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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, May 23, 2012

LEGISLATIVE CHAMBER

Capital District Health Authority
Nursing Staff Overtime Costs

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Public Accounts Committee

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[Ms. Kelly Regan replaced Hon. Manning MacDonald]
[Hon. Christopher d'Entremont replaced Mr. Chuck Porter]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Capital District Health Authority

Ms. Chris Power, President & CEO
Ms. Amanda Whitewood, Vice-President, Sustainability & CFO
Ms. Kathy MacNeil, Vice-President, People
Ms. Vickie Sullivan, Health Services Director

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, MAY 23, 2012

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Hon. Keith Colwell

VICE-CHAIRMAN
Mr. Howard Epstein

MR. CHAIRMAN: Good morning, I'd like to bring the meeting to order. We'll start with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you very much. I'd like to welcome our guests here this morning. We're anxiously awaiting your comments to start the meeting off, so I'd like to invite you to make your opening comments before we start questioning. Thank you.

MS. CHRIS POWER: Thank you very much and thank you to the members for inviting us here today. We know everyone is very conscious of the cost of providing health care services. Labour costs account for the greatest portion of health spending, by far.

At Capital Health we have a very skilled and dedicated workforce, including nurses, as well as physiotherapists, occupational therapists, personal care workers, social workers, lab technologists, and many others providing high-quality care to the people in this community and, through our specialty services, to people right across the province and the Atlantic Region.

Providing health care is a complex business, both in terms of the needs of the patients we serve and in terms of the coordination required to have the right group of people with the right mix of skills, to meet the demand for care at any given time. We look to historic patterns of use when planning our services and staffing levels but the day-to-day range in demand - how many people will require emergency care, surgery, or hospital admission at any particular time - is really wide.

Similarly, there are patterns in sick time use among our staff but it is difficult to plan ahead for illnesses that keep nurses and others from their scheduled shifts. We depend on the ability to have our specialized employees be able to work overtime hours, as required, based on surges in patient needs or staff shortages due to illness. We want to thank those dedicated staff who are flexible enough in their lives to respond to our needs as an employer, and most importantly to the needs of our patients, by working additional shifts when we have no other alternatives.

We know this is a costly way to meet needs and we are having success in reducing the use of overtime. Over the last three years both our use of overtime hours and the amount we have spent on overtime have been reduced by approximately 30 per cent. While we intend to continue to reduce the use of overtime hours, future financial savings will not be as large. Overtime costs are tied to wages, which are increasing every year.

This year about 71 per cent of our nursing staff will work some overtime. Of those working overtime, two-thirds worked fewer than 25 hours of overtime during the year. The projected cost of nursing overtime for 2012 is about $6.5 million.

There are three key ways we are working to contain and reduce our dependence on overtime. These are: consistent scheduling practices; the use of information technology for better real-time data to improve management decision making; and looking at different staffing models, such as the creation of a nursing resource team or specialized nursing staff available to be deployed as needed.

To compare Capital Health to other jurisdictions, we can look at the percentage of all hours worked that are overtime hours. As of February 2012, the rate at Capital Health was 1.3 per cent. The most recent national benchmark is 2 per cent from 2011. As we continue to carefully manage our staffing and take advantage of technology, we expect to see some further reductions of overtime use although, as we have noted, the ability to reduce costs is levelling off as basic wages increase.

At Capital Health we provide services through nine hospitals as well as dozens of community-based locations across the region. We serve the 400,000 residents of Halifax Region and West Hants, and provide specialist services to the rest of Nova Scotia and Atlantic Canada. We support care across Nova Scotia, so we have a key role in responding to crises around the province and caring for the most seriously ill wherever they may live. As an example, our Multi-Organ Transplant Program serves all of Atlantic Canada. The

opportunity to retrieve organs from donors can't be predicted and it can't be passed up, although it pulls on the resources of the whole hospital system.

Demand for our services is growing. It's insatiable. In the fiscal year that ended in March we performed 400 more surgeries than the year before or 1,000 more than we performed two years previous. Visits to the QEII emergency department, as an example, reached an all-time high last summer and have been up year over year for several years. While overall demand continues to climb steadily, day-to-day volumes can't be predicted. We need to staff based on typical demand rather than the worst-case scenario, but maintain the flexibility to respond when there are surges in volume or the seriousness of patients' illnesses. It's a matter of being efficient with our resources while providing quality, safe care.

Our present workforce includes just under 3,500 registered nurses and licensed practical nurses. It's important to note that because of the level of specialized care that we provide, we are not able to deploy any nurse to any vacant shift. We have an experienced and skilled workforce. When, for instance, we need to fill a shift in an intensive care unit, we would need to fill the shift with a nurse with the high skill level required to work in that setting. These are specialty positions mainly filled with senior staff at the top of the pay scale.

Our operating budget to meet increasing demand is not growing. To accommodate cost pressures due to wage increases and inflation, we are working on operational changes that would save about $15 million in the current fiscal year. Due to these constraints, our ability to hire new nurses has been limited. We have been eliminating vacant positions, including nursing positions, over the last two years due to fiscal constraints so fewer jobs have been available to new graduates. To be most efficient we want to have registered nurses doing the work that only they can do and not diverted to tasks that could be accomplished by others on the health care team. Throughout Capital Health, wherever possible, we are looking at what providers are best able to perform certain aspects of care according to the settings where they work and the range of skills of their professions.

Care teams organize tasks as a collective among registered nurses, licensed practical nurses, and care team assistants to best meet patient needs rather than be confined by their traditional position descriptions. That's an industrious approach, stemming from the best of intentions. What we would rather see, and the direction that we are taking with the work that we're doing, would be having the right mix of people in each work setting working to their full, appropriate capacity so that nurses can provide leadership to the team and trust their colleagues are in place to address other needs that patients and families may identify. Quality and patient safety are ensured by having the most appropriate care provider perform the most appropriate tasks to commit to the safest care possible.

Scheduling staff throughout our hospitals has largely been done with pen and paper until now - a cumbersome and time-consuming process repeated unit by unit across our

hospitals. However, with support from the Department of Health and Wellness Change and Innovation Fund, we are putting into place software called Kronos that helps to schedule working hours accurately and ensures consistent implementation across units. Improved staff scheduling flexibility and control ensures that individuals with the right skills are in the right place to meet critical needs. This software will help with planning and forecasting staffing needs. The data analysis tools and real-time reports will allow us to respond quickly to human resource and labour situations and even help avoid them through advanced human resource planning.

Another new province-wide information technology application supported by that innovation fund is the Bed Utilization Management Program, we know it as BUMP, planned to be operational, province-wide, by the end of this year. This will help give a better picture of how beds are used throughout the health care system. This software will assist in identifying when and where beds are ready or becoming available and provide better insight into the factors showing the flow of patients through the system. Information like this will assist us in using resources more efficiently and planning our staffing more effectively.

We need to acknowledge unit managers and charge nurses for their significant roles in the overtime reductions we've already seen. Their careful oversight and work to match staff resources to patient needs has been critical as we strive to maintain a high standard of care while balancing the pressures of volume and finances. I want to thank them for their work.

Filling a shift using staff as overtime is a last resort. Before taking that step, a charge nurse or unit manager would consider the patients in the unit at the time and whether the staffing complement can safely meet their needs. Other options that would be pursued before bringing in staff on overtime include shifting staff already working in other areas to cover a shortage, bringing in part-time or casual employees, or staff of third party agencies. While our overtime use has been dropping, our use of third party services has stayed relatively consistent over the last three years, projected to be about $2.6 million for fiscal 2012.

There are also other circumstances that can result in staff being paid overtime, according to the terms of their collective agreements, such as a change in schedule with little notice. Again, with better tools and information to assist with scheduling, we hope we are better able to avoid instances like these in the future as well.

