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COMMITTEE

ON

COMMUNITY SERVICES

Thursday, January 25, 2007

Committee Room 1

Department of Health
Continuing Care - 2006 Strategic Framework

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COMMUNITY SERVICES COMMITTEE

Ms. Marilyn More (Chairman)
Hon. Ronald Chisholm
Hon. Leonard Goucher
Mr. Patrick Dunn
Mr. Gordon Gosse
Mr. Trevor Zinck
Mr. Keith Colwell
Mr. Leo Glavine
Mr. Stephen McNeil

[Mr. Gordon Gosse was replaced by Mr. David Wilson (Sackville-Cobequid.)]

In Attendance:
Ms. Mora Stevens
Legislative Committee Clerk

WITNESSES

Department of Health

Ms. Cheryl Doiron
Deputy Minister

Mr. Keith Menzies
Executive Director of Continuing Care

Ms. Susan Weagle
Director of Standards and Policy

Ms. Lynn Cheek
Director of Systems Planning and Liaison

Ms. Karen McDuff
Director of Financial Services, Programs

Ms. Valerie Bellefontaine
Director of Communications

HALIFAX, THURSDAY, JANUARY 25, 2007

STANDING COMMITTEE ON COMMUNITY SERVICES

2:00 P.M.

CHAIRMAN
Ms. Marilyn More

MADAM CHAIRMAN: I'm going to call the Standing Committee on Community Services to order. I welcome everyone here today. Our topic is the Continuing Care 2006 Strategic Framework. We're very pleased to have the deputy minister and her staff with us today. I would suggest that we'll start by, perhaps, doing a round of introductions of the committee members.

[The committee members introduced themselves.]

MADAM CHAIRMAN: Perhaps we could have introductions from the staff from the Department of Health.

MS. CHERYL DOIRON: First of all, thank you for inviting us. We're very pleased to be here. I'm Cheryl Doiron, Deputy Minister of Health. Keith and I are going to try to address many of your issues or questions. This is Keith Menzies, Executive Director of Continuing Care. We brought reinforcements from the people who really know everything, who are sitting behind us here. We have Lynn Cheek, Liaison Director with System in our Continuing Care branch; Susan Weagle, Director of Policy and Planning for the Continuing Care branch; Karen McDuff, the finance person from the finance department in the Department of Health, who works with the Continuing Care branch; and Valerie Bellefontaine, Director of Communications. That's the group we have here today.

MADAM CHAIRMAN: I'd invite you, perhaps, to give an opening statement or an introductory presentation before we get into the rounds of questions.

MS. DOIRON: Madam Chairman, we're very pleased to do this, because, I think for us and, hopefully, for all Nova Scotians, this is a pretty exciting venture that we've been heading down the road with. The Continuing Care Strategy was built with a lot of input. I think we had about 1,400 people from Nova Scotia who helped to inform this in 30-some groups that were meeting across the province. Basically, I think we heard a lot of good things and how people really felt about their needs.

We also know that, while we have been building a great deal in home care over the last years, that we have not had an opportunity to do very much building for quite a long time in this province in the long-term care sector. We are now in a position of tremendous demand and great need, with a need that's going to continue to grow as opposed to shrink, for the next 20 years, probably. We're delighted that you are interested in hearing more about the Continuing Care Strategy.

If you look at the first slide in the group of overheads that we gave you - it's headed up, Government Context. This is something that we have been trying more and more to do. Wherever we're speaking, whether it's in front of Cabinet or it's in front of people out in the health delivery system - to basically kind of bring to their attention the fact that so much of what we do and so many of the people who require services from the Department of Health within Continuing Care and other areas, also sometimes, maybe at the same time but not always, also need services from the Department of Community Services.

During the last two or three years, the Deputy Minister of Community Services, Marian Tyson and I have kind of developed a joint working approach. In fact, we have our senior staff and other staff, assisted by a senior position that we jointly appointed with some help, to actually work across the continuum of both departments, to try to make sure that we are successfully working on behalf of both the individuals and the populations who need both, or who cross back and forth between our services. We just continue to see more and more to do in that arena. I think we currently have something like 32 joint projects going on.

Essentially, we've been trying to put the context around this that this is really all about a continuum of care, and a continuum of care and support. Usually the emphasis on the programs that come from Community Services are more on the support side, housing or other kinds of supports, whereas the programs that come from Health are generally more in the realm of care as opposed to support. We cross over a bit, but we're predominantly care and support.

Within the Department of Health, of course we have been working for the last while on developing the whole Continuing Care Strategy, and that was announced this past May, and the year one initiatives were approved in our budget in July. Actually

there were quite a few initiatives that were identified to kind of be pushed forward to year one, because we had expected to basically carry this out over a 10-year period with a 10-year plan, but the need is so demanding right now, and I think Cabinet decided that they wanted to push some of the year two and year three things up into the current year.

So we have a large number of initiatives, as you will see, that we are setting off now. Basically, around home care and community-based initiatives, we have $68 million approved for additional programming - either new programming, enhanced programming, more volume, or whatever it might lead to. As well, we had approval for 826 new beds to be built within the next three to four years. Consequently, once those beds open and we're starting to pay the per diems for care in those beds, that's approximately $194 million to the provincial budget that will have to be added.

During the same period of time, and you may have heard some about this - I'm sure you have - the Department of Community Services had been doing much revamping and renewal in their services for persons with disabilities. Both Health and Community Services, in terms of placement for individuals, are also working on one of our initiatives, which is the development of a joint setting. So there is a lot of work that's going on across that entire continuum.

[2:15 p.m.]

If you turn to the second slide, that starts to get in, a little more specifically, to the Continuing Care Strategy. The government of the day has actually committed to the long-term redesign of the continuing care system. I think that's important to note, because if the government had decided to take just beds as an initiative and not put as much emphasis on the community-based services, this just wouldn't work. If we don't have the supports out in the community - both in Health and in Community Services - that need to be part of this continuum, then probably we'd end up projecting the need for more beds. The continuum is important, and the whole collection of services along that continuum is an important aspect for the successful development of services to the population.

We also have a focus on investment in home and community care for that reason because, obviously, I think most people - almost all of the people we work with in the communities would prefer to stay at home, or in something that's more home-like. So the more we can build in supports for them at home, the better off they're going to be and their families and, actually, the better off the government is going to be because, of course, going into a bed is the highest cost approach to care.

Basically we are going to be working on expanding the type and benefits of all of our continuing care services. As well, we are investing in more research and evaluation, because the work that is now being done to analyze and show trending and so on is pretty complex, but we're kind of getting that to the point, particularly through

Susan behind us here - we're getting more and more and better and better developed. So we're projecting beds, for example, as you'll probably be seeing when the government announces all these things, we have been aiming at identifying where we need beds that are actually much more into the community levels.

So, as opposed to looking at building 100 or 200 beds in region A or B, we've been looking at where people live, how we can build units, maybe not as big ones as we had maybe in the past thought we should build, but how we build units that are sustainable but much closer to the smaller communities in which they live. Once we're able to share that kind of information, you'll see that it's quite a different kind of distribution of beds that we've had in the past. The research and evaluation is a huge portion of being able to support, and being able to continue to predict some of those matters, in terms of beds and other services.

We also, then, are going to be investing tremendously in infrastructure that has been needed for quite some time. You're probably aware that there have been very few beds built - new beds built in this province for well over a decade, probably almost two decades. They were needed yesterday not three years from now, but we know what we have to deal with. So, we're moving ahead.

We're also making sure, and working within this branch but working across the department and across multiple departments, that we are investing in health promotion and preventative services so we can work toward having an aging population that's a healthier population. That's all part of that entire continuum.

Basically, I think we are thrilled that the whole message seemed to be heard and supported. We also know that to accomplish all of this, and particularly to accomplish what's being asked for in the next few years, is a huge demand on staff. We don't have a huge staff. We felt that in order to continue doing the day-to-day work that has to occur, as well as all the additional works and projects that have to take place, that we needed to make sure we had the drive behind that that would allow us to deliver.

So, in order to accomplish that, we now have - and it was done, of course, through an RFP process - project offices set up to drive all this activity, both for the delivery of the beds throughout the province and in addition to the new beds, we also had approval to replace around 600 of the current beds that need to be replaced. So there's a lot of activity in the building world that's going to occur in this province over the next few years and beyond.

Then, of course, with the multiple initiatives that are on the books for program delivery and initiatives, we have a project office to drive that, as well, because we want to make sure that while we have this tremendous opportunity that we do everything we can to do this as quickly as we can, as well as we can, and make sure that we deliver. Essentially, that's a bit of an intro that I wanted to share with you. I'm going to ask Keith if he'd go through some of the specifics in the Continuing Care Strategy.

MR. KEITH MENZIES: Thank you, deputy. I won't take a lot of time with details on this, because it is in front of you, in terms of dollars attached to it and some of our timelines. The first slide you have there, in terms of the Continuing Care Strategy, Year 1 Update, what we're showing there is a number of initiatives where we have some monies available this year and the extent to which we are going to be able to implement them this year.

