being. I have an

onslaught of emails from this individual and her family saying these are automatic supports. It's a minimal investment.

The concern becomes is it – because now we're saying go back and really scrutinize the files that we had going for years to find a way to save money. When people make the comments we've over-serviced people for too long, define over-service. If you only need one car, you don't have three cars in your driveway, unless you have people to drive them and unless you're collecting them.

These people who have these particular needs were assessed somewhere along the way by a qualified social worker or a psychologist to need these types of services. Now that we're finding – and I just thought maybe it's a couple in my district and they're unique because it could be a unique social worker, it could be a unique day, but I'm challenging them. I'm getting the impression – I'm being told that there's a full-fledged push towards the social workers at the grassroots level to do complete audits with the intent of saving money.

That's alarming to me because it's going to have a major impact and it's not going to save us money. I know in the three I have I can see in a year, if we don't reverse some of these, you're going to see them in long-term care at the hospital on Bell Island, or you're going to see them having to be getting some supports out of the Waterford here. You're going to see ambulances on a daily basis leave. We just talked about road ambulances, what it will cost for Fewer's to drive ambulances from Bell Island constantly over and these type of needs.

I put that out there. I don't know if the department can have some influence with the regional health authorities. I suspect it's not only happening in my region. I do know it's happening more on the Avalon and maybe it's Eastern Health that pushed it. I know one of the targets have been special needs adults and I will tell you that. It's alarming because I know these cases and I say that coming from my background.

Knowing the minimal investment to improve their quality of life, their health care and their safety is nowhere near what it's going to cost the minute we pull those services. That's an alarm –

MS. ROGERS: (Inaudible.)

CHAIR: Yeah, I'm putting that on record, knowing a year down the road we'll talk about hundreds of thousands, if not millions of dollars, extra having to be put into the system for a handful of clients, because we didn't spend nickels and dimes on services that were being provided, because somebody had assessed it under their professionalism that these services need to be provided.

I don't know, John, exactly what response you may be able to make because it's different from a regional health authority.

MR. ABBOTT: Yeah.

CHAIR: It's alarming to me and I want it on record just for a discussion point.

MR. ABBOTT: In terms of that issue – I'm just sort of working backwards – from a policy end, we have done a review of the Home Support Program, and done right from all aspects of it. We are looking at the assessment process and reassessment process to make sure it's right and the people doing those assessments, all professionals in their own right, have the skills to do that and they're applying consistently to the degree that that's possible.

As part of that process, we have asked the health authorities, on their assessment and reassessments, to make sure they apply the appropriate tools to that assessment. There are very regimented tools to allow them to do those assessments. We leave it to the social worker or the community health nurse, or whoever does those assessments, to make sure they're done right and we have to rely on that.

There will be cases – and I know you and I talked on one of those – where the reassessment suggests less hours of care that is needed. Those then are reviewed by others in the health authority. They can be reviewed and appealed, as it were, to make sure they're done right.

We want to make sure people are getting the right amount of support, the right amount of

hours and support. That's where it is. It is not a fiscal issue as far as the department is concerned at all because the money is set aside for the program. We know there will be cases on either side of this – some will get some more hours of support, some will get less – but we've left it to those doing the assessments to get it right. Where there are some of the examples you've used – and for those that we're made aware of – we will ask the health authority and we'll go to senior management to make sure those cases are given a second review, or third review as the case may be, to make sure they can stand behind those assessments.

CHAIR: Fair enough.

I can understand a reassessment; if somebody is coming out from surgery, for example, and you need X number of hours and then it gets reduced because their mobility issues have improved. But a developmentally delayed 55-year-old lady who is 280 pounds and is four-foot-one, who can't reach a stove, has phobias galore and has a 65 IQ level; 20 years later it hasn't improved. There's no intervention we've done other than she's still socially in the program she's been in for the last 15 or 18 years which has been her social life. It's been her support mechanism. It's actually been even an educational component because they're trying to teach basic skills and this type of thing. She's now been diagnosed or acknowledged as being over-serviced.

My concern is I've gone through the social worker, I've gone through the social worker's supervisor who did a review, I've gone to the director who, before she reviewed the file, said to me: Well, you know, David – and this is somebody who I had worked with in a previous life which said – we've been over-servicing a number of clients. Then my natural bias – and this is a person who I would consider a colleague at times and a friend who's making comments like that. I'm thinking maybe the process itself is still not independent enough to make the proper decisions.

I have a real concern on this one, and this one I'll follow up, but I'm glad you put it on the record that there hasn't been a notice to Eastern Health or any of the health authorities to start cutting money in home care, other than the reassessment for the process, which I can live with that. We have to have checks and balances to ensure people get the service they need. Sometimes there's an increase. Sometimes it's less because their circumstances improve.

I do have concerns when there's a clientele group who their circumstances are never going to improve; they're going to be the same. So we have to maintain at least an adequate service that has, for want of a better phrase, kept them coherent and inclusive as much as possible and happy, safe and healthy to the best degree that we could. I just wanted that noted because it's one of the few things that I'm adamantly upset about – that I don't think there's been enough real thought gone into it – where I think a small group of our society got bottlenecked into another big group and they're going to end up reaping the negatively from the process.

Other than that, I do want to thank officials and the Auditor General's staff. I will ask the Auditor General again, from what you've heard there – and I know I go back and reiterate that it's a report from a previous Auditor, but you're obviously reviewing the response for it – nothing alarming that the deputy minister or his officials had noted that would bring up. We've already talked about the road ambulance but some of the issues that we've brought up since then?

MS. MULLALEY: No. No particular concerns.

From my perspective, I want to thank you just for the opportunity that these meetings present. I think they are very important meetings and an opportunity to hear about the implementation of the recommendations.

As I mentioned earlier, our office will be issuing a report this fall. That would be with respect to reports issued in 2015. Of the six reports that were discussed throughout today, three of those: The Prescription Drug Program, the Nutrition in Long-term Care Facilities and the Personal Care Home Regulations will be included in the report in the fall.

CHAIR: Okay.

MS. MULLALEY: Thank you again.

CHAIR: Perfect. I appreciate that.

With no other further comments, can I ask for a motion to adjourn?

So moved, Mr. King.

All in favour signify by saying ‘aye.’

SOME HON. MEMBERS: Aye.

CHAIR: Opposed, ‘nay.’

Again, I want to thank everybody. I want to thank Ms. Murphy, the Table Officer, for taking care of us. We look forward to any follow-up information that you have to share with us.

WITNESS: (Inaudible.)

CHAIR: Without a doubt. She has more knowledge than most of us.

Thank you.

On motion, the Committee adjourned *sine die*.