Once again I thank members of the committee for their interest in this subject. Controlling overtime costs has been an area of focus for us and one we've had significant success in addressing. With our expanding access to new and better information technology tools, we hope to continue this success. Now we will be happy to answer any of your questions. Thank you.

MR. CHAIRMAN: Thank you. Ms. Regan will start the questioning and you have 20 minutes.

MS. KELLY REGAN: Thank you for coming in today to join us to speak to this particular issue. I'm wondering if Capital Health District has ever done a nursing resource plan so that we would calculate how many nurses are actually needed for this area.

MS. KATHY MACNEIL: Thank you for the question. We at Capital Health participate in the province-wide resource planning for nursing resources, looking at what the whole system needs. As Chris mentioned in the opening comments, we do provide specialized services at Capital Health that may be unique compared to other areas in the province. We also understand that any needs we have at Capital Health also impact the rest of the system so we feel our planning needs to be done as a system and we participate with the other members of the system, also with our colleagues at Department of Health and Wellness to look at our projected needs, going forward for nursing resources, both RNs and LPNs.

MS. REGAN: I would take from that there has not been one done specifically for Capital Health? There has been a province-wide one done but not for Capital Health?

MS. KATHY MACNEIL: That's correct. We did do some projection work for Capital Health about three years back. One of the things that we are finding as we do some of this planning work for health human resources is it's predicated on some assumptions that may or may not play out to be true. One of those assumptions is looking at the average retirement age and what we're noticing is people are retiring later or not retiring at all. With that assumption it throws off some of those projected numbers that we have been doing. We have not done those projections within the last three years. We have been participating more in the system-wide work that has been happening.

MS. REGAN: So, how many nursing positions are currently vacant for which you're actively recruiting right now?

MS. KATHY MACNEIL: Today we have about 47 positions that are vacant at Capital Health. For the most part those are for registered nurses; we have another 17 for licensed practical nurses. For the most part, those registered nursing positions are in what we would call our special care areas. Those are areas or units that have specialty skills that are required - emergency department, intensive care units, intermediate care units, ORs. We will often find that we have vacancies in some of those areas. Those also happen to be some of the areas where we experience overtime.

MS. REGAN: I think it was yesterday on CareerBeacon, there was a notice for applications: "Pooling Registered Nurses for ORs at Capital Health". It said, "We are pooling applicants for possible future vacancies in our Operating Rooms." Is that standard practice? Is that something new? We haven't noticed it before.

MS. KATHY MACNEIL: We have been doing some work in our operating rooms in terms of efficiencies, working to work more efficiently and effectively with the resources we have. We often have what we would call standing postings. I suspect that particular posting for the ORs would be in conjunction with the work we're doing around our efficiency redesign work.

MS. REGAN: Similarly there is a posting for applicants, ". . . for possible future vacancies in our Emergency Departments." So is it the same kind of thing?

MS. KATHY MACNEIL: Yes, because we know these areas have specialized skill needs we will often proactively keep a posting in place so that we don't have a lag time when we do have people who choose to leave, or also maternity leaves. Eighty-one per cent of our population at Capital Health are female and so we do see a lot of movement with maternity leaves in our age demographic.

MS. REGAN: Earlier when Ms. Power was speaking, she talked about, "To accommodate cost pressures due to wage increases and inflation, we are working on operational changes that would save about $15 million in the current year." Is this part of that to try and get a handle on what you have available or is this just simply being ready when people leave?

MS. KATHY MACNEIL: The proactive nature of the postings would be something that we've tried to do as part of common practice - our business practice. The efficient use of our human resources and some of the work we're doing around overtime reduction is part of the $15 million business planning target that we have this year. Part of the work that we've done - and we've alluded to that, Chris alluded to it in the opening comments - is working with some technology to implement for staff scheduling so that we have some real time data. We can have a better view of where staff are working and when, and what overtime is being accrued in the real time way so we can make better decisions around staff allocation.

MS. REGAN: According to the information that was provided, the total complement of nursing staff is decreasing, is less in fiscal 2012 than in 2011. Is that because of the cost pressures, the wage increases and the need to absorb various increases in other costs?

MS. KATHY MACNEIL: There are a number of factors that would go into those numbers. First of all, we did implement some changes in our business plan last year and in order to minimize the impact of layoffs or staff reductions, we eliminated some vacant positions as a first pass. Some of those vacant positions would have been registered nurses and licensed practical nurse positions. Some other changes we made as part of that business planning process was the reduction of some in-patient bed capacity and there were some nursing positions attached to those in-patient beds as well that would have been reduced.

The third factor that is impacting the total complement numbers that you're seeing would be the work we're doing around models of care. Innovating some models of care would be looking at the type of care provider or - the way teams are configured with the care providers and the skill mix that are available to best meet patient needs. An example of what that might look like is, in a unit that may have been predominantly staffed with registered nurses, we would look to see what is the patient population need and bring in other kinds of care providers, including licensed practical nurses, or care team assistants, to round out that skill mix in that care team. So from a complement perspective, you may see fewer registered nurses but we may have actually added the licensed practical nurses or the care team assistant role.

I know that last year we did add a number of care team assistants to the skill mix at Capital Health, through the models of care work.

MS. REGAN: So I'm assuming this is having a fair impact on graduating nurses coming out. How many new nurses did you hire last year, do you know - graduating nurses, I guess?

MS. KATHY MACNEIL: Last year we hired, I think it was 20 graduate nurses. They were not in permanent, full-time positions. For the most part, they were hired into casual roles, because of exactly the reason that you've pointed out, our complement had changed. That is one of the innovations we're looking at this year, how can we create some capacity to hire some new graduate nurses, knowing that there are special skill needs that, as a new graduate, they need to acquire before they could be deployed to all areas at Capital Health.

We are looking at a concept that University Health Network in Toronto has worked on, called a nursing resource team where we would have a cohort of nurses some of whom would be new graduates, some of whom would be skilled nurses, who would work as a team but be available to be deployed out to units, based on their skill level. We see this as an approach to be able to hire some new graduates, keep them in the province, give them some skills, and also work as an alternative to using other casuals and overtime and the third party agencies.

MS. REGAN: That 20 number, how does that compare to previous years?

MS. KATHY MACNEIL: The year before, I believe, and I could be wrong, I believe that the year before we hired 80 new graduates.

MS. REGAN: Eight zero? So we're talking one-quarter of what we used to hire.

MS. KATHY MACNEIL: Yes.

MS. REGAN: So you must have heard from a lot of graduate nurses who are a little shocked that they have graduated and there is no place for them to work?

MS. KATHY MACNEIL: Yes. I think all of us are feeling that this is not the situation we would want for our new graduates, to find themselves - nor us, as a system. But as I said before, there are a number of factors that play into that, not the least of which is the fact that we have many people who are choosing to stay later in their career, with us, and who are also choosing to come back in casual capacities, after they've retired.

What happens is the positions just are not there. We don't feel it's responsible to make a commitment to people unless we can provide them with that work and the skill - the training and education that goes along with that.

MS. REGAN: Can you give me a figure for how many nurses actually work to age 65?

MS. KATHY MACNEIL: I don't have that number with us. In the package we circulated, we did give you some information around minimum and maximum ages, though. You'll see in that there are a number of nurses who are working beyond age 65. Page 10 and Page 11 kind of speak to the employee age. You'll see on Page 11 the maximum age for active employees in nursing, in terms of regular, full-time, the maximum ages look to be about 68; part-time are up around maximum age. Now this is not average but these would be individuals who would be in the system at the end of their career. These are people, if you look at regular, full-time and part-time, these are people who have not exercised their right to retire, so they are working beyond their retirement age.

MS. REGAN: And I'm assuming that if changes to OAS are implemented, we may, in fact, see more people working longer, which will make it more difficult to get new grads in because people won't be retiring?