Areas like Self Managed Care, which I think has been very successful, currently has about 51 clients involved, and will continue to grow and meet needs of people in a very unique way. The expanded Home Repair and Adaptation Program is money that we achieved through the strategy, and we simply asked Community Services to extend their current program - their Senior Citizens Assistance Program - by that amount of money. Again if you can maintain people in their homes, you can lessen the pressures in terms of people being maybe forced into being moved into nursing homes or other seniors facilities at too early an age. So, all of these initiatives will in one way or another support individuals in their homes and in their communities, hopefully delaying or eliminating the need to move into nursing homes at all.

Some of these are taking a little longer to implement than we had intended. On that page, the last three items, where we talk about New Home Care Entitlements and Respite Options, in fact, just the general growth in our home care uptake with our current program has actually used up all that money this year. We know from the trending information we have that we need to continue to build nursing home beds to meet the needs in the future. We also need to continue to expand our home care base to meet that need, as well.

The next slide actually shows areas that we will direct our attention to over the next few years - Years 2 and 3 - and after that we will move some of these initiatives forward as resources, and that includes people, enable us to do so. But I would note one thing on here, that in the original presentation of the strategy, developing a caregiver strategy was an item that was left for Year 4. We were asked - comments from the public, certainly, to our minister and to other people, was that that's too long to wait to begin to address a caregiver strategy if you want people to be able to support their family members. So we've actually moved that up into planning work this year, with hopefully some implementation of services next year.

The next page is about beds and long-term care facilities. The first group of beds, the ones in green on your overhead, are actually various projects that had begun last year or the year before and will be opening at various stages between now, basically in 2008 is when most of them will be opening, and some in 2009, like the Northwood facility in Bedford-Sackville.

At the same time as recognizing the strategy will take us where we need to go, we know that in order to really impact, it is going to take two to three years to get that capacity in place, so in the meantime we still have huge pressures in the system. To try

and relieve some of those pressures, we are looking at putting some additional beds on an interim basis - particularly here in Capital District - to deal with some of the wait list issue. We will also, over the next year, be looking at where else we can build capacity on an interim basis, until the new bed construction and the new Home Care Program pieces can be built over the next two to three years.

In terms of replacement beds - as many of you are aware, Richmond Villa was a 75-bed nursing home that was replaced and opened in a new location in St. Peters in August. There is a residential care facility in Truro that is being replaced, to be opened in April 2009. When the announcements are made about the 826 beds, there will also be a number of facilities identified for replacement, to be open by March 2010. So that's a three-year time period and it will take that time to make that happen.

I think I will stop at that. The next steps are there as well but one of the areas - well, there is a huge concentration in terms of assuring we get the bed project moving forward and get beds built because we know we need them. We also need to direct our attention very much to building up home care programs, to enable people to stay at home as long as possible.

MADAM CHAIRMAN: Thank you very much. Who would like to start the questioning?

Mr. David Wilson.

MR. DAVID WILSON (Sackville-Cobequid): Thank you again for the presentation. I know this has definitely been an issue that I think all members deal with on a regular basis and I know your department has dealt with, so I am sure I have enough questions that might take the rest of the day but I'll try to limit them to a few, to allow other people to ask a few. Then I'll come back and I'm sure I'll have many questions for the deputy in upcoming committee meetings or even the estimates, when the budget comes out.

So I think I would like to start with just a few of the concerns that have been brought to my attention on different issues on home care and maybe just see if you could give me some guidance on it. One is around blood collection for home care. I know in some areas in the province that VON, or whoever the home care worker is, are able to do that but they are unable to transport that, once they have collected that sample. So are there any programs, or have you looked at what we can do to help, especially some of the seniors who are in rural communities? I think it is easier for someone maybe in the metropolitan area to get it because there are a lot of opportunities and areas to get blood collection but those seniors in rural communities - have you had any discussions on what we can do to help those or to assist those individuals? I think if we can get early detection through blood work that we could prevent many things and, hopefully, keep them in their homes longer.

MR. MENZIES: Certainly that issue is one that we are well aware of and, as part of the strategy, we need to look at the solutions for that. I know right now one of the issues around transporting blood is transportation of dangerous goods, and how you balance that legislation with meeting the needs of people.

At this time it is fine for VON to collect it but then the transportation is the issue and we need to find solutions for that. We just need to look for some solutions and we don't have them yet but we know that issue is there.

MR. DAVID WILSON (Sackville-Cobequid): I think definitely it is an important issue and I think you can look at the whole area of how we can assist in that, not to say that I want to put more work on maybe paramedics in the province but that could be something we could look at, especially on down times for some of the paramedics - I'm not saying that's what we should do but it could be an area where even the supervisor for the area could swing by and do that.

The other thing is around transitional care beds, especially at the VG. We have - I'm not sure what the numbers are today - a lot of seniors and individuals at the VG and in a situation where I know our caucus doesn't feel it is most appropriate and I would think you would agree, to a certain extent, that it is not the most appropriate environment for someone who needs long-term care placement. We have people waiting for over a year to get into homes or long-term care facilities.

What is the avenue, or how can we address that issue as quickly as we can? I know you've said you're trying to ramp up creation of new beds and that, but what can we tell - you know I have individuals who call me on a weekly basis and I write the letters to the minister but I understand the lack of beds. What can I tell these families when they see their loved one or spouse in transitional care for so long? That's the issue, I think.

MS. DOIRON: I'm going to make a couple of comments and then maybe Keith might want to follow up. This is a real challenge and one of the realities, I guess, of the fact that we do not have enough beds now. We are not going to be able to deliver new beds in less than a few years, so we are going to have a period in between now and when we can deliver the new beds that is going to be extremely challenging.

We are already at the point where we have tremendous pressure on the acute care beds in the system and I'm sure that you probably all hear, in your own jurisdictions, from the districts that are running hospitals and so on, the impact that is having on their ability to deal with emergencies coming in, to put things through the ORs that should happen, and more and more that is becoming an escalating kind of issue.

[2:30 p.m.]

We are going to have to see what we can do, in terms of the most efficient delivery of enhanced or new home care services that might kind of have some impact on that but won't be the only answer. I think that quite likely we may have to look at even kind of more interim-type bed situations. That may not be the most desirable but one of the things we will have to do, if that is the case, I guess, is use whatever seems to be the best kind of judgment for how much you put into the aesthetics of that space and the cost of that, balancing that with what we all know is the most important thing, how the people are cared for and treated.

I know that the Transitional Unit in the Centennial Building is a real challenge for people and families. I know I have gone through there several times, a couple of times that were quite unofficial. One of the things that I feel good about when I walk through there - the set-up, if you've been in it, is sort of like a square - when you walk around there and you just happen to go by a door or come by somebody in the corridor talking to a patient, I have consistently heard staff dealing very, very kindly and very appropriately, in a caring way, with the patients which then made me feel that at least if they are getting cared for well and they are being treated appropriately, that's number one.

If we can do something, if we have a unit like that or other units like that, if we could do something that's not extremely costly to deal with some of the aesthetics, then I think we can try to look at that as well. I know that tomorrow morning - tomorrow is actually the day that once a month I meet, with some of my staff, with all the CEOs in the province, and tomorrow is our meeting day. What we have on the agenda, for the first two or three hours, is for us collectively to look at how are we going to deal with these kinds of demands in the interim until we can get more services and more beds out there. If it means that we have any opportunity for some other kind of transitional beds, then I think knowing how people feel about that unit at Centennial, then we need to think about them. What are the aesthetics and how does that impact people, both the people living in it and the people coming to visit in it?

Sometimes I think for many of the patients in the unit, if they're being cared for well and if they're being cared for appropriately in both a person-to-person as well as a nursing-care way, they're sometimes, I don't think, as upset about being there as some of their relatives are. So, how we deal with that effectively and how we can work with the district health authorities and their staff and their leadership to say, we all need to kind of approach this, and they need to approach it, at the interaction phase, the care-delivery level.

We are continuing to have those dialogues to see how we can collectively put whatever interim planning in place that's going to be most effective and actually use our imaginations to the greatest extent we can to bridge that gap until we have the services and beds we're going to really need. It's not going to be perfect in that period

of time, but neither are we going to walk away from it and say there's nothing we can do.

MR. DAVID WILSON (Sackville-Cobequid): No, and I would never question the care, especially the nursing care, because in Nova Scotia I think we're very lucky to have the professionals we do have. The biggest problem I find is the extras. Yes, their nursing care is being met, no question, but if they had the opportunity to be in a nursing home, the extras, like maybe having a dance or something like that, that's where - when you see somebody there for over a year, that's a lot of dances they're missing, or even just being able to sit in a chair and listen to music. That's where I'm thinking - I know we're not going to have the beds to target and to open up immediately. I think it wouldn't cost that much to try to throw some money to emphasize that we need to get a couple of the extras there.

Another question, and I'll pass it on right quick, is around the need - when I looked at the Continuing Care Strategy for the program areas and the new beds - how did you look at where you're going to target to put a new facility to add new beds? Did you look at transitional care units - how many people are waiting here? How did you come to get this list of beds, in the coming months or years?