MS. KATHY MACNEIL: I won't speculate on that. I know I'll be in that group myself. (Laughter)

MS. REGAN: I didn't think you would. (Laughter) Sort of the age 54 folks and down, I think, are looking at that quite closely.

In terms of surgery cancellation rates, both resource-related and patient-related cancellations are decreasing. Have there been any instances recently where the unavailability of human resources - for example, a nurse - would result in a surgery cancellation? I'm thinking, you know, of a case in my own riding where a woman I know had been waiting quite awhile for surgery for gastrointestinal problems - she was literally prepped and being rolled down the hall - and her surgery was cancelled because one of the surgical team had not shown up.

MS. POWER: We track all cancelled surgeries so I don't have information about a particular case or would know that.

MS. REGAN: No, no.

MS. POWER: But we certainly track and report on that on a monthly basis exactly why patients were cancelled. It would be unusual that we would cancel patients because a surgical team member hadn't shown up unless it was the surgeon, but that would be an unusual situation for us.

MS. REGAN: So it doesn't happen very often?

MS. POWER: Not that I'm aware of. We can certainly track back and look at that but I wouldn't suspect that that's a reason why surgeries are cancelled because we don't have a nurse to be in the room or a technical person. Usually the team is amazing at making that happen.

MS. REGAN: It was one of the surgeons. According to the overview section of the document entitled Nursing OT Cost to hourly rate analysis, one of the challenges noted are the specialty skills required of certain nurses making it impossible to avoid overtime. You need the appropriate bodies in the appropriate places. Is there any particular specialty or unit where the occurrence of overtime is more frequent than any other and, if so, which one and what would be the reasons for that?

MS. KATHY MACNEIL: I guess two examples of where we know we experience higher levels of overtime would be our emergency departments at the QEII and at Dartmouth General. I think there are a number of factors at play there. One is the unpredictable nature of the volume of patients that are seen, that come through the doors at any given time. I think there are also stresses in our emergency department that are created by the number of patients who may have to wait there for extended lengths of time to be able to be placed in-patient beds elsewhere in the hospitals. That presents some stresses, I would say, to the nursing staff in the emergency department who need to provide care to those patients as they await bed placement.

The other complicating factors you've pointed to are the levels of technology and skills required to work in the emergency department with the information technology systems, the equipment. It's not an area that a new graduate, for example, could be placed in easily to find their way and work safely and effectively. So there are a number of factors there that create some pressures in their emergency departments, in particular.

MS. REGAN: It was probably contained in here but I didn't note it. Earlier we were talking about minimizing the impact of layoffs. There were a number of things that were done to do that and one of them was to close some beds. Can you tell me how many beds were closed in Capital Health to minimize that?

MS. KATHY MACNEIL: I'll start this one and I may ask Vickie actually because Vickie has led many of the initiatives for our business plan. Last year, so it would have been fiscal 2011-12, we actually redistributed patients - that is the best way to describe how we did it - from one unit at the VG site which I believe was 9B, and those patients were situated or placed elsewhere in the organization. So one unit was closed but the employees that worked on 9B were actually moved to other areas of the facility as well. I don't have an exact number of beds at the end of it that ended up being closed, but I think Vickie may have that information.

MS. VICKIE SULLIVAN: Last October we closed 9B at the VG site; 9B, for a variety of reasons, was closed because it's an old facility with a lot of issues, particularly around heat. The patients who were being cared for in that particular area were general surgery patients, who are extremely heavy patients and for both staff and patients, a decision was made to close that particular unit. There were 26 general surgery beds, of which those 26 general surgery beds have actually been redistributed at the VG site. What we've done, for example, on one of our in-patient units, 3B, we had closed beds and those beds were being used as offices. They were actually turned back into beds, so what we did was we maximized the capacity on other units that physically - and certainly from an air control perspective - we're a lot more suitable for patient care and staff, so they've been all redistributed.

MS. POWER: Just to add to that, our long-term strategy is to vacate the Victoria General Hospital, as I'm sure you are aware. So as part of our strategy, we continue to look at how we can move patients out of that unsatisfactory and sometimes unsafe environment into a better one and so that was all part of the work that we were doing.

MS. REGAN: I just want to be clear, when we were talking about minimizing the impact of layoffs, the reduction of in-patient bed capacity, in fact, did that result in layoffs among nurses or were they redistributed among other units?

MS. KATHY MACNEIL: You are right. For the most part they were redistributed among other units. What that would have done is filled other vacancies that might have been created in other units, so those positions would not have been available to be posted and filled by new hires.

MS. REGAN: Thank you for clarifying that for me. The overview outlines that the report produced breaks down a number of hours that were paid at overtime rates as opposed to the total dollar amount paid out in compensation for the overtime hours worked. Despite the challenges associated with the comparisons, any idea how much was . . .

MR. CHAIRMAN: Order, please. Unfortunately, Ms. Regan, your time has expired. Mr. d'Entremont.

HON. CHRISTOPHER D'ENTREMONT: It's a pleasure to spend a few moments. I thank the folks with Capital Health for being here today. Ms. Power, it's always good to see you. I apologize for being a little late. I missed the beginning of your presentation. I did have a quick look at it as I was waiting. I was meeting with some physician assistant people, another interesting allied health professional that we might be able to have here in Nova Scotia, but let's talk about the issue at hand. I am going to talk about the nurse overtime issue as laid out. I'd also like to talk a little bit about the negotiation that we just finished up or at least is still ongoing with Local 42, if that's okay with you, for just a few moments. I know they go together a little bit because we are going to be talking about increased costs for staffing within the district.

My first question is, 76 per cent - and this is in the report - of the RN staff, working overtime, are paid at the two highest rates of pay. Eighty per cent of LPN overtime goes to the highest pay grade of LPN. In the staff scheduling process there are eight steps to avoid a situation where overtime is needed. If it is necessary for overtime to occur, how come the highest paid are claiming the majority of the overtime shifts? I think it goes a little bit to the ER answer. I know it's a big question so take some time.

MS. KATHY MACNEIL: Thank you for the question. It's interesting, if we look at that graph in its own isolation, it does look like the people who are at the highest rates of pay are working the majority of overtime. The reason for that is that most of our - it takes six years to work through these pay grades for a registered nurse - 76 per cent of our nursing staff are in the last two pay grades, so between step six and the 25-year retention increment - those are the last two that you see - so 76 per cent of our employees are in those groups. That's why 71 per cent of them are earning that overtime.

In the licensed practical nurse pay grade there are four steps, so it doesn't take long, as a new graduate, to get to the top of your salary scale; hence that's why the predominant amount of overtime rate is accrued in those higher levels of pay.

MR. D'ENTREMONT: What are the rules around consecutive hours a nurse can care for a patient during a 24-hour period or in a week? We continually hear of nurses being called back and called back, but what is the safe limit of how many hours a week a nurse should be working?

MS. KATHY MACNEIL: Again, unfortunately I'm not a registered nurse and I may ask my colleague registered nurses to answer this. For the most part the College of Registered Nurses has position statements around fatigue management and the consecutive working of overtime. It's my understanding that as a registered nurse there's a shared accountability between the employer and myself in terms of raising a flag when I feel that I may have worked too much, I'm not safe, or I am too tired or compromised in my care.

That said we do follow the provisions in the collective agreement around overtime shifts. We do rotate to the next most senior in offering those shifts as required for overtime,

we comply with the Occupational Health and Safety Act with respect to overtime work, and right now we are working on a fatigue management protocol that would look to have a little more clarity in terms of setting some guidelines where people can have a reference point in terms of measuring their fatigue and their capability to deliver safe and quality care.

MR. D'ENTREMONT: I also think it's not only a situation for the nursing staff itself but it's also, I think, a patient safety issue that you're getting jumbled up in your time, you're getting jumbled up in your patients, and all those things are going on. I know what happens to me when I don't sleep for 24 hours, and I know this continues to happen time and time again for different nurses and different allied health professionals in our system today.