MR. MENZIES: I'll maybe respond to that first, and then Cheryl can certainly add to it. The list of beds that you see there are various projects. Those beds came about largely in response to pressures before we had the strategy in place. So I want to talk about the strategy itself and the process - a very high level - we've used to determine where we're recommending that the beds go.

What we've done - about two years ago, Dr. David Rippey chaired a committee that looked at the future needs in long-term care, continuing care, around nursing home beds. We developed, through that committee, a methodology that basically looks at predicting the number of beds you need based on the population over the age of 75, and then you set a target. So, in our case, what we'll be looking for, is about 115 beds across the province for every 1,000 people over the age 75. Within that, you look closer, district by district, because we do have different use of health services by seniors - by all the population but by seniors in various districts in this province. So you want to be able to respond to the specific needs of particular districts.

What we developed was called a frailty index. It looks at 25 different health conditions for which seniors are often hospitalized or receiving ongoing care, and identifies the numbers per population over the age of 75 by district. So you can get a sense of which districts have a higher or greater need, therefore you would put a few more beds in those areas. We came out with an average and what we're looking for is to develop, basically, a benchmark, if you will, or an average of 115 beds per 1,000 population across the province, but then vary that up or down by each district depending on the particular health needs of the people in that district.

So that tells us what we want to have in place, and then it was simply a matter of looking at what we have now, and then how many beds you have to add in different communities and areas. That's the basis, and we will have that data available that talks about how we got to our recommendations, in terms of how those 800 beds would be distributed. That's basically it.

MADAM CHAIRMAN: Leo.

MR. LEO GLAVINE: Thank you for being here today. We've had a couple of rounds on this topic, of course, in the past. It's one which continues to be an enormous challenge for us. I appreciate your frankness in talking about that two-to-three year period, perhaps, in which we will be really challenged to meet the needs we will have.

One of the areas, when we say now we do certainly have wait lists and I'm familiar with them in the Valley - and I know there has been some very good work done - I know coordination seems to be coming along better. So I think I'll focus a little bit through what I see in the Valley, both along the lines of positive things, good things and also our needs. In terms of educating the current and the next generation of home care workers around, especially the LPNs and the home care staff, I'm just wondering if education needs are meeting the requirements of the number of professionals and para-professionals that the home care continuum does need and will continue to need? I'm just wondering how we are advancing in that particular area?

MS. DOIRON: Maybe I'll start this one. That's a very good issue, because along with building these beds, obviously we know we're going to have to staff them over and above whatever demands we have now. Over the last few years, of course, we have arrived at the point where there's basically a higher and more consistent level of education for continuing care assistants, many of whom work in nursing care and in home care and home care agencies. As that group of people are now being educated through our community college system - and of course one good thing about that is that college system is spread throughout the province - what we started to find is that the acute care system is also, through teaming differently with their caregivers, nurses and others, starting to absorb some of those positions as well.

We've had to interface, of course, with the community college system to try to talk about those issues. Of course we'll be talking much more with them about the LPN, CCA needs as we keep evolving more programs, both in home care and particularly when the beds open. We do have one of key staff who particularly pays attention to that whole area - Donna Dill, who works with that area and is very involved with it.

The other thing we've just done within the Department of Health is, we have engaged a person in a position now that we have for an executive director of human resources. Cheryl Burgess just started with the Department of Health within the last two weeks. One of her main roles is going to be to become more active in terms of the whole health human resource planning world. She has some good background. We will

be starting to look at the overall strategy for all health professions, but then within that start to target, what are some of the ones that we have to make sure we're dealing with at the front end. That's some of the work that's going on. Do you want to add to that, Keith?

MR. MENZIES: Just a couple of points. Specifically to recruiting - right now, we do have a bursary program available to the employers in the area that allow them to actually pay a considerable amount of the tuition for people coming into the program, so they can actually go out, if they can find staff who are interested in coming into the field; actually pay for part of their tuition to get them through the program. This past summer, we carried out a recruitment campaign simply making people more aware of that. This Fall, pretty much all of the programs for CCAs in the community colleges, as well as some of the private schools that teach this course were all full. So we are able to recruit some people, and we will continue to do that, because it's the ongoing attrition that we're faced with, but it's also that as we build capacity we need the people to do that work.

It's also other professions, though, so when Cheryl talks about the human resource strategy for the entire department, it's about the need for RNs, LPNs, OTs, physio, social workers, and looking into the future, in the longer range, how do we ensure all of them are there? There is a lot of work to do in this area.

MR. GLAVINE: In that regard, I was just wondering if we're going to see further developments, like we have at - I think it's North Hills, where we have a nurse practitioner? A couple of times when I've been at the manor in Berwick that Mr. Menzies is very familiar with, they're calling and a doctor has to come some distance, and there is a dedicated doctor, of course, for the manor. But when I think of cost saving and that efficiency and presence - is that something that you're getting into the comfort zone with perhaps doing more development in that area? Again, I see it as a wonderful cost saving measure. Geriatric care and monitoring of that elderly patient, I think, can become a precise part of experience and education. To me, a nurse practitioner could, in fact, play a very fine role there.

MS. DOIRON: A very good comment. Yes, that was basically the reason why we wanted to trial it in nursing homes. I'm quite confident that's going to be successful. To some extent, we're able to transfer monies in order to get some of those things up and running. We've also made it known to the health sector, so in long-term care or acute care, if they also want to start to move some of their funding around to make some of these opportunities available, certainly we encourage that and try to help them move it on.

We also, usually each year, try to get some more dollars to develop more collaborative practice teams. I think the role of the nurse practitioner in nursing homes is absolutely a really good thing for the future. We are also developing a program at this point for nurse practitioners in emergency rooms. They will not replace doctors,

but they probably can work as a team, and consequently we can probably stretch the effectiveness of the doctors or other professionals that we have in those settings.

The other thing that we are going to be embarking upon is - we do have a nursing strategy, for some time now. The nursing strategy has actually been pretty productive. We have a number of initiatives and strategies around physicians, but what we're going to be doing in the immediate future is developing a strategy for allied health professionals. We think that in some areas, both in the community but also in acute care, that that's going to hopefully help us, because shortages aren't going to go away overnight, as we know. We seem to be holding our own in some areas, but I think it will become an increasing challenge over the next five to 10 years.

[2:45 p.m.]

MR. GLAVINE: I was starting with this education area and so on. We always know that financing is a big part of delivery of any of our programs. When we talk about the wait lists that are there, is it a combination of non-sufficient human resources, the money to say that we need to shorten the wait list, is it the coordination of people who are there in the system, if you have 120 people who are working, roughly, in the Valley region, is it coordination, what is it?

It really hit me the other day, and this is an example - the family said, well, you do what you want, but it was a great one to, say, you could go to the media and have a field day with it - I had a call from a family, and they had used private care for a while, and they finally said, gee, our father is running out of the monetary means to keep this going, so we really have to get a combination of pay and provincial programming in place. They said their father was on a wait list. I said, is he quite ill, do I need to sound a sense of urgency when I call on your behalf? They said, well, he's on a wait list and he's 101. Perhaps he should get help, maybe right away. So it highlighted for me that real sense of well, gee, there are a lot of components when you look at a wait list.

What do you see, on a very serious note here - I mean, how can we attack the wait list? If we take a look at the Valley right now, in the seniors strategy we saw that there are three communities in the Valley that have 25 per cent of their population, 65 years of age and over and we have five out of eight in the province that have 20 per cent 65 years of age and over. We know that is going to be what is going to happen in other areas of the province as well. How are we going to attack the wait list, I guess, is my central question here?

MR. MENZIES: I guess there are many facets to that. One of the big issues, though, is the staffing. I think that is primarily our biggest issue right now, getting more people into the field, more trained people into the field, to be able to start addressing this. I think the last round of negotiations of collective agreements did take us a long way, in terms of the salary rate for people in home care now is basically equivalent to the rate that someone would be paid for working in a nursing home. So you levelled

that piece, there is no particular draw to one area versus another, which has been a great advantage. That will help.

There are still some issues in terms of home care, in terms of how staff are assigned work and the numbers of people with full-time hours available to them. So there is some room, I think, for some changes in the way people work but that's not the major part. The major part is recruiting staff in the first place.

MR. GLAVINE: Just one short question to finish with. Thank you. By the way, the local people I deal with did have a quick response to that gentleman, so it was a good news outcome there and I was pleased that they responded.

I am just wondering - you know I talked about this the last time you were here, Mr. Menzies, and I can't remember, Ms. Doiron, if you were here or not, but is there any concrete thinking about having at least a pilot of one of our DHAs, to see if we could just do a little bit better job, I mean any efficiencies today, when we're looking at tight dollars, that the delivery could, in fact, be a little bit stronger. I'm just wondering if there's anything - it's something that I keep hearing people comparing who have been in the continuing care and the home care for some time, they are able to compare the new model with the old model and maybe bringing some of both together, a little bit amorphous here, may be what is needed. A final thought on that, please.

MR. MENZIES: So you're speaking of integration of service delivery with the districts?

MR. GLAVINE: Yes.

MR. MENZIES: That's certainly an area that we would like to, and we do see in the long-term, making happen. I'm not sure of the timing of it but it's certainly worth pursuing and I think some provinces where service delivery is integrated at that level, there are definite advantages to it.

MS. DOIRON: I've lived through both, actually, and I think I could say with confidence that there are some advantages to having it in the hands of the local level. So now that we're into the huge number of initiatives we had, to do that transfer to the districts takes a little work, but we would be really happy to see an opportunity to kind of take that ahead or at least to kind of do it on a pilot basis.

MR. GLAVINE: Thank you very much.

MADAM CHAIRMAN: Thank you. Keith.

MR. KEITH COLWELL: I have a few questions around home care. I think the new beds are a wonderful thing and we badly need them and I am pleased the

government has seen the wisdom of moving forward with those and, unfortunately, it takes a long time for government to move. It is too bad it couldn't have been sooner but indeed, it's happening so I think that's very positive.

The other thing is, in my opinion, and this is an opinion that is shared by many people, it is more important to keep people in their homes, as long as they possibly can, as long as that is possible and makes sense from a medical standpoint. They seem to be happier and live longer and all the things that go with that. I've got some questions on the home care issues. I have had many, many issues raised in my constituency about home care, accessibility to it is one thing. One thing that really along those lines is when the home care is really needed, when I say really needed I mean someone who already has home care and, for whatever reason, they can't get the home care workers to schedule things around particular times of the day when it is important to have that home care and maybe the caregiver at home can't do certain things.

I am speaking from experience with one particular case here and I've had the same problem brought forward from many people. For instance, around suppertime when it may be very difficult to feed a person with certain kinds of disabilities or illnesses, the home care workers seem to have to leave at 4:30 p.m. when, indeed, they should be there until about 5:30 p.m., which is a real issue. Maybe at bedtime, when people have difficulty getting into bed or getting out of bed in the morning, or any of those surrounding factors, what processes do you have in place to try to ensure that's the case? I know I can identify - I won't identify here, of course - I could identify specific examples for you to work with.

MR. MENZIES: Certainly there are major issues around the timing of delivery of services at times. It is fairly complex, in terms of scheduling, how many people you have and what the demands are. We know they are there and we are working with the agencies to say, how do we start resolving this? It is the agencies that we need to resolve it. It has to do with their collective agreements at times as well, in terms of where they start and end. Again, that's about negotiating and saying we need different timelines here, we need to be able to structure work differently. All of those things need to be done.

Yes, you are right, there are periods of time where it seems certain individuals have specific needs and it is very difficult to get the staff there. Again, it comes down to recruiting more staff but also then how those staff are working and what the terms are in some of these agreements and how those agencies need to actually look to changing those terms so that they can provide more flexibility.

MR. COLWELL: Do you use all outside agencies to deliver home care?

MR. MENZIES: For the home support services, yes we do use all outside agencies.

MR. COLWELL: Now do they go by an RFP or do they negotiate a separate one? How are these people chosen?

MR. MENZIES: These are primarily non-profit agencies that have developed and have a budget relationship with government the same way the nursing homes do, in that they are agencies we use. The issue of an RFP is certainly one that we're looking at into the future because we recognize that these non-profit agencies don't always have enough capacity and by going to an RFP, there are some for-profit home support agencies out there that we could probably have them involved in the system as well.

MR. COLWELL: It seems like not-for-profit is sometimes by title only and it seems like maybe the executive directors and the staff get paid as well as a for-profit organization, so I'm not too sure there is too clear a separation between the two of them in this case. I appears that way, but that's just appearance.

MS. DOIRON: I think in introducing, we've talked a bit about the potential for introducing some competitiveness that might spark people to try to respond more adequately to some of the care requirements that we think they need to be responsive to. Trying to appreciate that you have people - it is sometimes very difficult to hire them to kind of be available for a few hours and have broken shifts and some of the things that sometimes actually are required if you are going to be where you need to be at the right times. So trying to strike an appropriate balance with that, there is still a considerable amount of work to be done in that arena. We have been taking on numerous things that probably need to be dealt with and developed in the whole continuing care world.

We have tried, I know in the last two or three years, to do some work with those agencies to try to stabilize a little more so, the number of people who are going into a person's home. Based on their needs, based on when their staff are coming and going or scheduled or whatever, sometimes you can get so many different people appearing at your door that that's disturbing and I think it's more disturbing even to people who are seniors. So issues like that, we have been talking with those agencies about and trying to find ways to improve it, but I think we do have considerably more work to do in those agencies.

MR. COLWELL: Also, this one really disturbs me if it's true and I don't know if it's true or not. Evidently some of the agencies, the workers got together and said look, we don't get enough hours in a day, and we want to work 40 hours or 20 hours a week, whatever the case may be. I don't know exactly, and I can get more details on this, outside of this forum, for you if you like.

Evidently, some of them went to 40 hours a week, and indeed didn't increase the number of hours they're actually working. They're getting paid for 40 hours a week, and in some cases maybe still only working two hours a day and getting paid for eight. If that's the case, I'm extremely alarmed about it. Again, I would be willing to talk to

you afterwards, or maybe in the future when I can gather more information. I was informed of this by someone who's in the business and claims that this is correct, in the last contract negotiations. Do you have any awareness of this?

MR. MENZIES: Not of that. If you do have information on it, we'd like to hear about it, too. In the last round of bargaining, there were provisions put in the contracts around guaranteed hours, it would be in a field where people would at least know that they have two days of work a week or three. Those staff would be scheduled for that full-time. Now if a client cancels, that person may have an hour block where they're not working, and the provisions are that you can reassign the person. To hear an extreme like they're paid for 40 hours a week and working two hours a day would be very extreme, and I'd like to hear about it, as well. We'd be going right back to the agency on it.

MR. COLWELL: Is there any way that you can police that, so you know for sure that, indeed, they're working 40 hours a week?

MR. MENZIES: The agencies do police that. It's a pressure that they have to respond to. That's a relatively new experience for them, they're working their way through that. It has come about quite well in most parts of the province. There are a couple of issues with one of the providers here, and they're working to resolve it. If you have information on that, I'd like to have it, too.

MR. COLWELL: I don't know if it's accurate or not. It's hearsay as far as I know until you investigate and say different. I'm sure you would correct it immediately if you knew about it.

MS. DOIRON: Something like that sounds like a pretty dramatic thing that needs to be dealt with right away. Generally speaking, I think we have been aware of and trying to go down the road to deal more effectively with both standards and monitoring out in the system. Maybe there are some things there that need to be enhanced. We have work to do to develop more maturity, if you like, in terms of how we look at how things like that are contracted, and then how we work with them. While they're making some progress, there's still a fair bit to go. I know that with the reorganization of Keith's branch about a year or two ago, we're starting to get into much more of that work.

[3:00 p.m.]

MR. COLWELL: How do you police - how do you actually audit - maybe that's the proper word - that you're actually getting value for money? In other words, you have an agency that books in, say, 500 hours a week of home care - how do you know you're actually getting the 500 hours a week? How do you know? What audit process do you have to prove that?

MR. MENZIES: We have a group of staff, and the deputy just referenced in terms of realigning the branch, we have a group that we call Monitoring and Evaluation. Their role is to carry out audits on home care service providers. They do the licensing inspections or auditing in the nursing home sector, as well. There's a lot of routine to that that they follow, in terms of looking at what's happening. If we become concerned about a particular area that's maybe not their expertise, where their expertise is mostly around the health services side of things, we are able to ask for financial audits to be done, to go in and look at some of their audit practices, compare the collective agreement to what's actually happening in the work site, and so on. We do have the right to audit, and do so, and do monitor them.

This whole area, as I said, around guaranteed hours is new in this last collective agreement. It's an area that we need to now go back and look at, how was it implemented and what other things are happening here that may be not what we were expecting or that the homes are expecting.

MR. COLWELL: Do you do routine audits on different agencies, financial audits compared to services and dollars that they charge to government?

MR. MENZIES: There are financial audits done. They all have an independent financial audit done, so we rely on their external auditor, but we also ask for certain information to be presented to us in audited form for ourselves. To go right in and actually compare payroll records to what people were assigned to, I'm not sure if we go to that detail, if we have a reason to we will.

MS. DOIRON: On a more informal basis, but also a somewhat effective basis, when the continuing care staff who are out in the field, in the communities, when they are doing the assessments to determine what services are needed by any particular client or household, they are the ones who are setting the definition of what services are to be provided. That information, of course, is shared with the patient, the client or the family members - whomever. If there's an expectation to service and it's not being delivered, there is already a relationship between those care coordinators and the people in the communities they're seeing.

The other thing that's done with the system more frequently now than it used to be, is going back into the homes of those clients and reassessing. So there is a continued relationship, and if you have an expectation that you're going to be receiving five hours of care a day from a homemaker and that's not being delivered, that's also another means of basically being able to identify where there are problem areas.