Nursing overtime in 2012 is still about $6.5 million compared to the purchase service cost of about $2.6 million. That's about 2.5 times more spent on overtime than regular hours - how are we going to adjust that? I know you did attack that a little bit in your presentation, but how do we continue to squish that in because it's always an issue of how many full-time staff you have, how many part-time staff you have, and try to work it out that way. So where are we going with that to try to rein that one in?

MS. KATHY MACNEIL: There are a number of initiatives underway to look at that. Just for the purpose of clarity, the purchase service amount that we quote here in the documents, that's a third-party agency support. But in terms of the overtime use or how we allocate overtime, there are a number of things that we have underway this year. The first one, I think, that we are quite excited by the potential for real-time information is the use of the staff scheduling technology.

We had established, in January 2011, what we call a nursing resource office, so centralizing scheduling for the QEII site as a pilot. What we're seeing is when we did that, we realized some efficiencies and some economies because we had some consistent interpretation of the collective agreement. We started to consistently apply the scheduling practices and we had some payroll consistency in terms of how shifts were being coded. There was a significant savings, and actually that was under Vickie Sullivan's leadership.

In extending that to the next step, that office right now is using a Microsoft SharePoint site in order to share information so that managers across the 29 units that it supports can access the information in a timely way. That's almost a homegrown solution. The technology that the Change and Innovation Fund has enabled is a best-practice staff scheduling solution that's used in health care across the country in other jurisdictions that will allow staff to be able to access their schedules on-line from home, make on-line requests to their manager for changes.

Those will be some efficiencies for employees. It will allow managers to see real time data, so patterns of use, patterns of peaks and valleys. It's going to be coupled with our

workload management tool, so they'll work in combination, complementary. As an organization, we'll have a better sense of how we're using the staff and how we can project, as Ms. Regan had suggested, to do better planning for health human resource needs.

We have established a target for this year of around $600,000 to realize more savings in overtime costs with the use of that technology. We're hoping, ourselves, Capital Health, IWK and Cumberland Health Authority are all participating in this innovation fund. We're anticipating that that technology will be implemented by the end of this fiscal year.

MR. D'ENTREMONT: So the technology system that we're using today - I go back to my time of talking about people so often talking about all the other programs that we had across the system that weren't making any sense to anybody, for the most part.

The question is, will it be up for abuse in a way that - I need a couple of extra shifts, would you mind giving me a couple of extra shifts and you call in sick and do all that kind of stuff, or are we going to be able to track it correctly? What kind of snapshots is it going to be giving us? There's a whole bunch of things that you can do to a system that might not give you the data that you need.

MS. KATHY MACNEIL: You are pointing to some anecdotal kind of stories - I call them legends - that people tell around overtime and it gets coupled with sick time, so in full transparency, people do kind of create these things and phenomena that are happening.

We don't have evidence right now to say that is, in fact, true. What we do know is we need to collect better information about how we schedule staff, how they are used when they are there and what the patterns are of that use, so that we can make better management decisions around that and we can create policy and we can work with our employees accordingly.

I think you're pointing to the fact that we'll have a system, we'll have information. The third step of this is we're going to have to use it for decision making and we have every intention of doing that.

MR. D'ENTREMONT: Okay, thank you. I'll move to - I've got 10 minutes gone, it doesn't take long to ask some questions for 20 minutes, so I'm going to maybe go to Chris and whoever else wants to answer it.

During the recent negotiations there was a fairly substantial increase in pay for the Capital Health workers. Some of them, of course, are nurses and other professionals. What is that cost going to be and how is the board going to be able to deal with that increase?

MS. POWER: We don't have the results of that arbitration yet, so we . . .

MR. D'ENTREMONT: You've got a range.

MS. POWER: We've got a range and we speculate. I'll ask Amanda, perhaps, to speak to that, as our CFO.

MR. CHAIRMAN: Ms. Whitewood.

MS. AMANDA WHITEWOOD: Thank you. We do have the cost pressure of the base of one per cent included in our business plan and associated mitigations to deal with that. Over and above that, we don't have a mitigation plan for that and, as you might expect, we are having conversations with our colleagues at the Department of Health and Wellness, in terms of how we go forward, as a system, as a collective, together.

MR. D'ENTREMONT: I know you are talking to the department but is the department necessarily pushing back a little bit, or are they playing the wait-and-see, we will see where the arbitration actually goes and we'll make a decision after that, or are they actually getting you to start doing some mitigation already on your budgets and getting you to cut things back already?

MS. WHITEWOOD: We do have an approved business plan, as you know, so we are actively involved in pursuing all of those savings that have been identified and approved. If we were to go deeper than those items that have been approved, I suspect we would need a formal process to do that. At this point we haven't been engaged in those dialogues.

MR. D'ENTREMONT: If you didn't have the essential services agreement in place, how many surgeries and procedures would have been cancelled throughout? I mean we hear the numbers that because of the possible impending strike that we did have to roll back a whole bunch of services for the time being, but of course that is matching up to the current agreement on essential service. Where could we have gotten had that gone a little further?

MS. POWER: I'll start this and any of my colleagues may want to join in. When we have to go into planning mode for a strike, even if a strike doesn't happen, there's a huge impact on our patients and on our staff and this time was no exception. The agreement that we had with NSGEU was for a very limited number of staff for emergency types of services so that really was for life and limb for our patients. So as you would have read in the paper, a significant number, hundreds, into the thousands of patients were affected and every single day that was the case.

Had we gone into a full strike, we were in effect - our staff weren't out on strike, but we were acting as if we were because we had to. We're a big organization. Every day would have been that number multiplied by each day that we were out, so a significant impact.

MR. D'ENTREMONT: How many - from the nursing standpoint itself - how do you staff, as you started to roll things down, how many staff were being shut down and how many people were being worked out? How many staff did it impact as it rolled around?

MS. SULLIVAN: In terms of our planning, what we did have to do is, at the HI site, we actually closed one of our orthopaedic units and the staff from that particular unit - the nursing staff - were redistributed to other in-patient units at the HI site. At the VG site we actually closed two units. We closed 9A, which is a 30-bed unit, and we closed 3B, which was a 25-bed unit. That was to consolidate staff on the other units to make sure that we had a safe level of staffing to actually provide for the patients who actually required our care.

MR. D'ENTREMONT: In that process - I'm just trying to think back to the time that I was involved in this one - how much work - and I know NSGEU was of course probably a part of it at the table trying to help you figure some of these things out, of where you were going. How was the relationship throughout those negotiations? Did the negotiations go as you had planned?

MS. KATHY MACNEIL: I'm assuming you're asking questions around the emergency services levels.

MR. D'ENTREMONT: Yes.

MS. KATHY MACNEIL: We're fortunate that we have that provision in our collective agreement with NSGEU for nursing and for Local 42 to negotiate the levels that we need for maintenance of life and limb, for emergency services. I would say that we had some good co-operation in negotiating that. We did have an arbitrator help us in some sticky areas where we needed to have some help coming to the numbers that were required. In general, if you roll everything to a cumulative number, we had about 27 per cent of our normal staffing levels were approved through the emergency staffing levels.

MR. D'ENTREMONT: So now we are a few weeks beyond that. How have things gotten back to normal? How are they feeling? Is everything back to normal or are we still seeing a little bit of that repercussion of cancelled surgeries and things?

MS. POWER: It doesn't take us long to get back to normal. The next day we were ramping up and by Monday of that week we were full steam ahead. My understanding is all of the patients who had their surgery postponed or their clinics cancelled or postponed in this process have all been rebooked. Most of the surgeries have been completed and those that haven't, those patients know when they're coming and it will be soon. We are back to as normal as we ever get.