MR. COLWELL: The only problem with that is - and I can tell you that from first-hand experience in dealing with seniors - if you go to a senior and say you're going to get five-hours-a-day care, which they probably need and I don't think the intake process is flawed as far as I can see, but if the home care worker comes and spends two hours a day, they're so scared they're going to lose the two hours a day that they won't

complain. I've seen this over and over and over again. So even when your people go back in, review the case, oh, yes, how's everything going, great, and in the meantime the services aren't being provided, services that should be. In some case - I'm saying some cases - I've seen this first-hand. That really worries me.

Back to the audit process. This is a very important program. Every little bit that we can help seniors, I think, or anyone who's in need of home care, I think is a bonus, and the money that's spent on it is well invested as long as it's spent prudently. I know the department feels the same way. Again, the audit process. This has me a little bit worried, because, indeed, if I had a non-profit organization or someone else had a non-profit organization and knew that they weren't going to be audited very much, and they had trouble with staff, they could juggle things to suit themselves and indeed still get the revenue to come in and still pay their staff. Indeed, the ultimate customer, the person who desperately needs the help, may not be getting the help they need.

I'm really concerned about this audit process, and that should be on a payroll. It should be compared to the hours people are supposed to be on-site, the travel time they have to have, and the travel costs; all those things should be audited, and compared to exactly what's happening. That should be really simple to do, in the process. You should have a formula geared up so that you can do that, very simple to put in place. Do you have anything like that now?

MR. MENZIES: I don't think we have anything that specific, but we can certainly go back and look to see how we satisfy that need so that we have the assurance. I know with one agency, we actually asked their auditor to track all of their processes and tell us how reliable they were in terms of what they were billing us, what they said they were billing versus what they were billing and what we were paying. Those audit results were 99 per cent; there was very little variation or difference. We need to do more of that, for sure.

MR. COLWELL: That's probably the case all across the board. It's just nice to have the reassurance when you're spending the money that that is indeed happening.

MS. DOIRON: We can do that, and there are some that we do. If we have any kind of concern or suspicion or report on a particular agency or home or issue, then we generally will kind of design an audit, not necessarily carried out by our own staff, we might actually - the Department of Finance has an internal auditing group, and we have been calling more on that group to assist us with audits that we want to do as opposed to other people identifying that. They will do it a couple of ways. They will do it directly with their own staff and work with us, or they will work with us to frame it and then they will manage it but outsource it. So we have some of that going on with a couple of issues right now that are related to the nursing home sector. If we know that there's any kind of question about any particular agency, we're quite prepared to do that.

MR. COLWELL: I figured you would be. Again, this may all be groundless, but the process is important to audit. If you can get it audited, you have comfort yourselves as you're maintaining these programs that you're getting maximum return on the dollars we invest. If we're not, the issue is not that we've spent the money so much, but there are seniors out there and other people who aren't getting the care they should have and could have, when you look at the two things. So anything you can save in the process that makes things more efficient, would mean there's better care and better service for the end patient, which is critical in this case.

The other thing is, too, there seems to . . .

MADAM CHAIRMAN: Could we save the next question for round two? Trevor.

MR. TREVOR ZINCK: Thank you for coming to see us today, with this presentation. As a newly-elected MLA, I've had the opportunity on several occasions to deal with seniors who have basically had to use their own life savings to allow them to have care in their home. This is usually long after one of the partners has been diagnosed with 24/7 care, that they've needed that. A lot of times what happens is both individuals, not the one who's ailing but also the partner who is a senior ends up becoming in danger in their own home. I'm just wondering, what's this strategy going to do to bridge that gap in determining the need and level of care, and then the opportunity to have a bed opening up? How is it going to allow that or bridge that gap?

MS. DOIRON: We're at the very front end of developing that strategy, but it is assigned and it is going to go forward. So we can't really, at this point, speak to what detail or what programming will be in that. Certainly, I agree that there has to be something more done to support people who are the caregivers in the home. You're right - with the elderly, it's often the partner, and they're also older and sometimes have chronic illnesses or whatever. If they don't get the effective support, then we have two people requiring care. We've started that off, but it's very early days for it. Keith might want to speak a bit to what some potential approaches might be.

MR. MENZIES: It is very early days with the caregiver strategy and how do we support seniors - all caregivers, not only seniors. It's an area that we're actually beginning to research right now with an expert in the field who is coming back to us with some recommendations of the kinds of things we may need to do. What you may need to do for seniors may be different than what you would do to support a family that has a younger person at home and doing that research and bringing it back to us. The issue, too, is one of awareness - to what extent do some people in the communities realize that there are even any services there and how do you access them? We know we have work to do there, in terms of making the public more generally aware of what the services are. That's not always easy. Like many people, I know I never really pay a lot of attention to something until I need it, and then if I don't really know where to

find it, it can be very frustrating and I just may work along on my own without ever really looking for that support.

We know that what was identified in the strategy is that many Nova Scotians don't know how to access the services we do have, even though they're not as robust as we would like. They don't even know how to access those. So we know we have a lot of work to do around awareness, which then may prevent those situations where families use up all their own resources.

MR. ZINCK: I think it's important because in particular cases I've dealt with, they recognize the fact that home care is available to them but it's of limited time. So, fortunately, some of them have been able to pay for private care out of their own pocket, but now they're going into debt. They're coming to us and saying, this is how the government cares for me, this is how the health care system cares for me. It's a definite burden, along with the fact that usually the partner is another senior who has ailments of their own. I think it's important to ramp that up as much as possible, as well, especially with the aging population.

MS. DOIRON: What we're not likely going to be able to do, though - and some people would like it if it could be done - it's very highly unlikely we're going to be able to provide 24/7 care in the home. That's a little frustrating, I think, for some people as well. They'd like to stay home, but when it gets to that level of care, then at some point we're going to have to talk to the family about the fact that we can provide care but if we can get them in an institution, it's probably going to be like in a nursing home type setting. That transition - and of course most of us have been through it. I know I have with family members, and it's so hard to go through, that acceptance that you're going to have to allow one of your own to go to a facility. That's part of the issue.

Where we should be providing support at home and how we can help caregivers to stay healthy, to be able to be supported in a manner that allows them to continue beyond when some might say I just can't do it anymore, that's what we'll be going after.

MR. ZINCK: Currently, there are several small options operators and some new people interested in opening up some smaller seniors' homes, and that's for seniors who might not need full-blown care, beyond Level 2 care. I'm going to quote something from the community consultation summary on Page 58. It states, "A number of home operators spent thousands of dollars to come up to par. . . . It appeared that inroads have been made with the province to license some of these facilities, but those involved report frustration that nothing seems to be moving, communication is poor at best."

Where does this issue stand with the strategy? Do you intend to incorporate the small options possibilities and work with those applicants? It could be an opportunity, on a smaller plane, to alleviate some of the wait times.

MR. MENZIES: In terms of the new beds that are being built, part of developing the numbers of beds by district, within each health district and county area, we also looked at the size of a lot of those facilities. So we know, for example, if you're talking about a Level 2 nursing home, we don't want to build 10-bed nursing homes, so we'll set a minimum size on that. But the strategy and those bed allocations will also include smaller facilities, like 10-bed RCFs and community-based options. We will be identifying our needs that way. What we'll be doing is looking for providers to respond through an RFP process, if they would like to be the operator of that.

[3:15 p.m.]

MR. ZINCK: One final question, it's a question I have to ask on behalf of one of my colleagues who was elected in June - the member for Shelburne. Upon entering the House, one of his main objectives for that area - many of the debates that have taken place in the House have been around the 30-year, now 31-year planned beds at Bayside Home. I'm just wondering, as he is now - is that on the radar? We've seen some areas named in this strategy. Is it on the radar? I don't need exact times, but those people have been waiting, the plans have been there. That question has to be laid to rest.

MR. MENZIES: It is on the radar. It's more than on the radar, we're working with the group from there. I went and met with the board of the home in Barrington in December, and went back and spoke to council in December, confirming that, very much, it is part of our process and to be in place and built along with the first 826 beds. Those 40 beds - we're talking about the Barrington Passage home, right? Yes, I wanted to be clear on that. Those 40 beds are definitely a commitment that has been made. When we go forward with an RFP, those 40 beds won't be part of it. The commitment is already to that home.

The only patience I've asked for from the board and the community is that where we're building 826 beds - we cannot build, we cannot work with 100 different providers individually. We need to get some process here, so we can move everybody along quickly at the same time and ask them to work along with us on that. The board was a little disappointed, because I'm quoting 2010 as the outside opening time. They're saying, if they can move a little faster, is it okay, and we're saying yes, but please understand the process is first. It's very much in the works.

MR. PATRICK DUNN: Thank you for the presentation. The DoH continues to add resources to existing programs. One program that I'm interested in, due to questions I've received, is the mobile oxygen program. Do you have any information on that, any data? Apparently it was expanded. Is it fully covered, partially covered, is there any cost to the individual, et cetera?

MR. MENZIES: We have a home oxygen program in place and it has been there for many years. One of the initiatives that we identified for this year was to expand it so that they'd have portable oxygen available, as well, for those who would benefit

from having it. We're in the process of finalizing the policy around that. Our contract with the home oxygen providers is expiring at the end of March, and so we'll be including a home oxygen provision in that contract. So it will be available as of April 1st. I just want to ask Susan one quick question around that.

MS. DOIRON: We've had concerns expressed over time about the fact that while the home oxygen was there, people couldn't get out. The portable oxygen component will allow them to do that, if they're well enough to do that. That will be included in the new RFP for the company.

MR. MENZIES: I was just trying to clarify, in terms of your question about a fee for it, the home oxygen program does have fees attached to it for people of certain income, but it would be to the entire program, not just the portable oxygen part. They would only pay one fee - they wouldn't pay a fee for home oxygen and another fee for portable oxygen. It would be one fee, if they had to pay it at all.

MR. DUNN: Dealing with the Continuing Care Bursary Program - I would ask you to expand on that, as far as, is it easy to obtain people to go into that program? Then when you have them, and they complete the program, what's the retention aspect of it?

MR. MENZIES: In terms of access to the program itself, we have approximately $900,000 that we distribute across the province to the home care agencies and the nursing home sector. It's the responsibility of the agency or the home to actually recruit the staff, so they can go out and say, we're looking for staff, we will pay for part of your tuition or most of your tuition and in return, the home, the agency gets a return-for-service agreement, so that when we pay for it, there is an expectation you'll come back and work in that agency or some other agency or home. I don't know that we've looked at retention patterns yet, in terms of how successful that is at keeping people in the system.

MS. DOIRON: We're pretty typically now, with whatever profession we provide bursaries to, requiring a return-of-service agreement. For example, we have been educating lab techs in New Brunswick for some time, and we were getting very few coming back, very few. A few years ago we made some arrangements with New Brunswick to educate a higher number from Nova Scotia, but we also provided bursaries for them with a return-for-service agreement, and it's actually working. So those who are graduating are coming back. I think next year, we start our own program at the new community college.

MR. DUNN: Just one last quick question, dealing with the aging population. I know there have been a lot of studies and so on dealing with the aging population. I've run into a lot of seniors, of course, like most of us, and they want to stay in their own homes, therefore there are a lot of programs that have to be included to make that happen. Is there a particular time when we're going to be facing the crunch time, where

there is going to be so many of our aging population staying at home that it's going to cause problems?

MS. DOIRON: Now.

MR. DUNN: Right now? (Laughter) I was hoping you were going to say 10 to 20 years.

MS. DOIRON: Actually, what's going to happen is that the number of seniors will peak in about 20 years. As we've seen in the school system, when they went through, that's the population that's coming through. One of the realities that we face is in about another 20 years, when we have an increasing aging population. We've been staying pretty consistent, as we have more seniors we still have maybe 5 per cent who ever end up in a nursing home. So that's not proportionately growing, but the numbers are growing. Actually, what we'd like to do with the enhancements in home care is bring that down a bit. That having been said, we will still need those beds for people as the numbers increase.

The other thing that is, of course, happening is that there's a strategy to try to encourage all of us, I guess, but certainly as you go into your senior years, to remain healthier. That could have a major effect, in terms of demand for service within, hopefully less than 20 years.

There are also other realities, for example, that we're seeing now. As the population increases in age, the incidence of certain diseases also increases, like cancer. So, we've been seeing a rising number of cancer cases, largely attributable to a growing aging population. On the other hand, we've also been seeing a lot of success in cancer treatment. So we also have a hugely growing population of people living with cancer for much longer periods, cancer survivors.

This year's budget reflects some of that reality, because we had put in $3 million this year to oncology operations, hopefully to annualize to $6 million next year. Oncology drugs have been growing at the rate of 25 per cent per year. So we have been tracking that and trying to give the districts some additional money as that evolved during the year. This year it was put into the budget right at the beginning of the year. We had a program some time ago, maybe half a dozen years or so back, where there was a program that was a demonstration project funded by Health Canada on palliative care that was carried out in the northern regions, which would now be Districts 4, 5 and 6, where in addition to other parts of the program, one of the aspects was the provision of drugs to oncology patients at home, particularly palliative care patients.

The drugs can be so expensive that some patients don't feel they can go home if they have to pay for those drugs. In this year's budget, the dollars were put in to expand that drug coverage throughout the entire province. As we see some of those incidences occurring, while we're doing lots of things on the side of home care and

palliative care, there's other programming in other areas that we're having to look at and adjust as well in order to give appropriate response. Hopefully, some of the work we're doing now, we have a chronic disease prevention strategy, we're now working on a chronic disease management strategy, which hopefully - as we age and get into our middle years and so on, sometimes develop some of those chronic illnesses - if we can start to both prevent them and manage them earlier, will also hopefully have a positive impact on how people live with them as they age. So there's all kinds of things going on around that.

MADAM CHAIRMAN: Len.

MR. LEONARD GOUCHER: I guess I'm one of those people who's going to be on the upward peak as we start moving that way. I'm in a situation right now actually where I have two parents, 88 and 86. My dad is blind, he has cancer; my mom broke her hip and is very immobile, but they're still home. It's the safest place, the best place to keep them if I can. I haven't called on the system at all. It has been me and my family. We're trying to keep them there.

The question - we beat the question around enough, Madam Chairman, I guess - and I am concerned, and you know what, you guys do a great job. I wouldn't want to be in your shoes for all the world. I am concerned about, with the number of seniors coming along - including myself at some point in time, and all of us in this room - how we're going to maintain it, and how we're going to maintain the operation? That really does concern me. The only question I can ask, and I think maybe a member opposite probably asked the question - contracting out - is there any way we can try to free up some of the funds, try to increase the availability of in-home help for seniors as they get older? I haven't touched the system yet, and I hope I don't have to. Is there any possibility, or is there any thought to contracting some of this stuff out - I shouldn't say stuff, some of the work out, to try to help the system?

MS. DOIRON: Contracting care out?

MR. GOUCHER: Or is that something that has to be on a professional basis? This is what I'm wondering. I know we talked about non-profit groups, but are there any other ways to try to boost the system?

MS. DOIRON: Much of the care that we provide to the continuing care and home care system now is actually contracted out. Almost all the nursing care in this province is contracted to VON. Then, all of the home support is all contracted out. We don't directly provide any of those services. I think that we have been working at it, and I think we need to continue to get better, in terms of defining the parameters around contracts and monitoring them and auditing things. I think there's more to be done in the growth of that. I think that, also, the concept of having those things managed within the districts that are closer to the communities is also probably a good thing - not probably, would be a good thing. So I think there are some changes that we can make

or we can redefine the system in ways that will hopefully allow that to work more effectively.

In some ways, when you're contracting out, as well, if you get that contracting process working well, and you have the right kinds of standards and contract parameters and whatever, then you can enter in, as well, to the potential for some competition to impact, I think, both the standards of what is being delivered as well as potentially the cost.

MR. GOUCHER: That's what I was wondering.

MS. DOIRON: That's some of the way we have been thinking. There has been so much to do in this system - to keep getting to the next thing has been probably our biggest challenge. I think that's right thinking. I congratulate you and thank you, because that's a tremendous burden on a family with what you describe your parents are going through. I know there are many people out there who are doing that, which is part of the reason why I think we need to have a caregiver strategy, and we need it to be well known, and hopefully people like your own family will be able to benefit from some of that once we go down the road and consult and get that developed.

MR. GOUCHER: Well, I think we all agree that probably for the system and for everybody involved, the longer we can keep people at home, it's better for the system, it allows us to put resources in other areas where they're needed. I congratulate you on that job.

Can I ask one more quick question? Palliative care. We had a good presentation, actually, yesterday on palliative care. Can you briefly just tell me, are there any areas in the province outside of the northern area where they've had some, are there any other areas where this is going to be expanded into, where there will be help coming? I guess the term they used, everybody deserves a good death, everybody is going to die, and I know it's kind of morbid saying that, but everybody does deserve that. Palliative care is a big lever in that particular effort. Are there other areas where it's going to be expanded?

[3:30 p.m.]

MS. DOIRON: There are other areas where it already is expanded. So there's a variation in the kinds of services when you go from one district to another that actually they are operating. Largely, that has been driven by the kind of model or components of palliative care that that particular community or district has thought was going to be best serving their population. The only area that really had hardly any organized palliative care services was down around the Yarmouth area, and that was addressed in the budget, at least partially addressed two years ago.

There have been a lot of palliative care studies, and so we had all kinds of reports sitting on shelves in this province. Essentially, we took all that, a couple of years ago, and said, well, we need to go beyond that and we need to really create a model that people can work on, and basically do it on a provincial basis. So we have that. That's available. The system understands it and works with it. It's one of those kinds of approaches where every district can look at the model and determine where they have gaps in their system, and then through the business planning process attempt to close some of those gaps, which is exactly what District 2 did two years ago.

We don't have all components of a comprehensive palliative care model in any part of the province, probably - certainly not in all parts of the province. So there is a lot more that could be done. I know that when we meet fairly regularly, and the minister meets with the Nova Scotia Hospice Palliative Care Association and of course there's a lot of work that's done around palliative care with Cancer Care Nova Scotia, so we're in fairly regular contact with those folks, and one of the things they would like us to do is to basically put a palliative care coordinator position in the Department of Health, and preferably one in every district through the province, to kind of be the energy that would be behind facilitating a lot more work at each of those community levels.