MR. D'ENTREMONT: Going back to nursing - and the one that I enjoyed working on with the district health authorities, which was the nursing model of care - I'm just wondering how many units do you have using a new model of care and what is the learned

information from those now? I've heard different reports whether some of them have worked, some of them haven't, and depending on who you are within that team, or whether it works or not for you - maybe just some over-arching issues on the model of care?

MS. POWER: Okay, I'll start and maybe Vickie might have some comments to add. We have had - 100 per cent of our units have been engaged in the model of care work over this time throughout Capital Health. Have all of them been a success? We've had varying degrees of success and we've had varying degrees of implementation. It remains a work in progress - we are a huge organization and we continue to have this as a priority for our organization. As Kathy mentioned, we've had a lot of changes in our staffing mix in many of our areas and they are working well.

Change is difficult. We have been in, you know, a way of doing business for a long time in the health care world with just some incremental changes in some of our areas. So this takes a lot of work and a lot of continued work. It doesn't happen and then you walk away, this is continual. So I would say it has been a success story for us. It certainly was well worth the investment we put in. It's a tremendous investment because it's about changing the way people work and think, but we still have a long way to go in order to be where we want to be at the end of the day. Anything you would like to add?

MS. SULLIVAN: Yes, just in terms of - I mean, the work we've done has been primarily in the in-patient areas. I think, as Chris had indicated, we have some experience now, years of experience, and some of our areas we are looking at the mix that we put there. Some of that has been driven by the changes in the patient population. Some of it is driven by whether or not we got it right the first time and whether or not we need to revisit the mix of staff we have on that particular unit.

Where we still have work to do is in our ambulatory areas and in many of our areas now we are currently embarking on looking at who are the right care providers to actually have around our patients in our different ambulatory areas.

MR. D'ENTREMONT: Thank you very much because it's always good to hear of projects that have started sometime ago now, to see where they are actually rolling out and, you know, what kind of success we've been seeing in them.

I see my time is getting close to an end. I just want to again thank you for being here. I got double-booked today unfortunately so I'm going to have to fly off to my next meeting but I will leave you with my able colleague, Mr. MacMaster, for the second round of questioning but, again, just to thank you so much for being here today.

MR. CHAIRMAN: Order, please. Your time has expired. Mr. Ramey.

MR. GARY RAMEY: I've been listening with interest to what you've been saying and the word "change" does keep coming up. I'll say something and you tell me if I'm

characterizing it correctly. What I think I've been hearing is that, you know, everything occurs in context and we hear daily on the news - as recently as yesterday yet again - about countries and jurisdictions and states that are in fiscal trouble because they're not managing their finances wisely or they refuse to bite the bullet and do what they need to do.

So would I characterize correctly, some of the challenges that you're facing as trying to work within a reasonable fiscal envelope, having staff that continue to work for longer than perhaps they used to, and the unpredictability of the nature of the work that you're involved in has been three critical factors that have to be considered in trying to get things to work properly? Am I correct on that and if there are others, feel free to add what they are too?

MS. POWER: Well, I would say you're correct in characterizing that those are certainly factors that are influencing the work that we're doing. What we are here to do is care for the people who need us and we want to be sure that our community and our citizens know that we'll be there for them. What we are trying hard to do is to work with our community to share that accountability around health and wellness.

So although we talk about an insatiable demand and the unpredictability of people who continue to come and need our services and we need to be there for them, part of the work that we're doing and we often just go to the in-hospital, the sickest patients because that's where we spend most of our money and our time. But we are really trying to change the face of health care at Capital Health, so a lot of the work that we're doing is to try to keep you and us healthy so you won't need those services.

So, yes, we are in very unpredictable times. We have a high disease burden in this province; we have an insatiable demand on our service. We have a great fiscal record over the last six or seven years of meeting our budget targets and coming in on budget and providing the care our patients need, but it is a juggling act and it is always a work in progress and we are always driving that change that you mentioned to work to best practice and to be the best we can be.

MR. RAMEY: I couldn't agree more with that. I think the best health care plan is one where you don't go to the hospital in the first place - and you've just addressed that and you're absolutely right. I don't envy the task you have. I have to say I think you're doing a remarkable job given the confines you have to work in.

When did you start looking at reducing the amount of overtime that nurses worked, when did that examination take place - how long ago?

MS. POWER: This has been an age-old challenge for us. I'll let Kathy talk more specifically to the last few years that we've been really addressing it. We've been looking at sick time and overtime because there has been a relationship between them for a number of years.

Kathy, maybe you want to speak to specific areas.

MS. KATHY MACNEIL: I think that we saw opportunities to do things quite differently following our H1N1 experience. So 2009-10 were, I think, the years that we shifted. We made some changes and one of those big changes was looking at the nursing resource office as a concept - so centralizing some decision making, centralizing how overtime is allocated and the process. Although there are many steps and, actually, there are multiple off-ramps in those many steps that could avoid overtime - so getting more rigour around that, I would say, since 2009-10.

However, I don't want to leave the impression that this has not been an opportunity that we in the system have not seen and worked on over many years. I think what we understand and what we see in our staffing and with health human resource planning is we have waves. We have waves of time where we have many people and few jobs, and then we have waves of time where there are few people and many jobs. We have to continue to do that dance of recruitment and efficiency management all at the same time.

I would say this past round has been those last two years and I think the numbers we put in the package show some real success in managing the overtime costs over those last two to three years.

MR. RAMEY: Was I correct when I was looking at the information that in terms of overtime we're a bit below the national average? We're 1.3 and the national average is 2 - am I correct on that?

MS. KATHY MACNEIL: Yes, we participate in a national benchmarking exercise, it's called HRBN. There are 70 organizations across the country that participate - about 50 of them are health care. The national average is, as they express overtime as a percentage of total wage costs, their benchmark is 2 per cent. We're, as of February this year, at 1.3 per cent. So we're significantly underneath the national benchmark, and I think that is in no small part due to some of these changes that we've been making.

MR. RAMEY: Maybe you don't want to talk too much about this, I don't know, but do you have a goal that you're trying to get to - do you have a benchmark in your minds here in Nova Scotia that you're trying to reach or are you just quite satisfied in making sure that you're below the Canadian average at this point in time?

MS. KATHY MACNEIL: I think we'll ask Amanda to speak to that one.

MS. WHITEWOOD: As we've been saying this morning, we have been successful in reducing not only the hours of overtime but the actual cost of overtime by approximately 30 per cent over the last three years. Our milestone that was included in our three-year business plan, our target, was a 10 per cent reduction. So it's not often that a system of care

such as ours gets a point to celebrate like this - it’s a huge point of change and success for us.

Having said that, we have a target of approximately $640,000 for this fiscal year, mostly attributed to the new scheduling system that has been mentioned to further reduce overtime. And I think it’s fair to note that the dramatic change we've seen - because we are outperforming the benchmark right now - the dramatic shift that we've seen of 30 per cent over the last years will not continue. That was based on one per cent wage increments and, as we see, wages go up. Even if we do have a further reduction of a small amount of hours going down, we really don't expect this type of quantum to repeat itself going forward.

MR. RAMEY: You touched on something there when you were answering that question that I continue to be interested in, and it has been referenced a couple of times maybe by my colleagues as well. You talked about the staffing project that is in process that will track the hours of employees and so on - Kronos, is that what it is called? Yes. Can you tell us when that project started, how long ago and what the status of it is right now, what part you're at right now?

MS. SULLIVAN: Okay, the staff scheduling project actually began right after H1N1, so December of 2010. I think our experience then told us that we had an opportunity to do things differently and to look at consistent practices across the organization. That actually was an approved business initiative at Capital Health.

Then we had an opportunity to partner with our other colleagues in Nova Scotia, our two other districts, IWK and Cumberland, to actually look at a staffing solution which is electronic. I think it's important to reiterate an electronic scheduling system alone will not produce results - you need some changes in workforce planning, but also in terms of scheduling practices. What we've had, the opportunity at Capital Health over the last year-plus is to actually do those changes and move towards a centralized approach. So the office has actually been functioning since January 2011, and we have put in manual systems and processes and that is when we've been using SharePoint.

In the meantime there had to be an RFP put out for the electronic solution, and Kronos is actually the successful vendor. We are doing the background work now in terms of getting the Kronos system ready, with the plan for implementation late Fall/early winter in the three districts, but I think it's a combination of factors.

What the electronic solution will actually provide us is with that real time data so, as a manager, rather than waiting to get something out the back end in a six-month time frame, we have an ability to get reports on a daily basis - looking at who is coming to work, who is not, and what have you. So it's that real time data that makes it a lot easier for managers to manage in a proactive fashion.

MR. RAMEY: So when you say the three districts, which are you referring to?

MS. SULLIVAN: The pilot with Kronos and with the staff scheduling project was a pilot that involved the three districts, so Capital Health, IWK, and Cumberland are the three early adopters, my understanding is that with a plan for future provincial rollout but a lot of it was dependent on the pilot.

MR. RAMEY: So are you telling me that eventually, all things being equal and if things work out the way we hope they will, that there will eventually be a province-wide system where all the DHAs or whatever will feed information into this system and it will track the staffing for the whole province - am I correct in that?

MS. SULLIVAN: I think Kathy is best to answer that. She has been the provincial lead.

MR. CHAIRMAN: Ms. MacNeil.

MS. KATHY MACNEIL: So we have funding now to implement in those three organizations. The way we are configuring this system is with a view to eventually have the ability to use it across the whole province. We don't have funding to implement it across the province, as we sit here today, and we need to make sure we get it in, we get it working, we make good decisions, we road test it and we prove that the investment was worth it, and then look to what the capacity is at the provincial level to apply it across all the district health authorities and the IWK.

MR. RAMEY: So the pilot you are running with the IWK, Capital Health, and Cumberland, you'll hopefully get the glitches worked out and see if you can tweak it and do that sort of thing and then it would be ready, possibly, if funding is available to put it across the province.

Now in that system, this other program you have called BUMP, the Bed Utilization Mechanism Program, is that also tracked in this same system or is that a separate thing?

MS. KATHY MACNEIL: It is a separate system. It’s a system by the vendor, MedWorks. That is a province-wide implementation that will look at acute care beds across all of the district health authorities and the IWK and really will be a tool that we as a province can use for patient flow and can best help us make decisions around patient placement, returning patients to home hospitals, patients coming into Capital Health for care.

We had a bit of a window into what a province-wide bed utilization process would look like when we implemented an ICU bed dashboard as part of our contingency planning work for the Local 42 negotiations, and we had great co-operation across the province from the district health authorities that had intensive care beds in their footprint and we started the process around coordinating patient placement in ICU. So that was an early view into what that might look like when the whole system is implemented.

MR. RAMEY: Fantastic, that makes total sense to me too. If we know where the beds are and if they are occupied or not, that would seem to me to be very valuable, and getting away from a manual system, the same way you would in any modern business - I mean, most people aren't writing out receipt books, constantly, and doing that sort of thing.

My final question - because I'm going to run out of time and we may not even have time for you to answer it, but I'll throw it out there anyway – and you may not have this information with you today.

The Capital Health District is in a unique position, as I understand it, because we also look after folk from other provinces who have very severe issues and need to come here. How do the other provinces who use our Capital Health Care system - which I'm very pleased that we offer up and everything - how do they pay us or what are the fiscal mechanisms in place for, let's say, people coming from PEI, Newfoundland and Labrador, or New Brunswick, who need to come to Capital District for major issues?

MS. POWER: I'll start and Amanda can fill in any of the blanks. There is an interprovincial rate that is negotiated between all provinces. It really was put in place to contemplate if, for instance, you were on vacation in Ontario, in Toronto, and you fell and broke your leg, that you could go and you'd have your service there and it would be billed back and forth. The difference for us is that we are providing care, routinely, to Atlantic Canadians, so the rates aren't often reflective of what the actual cost is continually. Because of that, we have been working closely with the Department of Health and Wellness who has been looking at the interprovincial rates to be sure that we are recovering the costs.

The costs for in-patient care provided to people outside of Nova Scotia comes back to the Department of Health and Wellness; it does not come into our budget, which causes some interesting issues for us, particularly around things like transplantation where our numbers - we're a victim of our success; we're the best in the country in terms of organ donation now. We are seeing amazing success. It has huge costs and we aren't getting back what it really costs us. We are seeing an effect of that, but there is a mechanism in place and where we have outstanding issues such as, for example, internal defibrillators, we have relationships and special agreements with various provinces to pay to actually cover the cost of those devices.

I don't know, Amanda, if there's anything you want to add that I haven't covered.

MS. WHITEWOOD: Perhaps just to note that as we look forward to more science in the way that we do our nursing staffing and so on, we also look forward to more science in our language around the costs of health care. Part of that is case costing and embarking on that initiative with the support of the Canadian Institute for Health Information.

Right now we are, with the most recent addition of IWK, two of the only sites east of Ontario as designated case-costing sites. You will, over the coming years hear us talk about the full costs of cases – patient costing is also another name for it - that will help us understand things like recoveries from other provinces and what is embedded in our base budgets. It will help us understand our quality of patient care delivery and efficiency compared to other locales, so an important initiative in building on the science that we will also bring to bear with overtime.

MR. RAMEY: I guess this will be my final question; it's a fairly long one but it probably doesn't require a long answer. I've heard lots of people say that if you took all the money that you pay nurses to work overtime and just hired more nurses you could fix a lot of problems. I'm not saying this is the truth, I'm saying it's a common perception. But it seems to me given the unpredictability of health care, which we talked about a little while ago, there will always be the need for a certain amount of overtime and that the nurses working overtime, I think you've already mentioned, many of them have specialized skills, you can't just pop anybody in there. Can you comment on that just briefly, before we run out of time?

MS. KATHY MACNEIL: I think you've almost answered the question for us. That's exactly the issue; as we outlined, a nurse is not a nurse is not a nurse. Because of the specialties, because of the high advanced training, technology in the equipment, and the patient population needs, it would be difficult to hire the people and provide them with regular full-time work, when we really know that we're going to need them in a contingent type of way, on an as-needed basis either to fill absences or to manage the patient care needs that come up in an unpredictable or unplanned way.

So I think you're absolutely right, there will always be an element of overtime, and I will point to some organizations that have tried - in fact, we had the history, many years back, of policy where we refused overtime, or would say no overtime was allowed. We know from a patient care perspective that's not the right way to go either. There are circumstances where we need to ensure that managers and employees can make decisions in real time that best meet patient needs. So there will always be an element of kind of contingent requirements that come up in the moment. What we are trying to do is ensure that we're using that appropriately and effectively so that we have sustainable health human resource.

MR. CHAIRMAN: Order, please. Unfortunately Mr. Ramey's time has expired.

Ms. Regan, we have 14 minutes in the second round.

MS. REGAN: Okay, thank you very much. According to the business plan the district is going to be mitigating about $2 million in costs by maintaining operating rooms at current volume but we heard earlier today that the number of operations has gone up. I'm just wondering, will that not lead to increased wait times for surgeries?

MS. POWER: Thanks, that's a great question. We have been working with our operating rooms on an efficiency process and we have, this year, taken out a significant amount of money and the plan is next year to continue with that efficiency. All of the surgeries that were done this year, the additional surgeries, were done at a cost - when we looked at the overall cost of our operating rooms, we had a reduced cost this year than we did last year. So we are becoming more efficient, we are getting better in terms of our supplies, our contracts that we're having with people. So it's a look at our whole operating process. The intention is certainly not to reduce, we know we've got long waiting lists for many of our surgical procedures, so we're working hard to increase the number of surgeries but at a reduced cost due to efficiencies, contract negotiations, and a number of other initiatives underway.