We have a lot of requests, somewhat of that type but others as well. We are going to attempt, this coming year, to at least put somebody in the department to start driving and coordinating more of that.

I don't know what your thoughts are, when we're all sitting here, when you're dealing with your own personal situations and for you, you obviously get so many of your constituents coming to you so you get a lot of first-hand knowledge. It's a real question in my mind, and I think in the minds of many of us who are trying to deal with what do we choose to put forward to government - that's about where do we spend dollars. We all know that the health care system is growing at a rate of inflation that's - what? - triple or more than normal inflation is growing. It's like, how do we keep doing that, because there are so many good things that we could do. There are so many more things, good programming, everything that we could do, and part of our dilemma is figuring out how to make the choices.

We have started to really build an ethical framework in the department that will be overlaying things like clinical analysis, scientific analysis, economic analysis and also like values and ethics analyses, to try to help us in making those decisions and helping our decision makers decide where to go.

It's a huge question - if you have only so much money, do you want to put a whole lot more money for the last days of care or do you want to drive a healthier population on the front end? Questions like that are ever-present, so I just throw that out. But at the same time I say that, we have been making some advances in the palliative care field. We understand it a lot better and so do the districts; they're making choices, too. They are saying, do I put in my business plan that palliative care is a

priority this year, or is my priority over here with something else? So we're all struggling with that, but we're continuing to still build a little bit more as we go.

MR. GOUCHER: Madam Chairman, just very quickly, I know that we were discussing this with some folks from palliative care. They were saying that really across Canada there is no real good model. They said that really nobody - they made some advances in a couple of the provinces but nobody really has a good model, but they say that folks here in Nova Scotia are heading in the right direction. I'm very proud of it and anyway, the people who work in palliative care deserve a whole lot of credit. Thank you.

MADAM CHAIRMAN: Thank you. I'd like to ask just a few brief questions. Our vice-chairman is not here today, so I'm going to ask the indulgence of the committee members to stay in the Chair. I'm really conscious of the fact that several members have asked to do a second round of questions, so I'd really appreciate it if you perhaps could briefly respond and I could at least get some points on the record before we move on.

I just want to look briefly at the big picture. I guess one of the advantages of being at my stage of life is that I've seen it all before. Quite frankly, I was surprised to hear we're going to have another caregiver strategy, because I think I've been part of two previously. I'm just wondering what happened to them, because quite frankly - and I think this adds to the cynical attitude that a lot of the public have about politicians and the political process - when study and consultation is used just to delay the known result, which is that we do have to do more, put more money on this, I think it just adds to people's frustration. So I'm just wondering, what happened to the other caregiver strategies and studies that have been done provincially?

MR. MENZIES: I'm glad you asked that, because it gives me a chance to clarify. When I said we were looking at that this year, it is to pull together all of the information we have and say, now this is a service that we should put in place, or these are the options.

When the Continuing Care Strategy was developed it was clearly identified that there had been strategies done before and we need to pull those forward, but now it's getting to the specifics of what do we actually implement. We've been cautioned, we really have to do what works for people, not what looks good to ourselves or whatever, so it's getting that piece. It's not going to be a long, lengthy delay, it's about doing it quickly.

MADAM CHAIRMAN: I'd like to suggest that we need to use a lot of common sense on this. It's my understanding that fewer than 5 per cent of seniors are in nursing homes and believe me, I recognize the problems we're having with the backlog. I mean when you get a community-run, high-quality nursing home like Oakwood Terrace in

my area that's across the street from a hospital and they can't get permission to renovate or expand - again, where's the common sense?

I have no idea if you've done studies to see what percentage of the population are supported through home care, but I don't think I'm out of line in suggesting that the majority of people are families who are supporting their family members entirely by themselves or with some help from friends and neighbours. So it just makes sense to me that we've got to reinforce that support infrastructure there for the family and for the community.

I guess some of the most heart-rending stories that are told to me in my constituency office are families who, to me, are doing absolutely heroic measures to look after either a person with a disability or a chronic condition or someone towards the end of life or a senior who is getting more frail. I'm humbled by the stories they tell me of the sacrifice they are making - women and men giving up paid work in order to stay home with their loved ones and begging for that tiny bit of extra help that's going to allow them to continue to do that.

Why can't we jump in and provide that support? We know what's needed. I don't think looking at best practices - I'm pleased to hear it is going to be fast-tracked, but families giving care in this province are in crisis and we have to react quickly - yesterday.

MS. DOIRON: I think we feel the same kind of sense of urgency as you do. We now have permission to go out and do a lot of things we didn't have permission to do before, with the expectation that we'll have the funding to do it. Basically I think we've become quite a bit more effective. We don't want to do work to simply delay things or to put things on shelves. What we're trying to do is when we're doing work, that we carry it directly from whatever needs to be defined right through to an implementation plan. Sometimes we've done that and been stopped by whatever decision making of the day has occurred, but mostly we've been doing that work now on a basis where if we keep our decision makers informed as we go, and they know at the beginning that there are going to be expectations coming, then they can decide up front whether they want us to go down certain roads or not, and we've been given permission to go down a lot of roads in the last years.

We can't respond fast enough through how much work can get done as quickly as possible, to when we could get staffing available, et cetera, because we have a lot more that needs to happen across this Continuing Care Strategy but also, as we heard today, we need more things done in primary health care development. We need more things done in mental health. Basically what we've taken as staff and leaders in the Department of Health is, we think our priority program areas - even though everything else has to keep going - our priority areas are: continuing care, primary health care and mental health. That's where we see the greatest gaps and the greatest needs to keep going.

Where we are getting more effective, in terms of as soon a we get permission to move anything, to translate it into an action plan and get it implemented. So it does take time.

One of the things I think that's frustrating for us, probably, as well as people out in the system and people who need services, is that there's a certain extent, I think, with any program deliverer, whether it's government or not, there is a certain amount of parameters, I guess, that you put around what service you give and what you fund. To have something that would be loose enough that you could say, oh here's a need over here but we don't really have anything designed, we don't have any policy around that, we don't have any program definition or whatever, but we're just going to have like a cache of money so that even if it's not a defined program, we could go out and kind of help.

There's got to be a balance, I think, in terms of what level of flexibility can we bring to response and where do we have to then also be, particularly in the government, accountable relative to the public purse and what we're asking taxpayers to do. We are held, as you know, to a pretty high level of accountability about how we define, how we manage and are we delivering within the parameters of what we set up to do, et cetera. So there's a pull and tug there all the time and we're continually trying to work with that, to say, how do we redefine this in a way that can be more responsive?

MADAM CHAIRMAN: Well, I guess I would suggest we should learn from our own experience, because 15 or 20 years ago we had the Coordinated Home Care Program in this province and in some districts or regions - I can't remember which phase of health reform that was in - some of it worked extremely well. It was very client-focused, very flexible. So for a senior, for example, a homemaker might go in and do the spring cleaning or the annual cleaning, move things around.

There was an ability - there was some funding available at the regional level to start volunteer services to fill in some of the gaps. It seemed to be a more comprehensive, integrated system than we have now. I think in some ways we've thrown out the baby with the bathwater. Some of it worked very well and now we have homemakers who can only dust, they don't move furniture and they don't prepare meals. They will heat, if a family member has prepared the meal. It seems to be a very superficial level of help, compared to what it used to be.

Believe me, I understand some of the complexities and challenges the department is working with, but we all serve the general public. When you hear how wide the gaps are growing, in terms of home care and support and respite for family caregivers, sometimes you have to wonder if we really are going in the right direction. So thank you very much.

Now we'll go into round two, but I suggest one question per member. So far I have Dave, Keith and Leo on the list. One question.

MR. DAVID WILSON (Sackville-Cobequid): One question, that's going to be tough. I'm glad to see that the deputy is saying she has the permission to go forward now. That's an important thing and you're very diplomatic in your answer to that. We all know it's because of the lack of priorities in home care from government to allow you to continue on.

[3:45 p.m.]

One of the things I want to see, and I hope that it's happening, is the choices that you are going to make, which you have indicated earlier, are based on the needs of the community and the needs of the seniors and the needs of the people of rural Nova Scotia and urban Nova Scotia. I know Mr. Menzies mentioned earlier to a question I asked around how you came up with this list, and I believe it was a committee or a group of individuals who used whatever avenue they had and evidence they had to come up with it.

Is that list - with one question, it's tough - with that list, who has final approval? What I want to ensure is that this, as I said earlier, is a needs-based list and not a political list. We all know how around elections we hear the commitments to nursing homes and all those. So I want to know, if you can provide it, is there a list that this committee had that you could provide to the public, to myself, and is it the same list that we're going to see when construction starts over the next couple of years? I guess in one question.

MS. DOIRON: Yes, we can provide the list that's in the full report and give you more information on that. What I can tell you about this is that when we took it forward, with sort of the 10-year strategy and all the components of it, we did not have anything changed or added. We had some stuff pushed up to the front that we thought was going to make it harder, the front ends busier, to kind of deliver as many of the components, but good.