MS. WHITEWOOD: Maybe I can just add to that. To touch on my earlier comment about case costing, if we look at an area like surgeries where we have growth and volumes, and at the same time we've been reducing their budgets, the cost per case has actually come down at the same time - so, again, another major point of success for the system while quality is still maintained. To give you an idea of that, while the numbers don't seem that significant, they certainly are. In fiscal 2010 our average surgery case cost would have been $2,318; in fiscal 2012 we were looking at $2,234. So if you keep in mind that there's movement in the denominator and numerator, that is a significant shift, so impressive results from our surgery team there.

MS. REGAN: Now the mental health budget indicated - we saw before we left the House - that there were going to be $340,000 in costs mitigated within the existing funding envelope, to meet new pressures. Will this now increase wait times for mental health?

MS. POWER: Our mental health programs are working as everybody else is, to understand what we need to do to mitigate costs within. Our cost envelope is not increasing, so everybody is facing the same challenges, mental health among them, to understand and to put in place processes to care for the patients who are requiring our needs but to really start to look at the processes that we are currently using - are they the best? We look to best practices, is this the best in the country, are there different ways we can be doing business? We have seen some significant changes in our mental health program, as we have in all of our programs.

The last thing we want to do is increase waiting lists for any of our patients but certainly our mental health clients, we know that many of them have very acute needs and immediate needs and our teams are working hard to be sure that we are addressing those.

MS. REGAN: Similarly, we have ambulatory care reduction initiatives. I think one of you spoke to that earlier. The business plan indicates changes will save the district $1 million. Now I'm wondering, we had changes last year in the lab test protocol, 18,083 were not performed, so I'm just wondering what the impact is going to be with the ambulatory care reduction on patients. What are the changes we're talking about?

MS. SULLIVAN: With respect to the ambulatory redesign, I think it is probably a little bit early to comment on the actual impact, from a patient care perspective. What I can tell you, though, is every one of the services and programs are currently looking at the patient populations who are actually visiting the ambulatory areas and examining whether or not that care is care that is required to be provided within the Capital Health facilities. Would it be more appropriate care to be supported or provided in the community and by other health care providers at a different level of cost?

I think it's really examining the services we are providing and where best to provide them. In addition to that, looking at the models of care, we're looking at consolidation of a lot of our ambulatory activities. In fact, we have at the HI site, for example, work began last year, looking at rather than clinics operating in silos, looking at how you better leverage it from a centralized approach, so from a booking perspective, rather than each clinic having a booking clerk, for example, you may be able to leverage opportunities by having a centralized approach. Those are the activities we're really looking at.

MS. REGAN: Thank you, but I think if we're talking about cutting out $1 million from that, it's going to be more than just clerks, having a centralized clerk. There must be some major changes ahead for patients who are in post-surgery.

We have a lot of different indicators here in the business plan that there are a lot of changes ahead. If we look at laboratory services activity and utilization practice changes, saving the district about $2.3 million, that's another big, huge dollar amount that signals to anybody reading a budget that there are big changes coming. So I'm wondering, what are the impacts going to be? Once again, in that particular area, do we know how patients are going to be impacted and, you know, what this is going to mean for them?

MS. SULLIVAN: I think, just to reiterate, in terms of the patient impact, I think it is too early to actually - I believe you're asking for a specific response. I think what we are trying to look at is really looking at where the best place is for those patients to be receiving care and who the appropriate care providers are.

I will add one other comment. In ambulatory areas we also use a lot of supplies and as we have done in the OR, we will be looking and examining our opportunities for leveraging contract efficiencies as well as supply efficiencies by centralizing as well. Those do offer a lot of opportunities for potential savings.

MS. WHITEWOOD: In terms of the overall budget for ambulatory care, although it is a distributed model, we know that our annual spend is in excess of $50 million in ambulatory care. So, unfortunately, you don't have those numbers in front of you when you're looking at an efficiency of $1 million. So we believe it's feasible and also in terms of the patient perspective, a person-centred focus, we hear from our patients that there is duplication in our system and that they don't enjoy that either. So we're working hard to listen to them, to hear their concerns, and to eliminate areas where we do have duplication.

MS. POWER: You're asking great questions based on the budget that's in front of you. You don't take out that kind of money from a system when wages are going up - and we see changes - without there being change. What we have gone into this process, as we have for the last two years, is saying the impact on our patients will be the least it can be and so that is the guiding principle that takes us through every decision that we make. This is about providing safe, appropriate care to our patients. Will patients see a difference? They may.

When you look at the lab utilization budget, for instance, what we know is that tests were being ordered on patients over and over and over again that were required and so when we look at that kind of work on utilization, cutting out somebody having blood work done six times when they only needed it once, is not an impact on the patient. Well, in fact, it is, it is a great impact on a patient for the inconvenience of coming but from a therapeutic perspective or from a treatment perspective, that really wasn't necessary. It may have been that they went to different doctors, it may have been that the physician treating them thought that that was most appropriate to do.

So it's those kinds of initiatives. As Amanda says, there's duplication in the system, we know that. We want to make the experience good for our patients. We want to be sure we're providing safe care. So, will patients have to wait longer? That's not the intent and that's not what we're trying to do in all of the work that we're doing. It may happen to some but that's not how we're moving forward with the work at hand.

MS. REGAN: Actually since we did talk about those blood tests, there were 18,000-plus tests that were not done, correct, and some of those did need to be done. Have you worked out a way to figure out if a test is being performed outside what you consider the norm but the doctor very much feels it needs to be done? Have you worked out a protocol for that now?

MS. POWER: I can't speak to the specific of protocol for that particular test. What I will say is that our laboratories have been going under the same process that we've been working in our operating rooms around efficiencies to match their targets. We know that we can do things differently and better, based on what we see around the country. They've done some amazing work already but we know there's still room to go. All of those factors around utilization which is a big part of the work that's being done in the lab is being looked at.

We want to be there to support physicians in the community and within our health care system and, in fact, around the province because we provide service to the whole province. Part of that is around education - educating our family physicians and others about appropriate tests, about changes in testing, because sometimes changes happen around what's the standard testing. So that's all part and parcel of the work that's happening.

MS. REGAN: There have been rumours floating around that one or more of the blood collection sites is going to close - is that going to happen?

MS. POWER: Is that a blood collection site that Capital Health manages?

MS. REGAN: That would be the one at Bayers Road or St. Margarets Bay.

MS. POWER: I don't believe that we have any decision around Bayers Road for sure. We know that one, but I would say that, as I just mentioned to you, the lab system and the Department of Laboratory Medicine are looking at everything - how do we provide service, where is the most appropriate place to provide that service, and where is our catchment area? I don't have the answer for St. Margarets Bay, but I will say that when we look at these kinds of change initiatives we look at everything that we're doing to be sure we're doing it as efficiently as possible.

MS. REGAN: So therefore are you looking also at the blood collection site at the VG or the Dartmouth General - are those in the mix as well?

MS. POWER: Always; everything we do is always in the mix. We are changing continually. We continually look and evaluate the services we provide. I don't know the details for you about what the lab is looking at, but we would always track the number of people coming into those various collection areas within our organization - is that still the most effective and appropriate place to see those patients? We look at our whole operation on a continual basis.

MS. KATHY MACNEIL: I just wanted to put in - around change the lab is a very good area to point to in terms of the technological change, and so the enablement of change in process that things like technology . . .

MR. CHAIRMAN: Order, please. Ms. Regan's time has expired.

Mr. MacMaster.

MR. ALLAN MACMASTER: Thank you, Mr. Chairman. My first question, I noted that in your presentation, I believe about 25 per cent work greater than 25 overtime hours per year - do any of those people, are they part of the decision- making chain for deciding who gets those hours or is that completely separate?