We did not have any interference with the feedback that came back. That was based on both - we had all through the consultations that were going on, a group of people who were literally providing all the data analysis and looking at all the aspects of information and data that could be offered to the groups that we were consulting, as well as to our staff, and then of course all the feedback and consultation that comes directly from the people in the communities and the agencies or whatever. So we didn't really have interference in that it hasn't changed, really. Most of the work we've done has been that way and I think it's because despite the fact that in the past it used to be - often decisions were made within the time frame of sitting government- we haven't been doing that hardly at all.

When we've done our work well and gone and looked at where we need to go over the next 10 years - seven or 10 or whatever years - and had good evidence behind it and brought it forward, generally it's been pretty well accepted. Now how fast we

can fund it, because particularly these plans are multi-year plans, you can't make the changes all at once if somebody told you to go do it. So with the mental health area, with public health, with primary health care, continuing care, we have good visions, plans, action plans, things drawn out and we're incrementally working toward filling those gaps and so this stayed intact.

MADAM CHAIRMAN: Thank you. I have Keith, Leo and Ron.

MR. COLWELL: Okay, I'll try to wrap my several questions into one. Actually they are all related.

The other issue with the home care workers, and I think the home care workers who provide the care in the home do an excellent job, that's not the issue. The issue is whether they're working enough on-site and the province is paying for actual on-site work and associated travel or whatever goes with that. The other issue I have is in rural areas there is a tremendous amount of time spent on the road, travelling an hour here and they spend a hour on the road and an hour here, back over here. I think it is very poor coordination and it goes right back to the management of the organizations that I think should be audited, really think should be audited, and it doesn't give enough time with the people who need the care.

It is an issue, it's a multi-purpose issue. I would say the question would be, number one, it appears that the management process in the organizations that do this is lacking because in a normal business atmosphere this just wouldn't happen. You wouldn't have people on the road more than they're actually working, so that doesn't make sense. At the same time it is not giving the care to the people who really need the care, so we're losing both ways. It is not fair to the workers either because travelling in the wintertime is not fair - you can get in an accident pretty easily and it costs more for insurance and everything else that goes with that.

Is there a standard that's tied into that, of the number of hours that people have to actually provide care, as compared to travelling? If there was an RFP put out, that would be one issue that should be addressed.

MR. MENZIES: I can't answer that question, I don't know that we do have a standard there. We can go back and look at that and actually you're identifying some very specific concerns. I'd probably like to talk to you at some point outside and get to more specifics.

MR. COLWELL: This is not specifically the one case, this is in general that it is happening.

MR. MENZIES: No, we're seeing that generally, yes.

MR. COLWELL: I hear it over and over again from all different people.

MS. DOIRON: I think there are some models that we can look at as well. I know when I first came into the province six years ago, that it was very difficult to get an understanding of what we were doing in home care. I kept asking questions and I wasn't getting the right answers, if I was getting answers at all. Then I figured out that basically what had happened when home care started up in this province, it tended to start up at the municipal level and every home care office that started up kind of made its own rules and kept their statistics or their finances, whatever way they decided to do it.

When it was finally sent over to the provincial government, there was no way to collect anything or roll anything up. We had to literally start back from the beginning, redesign what we would look for in terms of statistics and finances, teach the system and then start to collect it. Even that took a fair bit of time.

Prior to that we couldn't even look at anything that would tell us, is the right budget over here versus here? Does this group have a surplus or how do we move things around to where we really need to put it - stuff like that. So every time we turn over another rock, there are those kinds of major things to do. One of the things we have not completed our work in is that whole arena of standards and how you would actually define a contract or an RFP, if you went after it, but we've been working toward it and we're getting there but we have not completed that work yet and I think we do need to complete it. Then we'll be in a position to fully address those kinds of questions.

Now we do have some information so, as Keith said, maybe you can get together and figure out how we could satisfy some of that inquiry.

MR. COLWELL: Just one quick last topic . . .

MADAM CHAIRMAN: I'm sorry, we're not going to have the time to do a closing presentation if we don't move on, I apologize. Leo.

MR. GLAVINE: Just very quickly, we also have Nova Scotians who want to be part of the solution, of course, as well to home care. I have one gentleman because this kind of maybe typifies and profiles others, he has been looking after his wife - it is either MS or Lou Gehrig's. He left the military early to do this and this has been his labour of love, if you wish, and a very close relationship with his wife. He has been giving her all that kind of personal care that she needs. He had an assessment done just recently and it would cost $3,653 to deliver monthly care through home care. He is prepared to do that for one-third the cost and have the money to enhance their quality of life because where he left the service early, he doesn't get a big pension.

Is there room for that kind of flexibility, where it is perfectly documented, you know the people from your department can see the history, the revenues, et cetera? He would like to continue to do this but in order to help with the quality of life, he feels he needs now to try to get a few hours of extra work by having somebody come in to take

care. She's a person not really comfortable with other people. Just as an observation, I guess.

MR. MENZIES: Well we have the self-managed care program now. I don't know whether she would be able to act as a self-manager with his support, which would allow so that could be explored - that avenue. We know that the self-managed care program we have is only the beginning of what many Nova Scotians have told us that they would like to see in place, the examples being a person whose spouse has dementia and they'd like to be able to manage the care for that person, hire the workers and oversee them and everything and manage the payment. That's the direction we know we need to go but that program is not in place at this time.

MADAM CHAIRMAN: Thank you. Ron.

HON. RONALD CHISHOLM: Thank you very much, Madam Chairman. Just very quickly, most of the things I was thinking about to ask were already asked, about the oxygen, that sort of thing.

Just to go along with my colleague from Preston and Madam Chair on the home care, I know in my riding I get probably two or three calls a week on home care issues. There's a recent study not too long ago where Canadian seniors were polled and the most pressing issue for them was the house care, to get them to stay in the homes. That's an issue that I get all the time. I agree with Mr. Colwell, back I guess when I was on the old municipal - services were provided there. I think at that time in the District of St. Mary's, we were only a small municipal unit, we had one supervisor and probably five or six workers that provided the program. They did the housework, they did all that sort of thing and now it seems that is gone. I think you alluded to, Madam Chair, that they don't do any housework, they may do dusting. There is a lot of people in my riding from East Ship Harbour right through Canso to Mulgrave that are seniors that stay in their home, they want to stay in their home. They don't want to go to a nursing home. I think the more we can do to keep them in their homes, the better off they are, the better off the system is as well.

Anyway, having said that, just to follow-up on what my colleagues have said, I think this is an issue that has to be dealt with and I hope it can be dealt with.

The other avenue, on the oxygen thing, is that the first of April you said that that was going to . . .

MR. MENZIES: We expect to have that in place by the beginning of April, yes.

MR. CHISHOLM: I have a few clients in my riding who are looking very much forward to certainly having that service provided. They travel to Antigonish from Country Harbour in Guysborough County to a doctor's appointment and have to take

an oxygen bottle to carry along with them and may not last the whole trip but have to get another bottle to get back home.

MADAM CHAIRMAN: Thank you. We do recognize that continuing care is an important part of your work and I think we do appreciate the competing interests and pressures on the decisions and resources that you have. Obviously there is a lot of interest around the table because it hits people - any gaps in service really hit people at a vulnerable stage of their life, as you well know. I am just wondering, do you want to take a couple of minutes and sort of wrap or add anything to the discussion?

MS. DOIRON: I don't think too much time except that I think we feel for the first time, I think probably in the time that Keith and I and some others have been in the department, that we have a chance to approach this in a more comprehensive way. It will take us some time to get that into the delivery system and we can't do it fast enough. I think it is approaching a much more satisfactory kind of mode of service to people at a much sort of more considerate level of what needs to take place at the community level.

The other thing is that I want to emphasize again that while there is a lot of care and service that is required, there is much also that communities can do to enable themselves. We want to be part of kind of stimulating that. Good examples of things across the province, like in the Annapolis Valley, for example, people from the system, volunteers and others, brought themselves together around supporting an approach to transportation for seniors. It is sometimes something that is simple that allows somebody, if they can get a drive to the doctor and back, a drive to get groceries and back, that will enable people to stay home longer sometimes.

So we want to work with all those kinds of levels of help and service provision. So I think that when you are back in your own communities, that there is much of that which can be encouraged and prompted, and we will do whatever we can to try and enable people to kind of be part of how we can all serve others better.

MADAM CHAIRMAN: Thank you very much. We certainly appreciate all of you taking so much time out of your schedule today to come and meet with us. This is a very important topic.

Just before committee members leave I want to check with you. We talked previously about doing an update on the forum on poverty. I am just wondering if the date of Thursday, February 15th, is agreeable to the committee. That would be both morning and afternoon.

If you cannot be there, could you arrange to have a replacement. This is a very important issue and we do want to continue moving forward on it. Yes.

MR. COLWELL: You said all day?

MADAM CHAIRMAN: Yes, it is. Yes, 9:00 a.m. to 12:00 noon and then 1:30 p.m. to 4:00 p.m. Okay, so we have consensus that we will go ahead with the February 15th. Thank you very much.

The meeting is adjourned.

[The meeting adjourned at 4:01 p.m.]