MS. KATHY MACNEIL: The ability – and I may ask Vickie to kind of walk through more detail if it's required, but we adhere to the provisions in the collective agreement around assigning overtime or offering overtime shifts. It's done in a rotational basis to the next most senior on the list. It doesn't always go back to the top of the list, but where we've left off we go to the next most senior on the list to make the calls to award the next overtime shift.

MR. MACMASTER: Okay. Does the overtime demand come from specialty positions primarily?

MS. KATHY MACNEIL: When I look at the groups of areas that have the most use of overtime, it's predominantly from the emergency departments, our critical care areas that include our ICU and our intermediate care units, and the next one would be our general medicine units.

There has been significant work this year completed in the operating room - the operating room used to have a large use of overtime, but with the efficiency work that has happened there we've reduced a lot of that.

MR. MACMASTER: So primarily the overtime is awarded in a sense - some people might not want to work the extra hours, I guess it's awarded in the sense that people who get first crack will be based on seniority. Have you ever seen any instances of abuse in the system?

MS. KATHY MACNEIL: I would say that there's always unintended consequences to any process, and one of the things I would say rather than use the term "abuse," there are inconsistent practices. I think as long as there is decentralized decision making and people are deferring to their judgement, oftentimes some people can interpret clauses differently and that could then be inconsistent and others might see that as favouritism. Because we've done a lot of work in centralizing that process through the nursing resource office, we really got clarity around consistent process and decision making around overtime.

MR. MACMASTER: It sounds like it's being fixed, but are there any repercussions for the inconsistent practices?

MS. KATHY MACNEIL: We make those changes as we need to go. We always have process around discipline if there are procedural violations or policy violations. It certainly isn't to that degree that we would see that kind of intent around it. It's more that our managers and others are very busy and oftentimes we're making these decisions on the fly. Many times there are incidents of patient care needs that are driving that and we're trying to make the best decision with the information we have at the time. I think all of the things that we have underway from the decision- making process in the central staffing office with the technology and real-time data, that will all lend itself to better decision making.

MR. MACMASTER: And the new information technology that you'll be using will be helpful for the people who are trying to manage that system too. I can imagine it's very complicated - lots of people involved and lots of chaos.

I was just looking at some of the information you had provided us with this morning and I notice that there has been a reduction in the number of overtime hours, but the cost for each overtime hour has gone up. Are there any factors outside of those driven by collective bargaining, overtime rates, those kinds of things, that would be reason for that increase going up per hour?

MS. KATHY MACNEIL: Our overtime rates are directly attached to the wage rates. In the last two years, the wage rates have been contained at 1 per cent increases year over year. This year our NSGEU nurses were awarded a 5.1 per cent increase over the year. That will adjust that overtime rate this year, so the cost - although the hours may go down, the cost may stay the same or go up.

MR. MACMASTER: Do you feel that there has been sort of an inconsistent message from government, going from the 1 per cent per year wage increase rate to what we've just seen in that they're trying to ask you to contain the cost of health care, but now with the recent change in wages that's going to affect your ability to manage the system and continue to contain the cost of the system - do you find there's a mixed message coming from government there?

MS. KATHY MACNEIL: I think the government is trying to balance the needs of the system, the sustainability of the system in the long term, as well as understanding that we have people who work in the system who are trying to pay bills and keep up with the cost of living, and that's always a balance.

The other element that plays into this - from a health human resource planning perspective - is the ability to recruit and retain people over time, and those have costs as well. So it's not simple in managing this in the long term, and trying to keep all those interests in balance, I think, is challenging.

MR. MACMASTER: Do you feel that - we try to make light of it in the Legislature here about people being thrown under the bus, for instance - do you feel like you've been kind of put in a position where you're asked to contain costs, but then that power to contain them is taken away from you?

MS. KATHY MACNEIL: I think we're all being called to leadership in challenging times. There are no simple answers anymore. I think if there were simple answers to these problems, then everybody would be doing the same thing. I know when we look across the country- here in Nova Scotia we're not much different than many other of our partners in other jurisdictions across the country. Health care is the largest expense of the provincial budgets, and it is incumbent on us to do what we can to manage those increasing costs.

Drug costs, technology costs, and labour costs are big cost drivers. So, as leaders, that's our job, to look at how we can best manage those, to try and flatten the curve of

growth that we would see for the long term. I believe that's our job to do, so I don't feel that there's any untoward - it's the work that we've been asked to do and it's the work that we've agreed to do.

MR. MACMASTER: I just sympathize with you because you can't control the demand of work coming into the system from the people who need the health care, and you can't really control the price or the cost of the labour force, but you're asked to try to live within your means. I guess sometimes I feel like you're being put in a position where you're asked to do something but you're not really being given the empowerment to be able to do it, so I sympathize with you there.

Recently we had the lead up to the potential strike - what was the general feeling of your medical staff when surgeries and other procedures were being cancelled during the ramp down?

MR. CHAIRMAN: Ms. Power.

MS. POWER: I will say that this time probably like no other - my background is nursing and so I've worked with medical staff for many, many years - I don't think I've ever seen them rise to the occasion that they did. They stepped into a wonderful leadership role in our organization. They understood that this was a process we needed to go through; we needed to bargain in good faith. We have a collective agreement, we were at the table doing that, but we also needed to prepare our organization in the event of a strike, for safety, and they stepped into that leadership space in a significant way.

There is no question that their work was affected by this, as was everybody's, but I must say that it was a proud moment for all of us as they sat around our table and helped us to bring our organization down and then to help us quickly bring it up in a safe, responsible way.

MR. MACMASTER: There was quite a substantial move from the initial offer made to the final deal that was negotiated - what concessions did your side have to give up in order to secure the best deal for the employees?

MS. KATHY MACNEIL: We went into this round of bargaining with, I guess, the philosophy or principle around efficiency, so again continuing this work that we've done. So we did bring some proposals into bargaining that focused on changes to overtime rates and sick time rates, understanding that those were two particular cost drivers that are currently in the collective agreement. Those are not unique to Capital Health; they are also cost drivers to other employers in the health system in the province.

We didn't move on those items, so we've been left with the provisions in the collective agreement. It's all part of the process of educating and moving forward. We are

confident that we'll continue to work at creating those efficiencies and looking at how we can manage best within the language of the collective agreement.

MR. MACMASTER: Does the wage increase that was offered - and I know that there's always competition for the best health care staff to have in the province - does the increase contribute to the problem where we have other areas of the country comparing themselves to other areas of the country, once a significant raise is given, that becomes the new high-water mark? How do you deal with that?

MS. KATHY MACNEIL: In Nova Scotia we have situated ourselves, strategically, to be pretty much the middle of the pack. There have been some arbitration decisions in the past that have named us as highest in Atlantic Canada or in the Maritimes. The most recent arbitration for the NSGEU nurses positioned them to be the highest in the Maritimes - Newfoundland and Labrador is still higher paid.

The circumstance for Local 42 was a little different. We knew our nurses were behind when we did the comparative across the country. The group of employees represented by Local 42, it's a varied group, a lot of diversity of positions in that bargaining unit, and they were not in the same situation, so they were, relatively speaking, fairly highly paid in the Maritimes. That's why I think you see a little bit of a different wage package on the table there. That's where we try and position ourselves - somewhere in the middle of the pack.

MR. MACMASTER: And the government had been kind of firm in its 1 per cent per year goal in the not-too-distant past - did they give any reason why they were willing to move away from that?

MS. KATHY MACNEIL: I think it is part of the bargaining process.

MR. MACMASTER: So it's something that was behind closed doors?

MS. KATHY MACNEIL: As Chris mentioned, it is part of the process. We start at one place and we end up in different places, and it's both the going back and forth.

MR. MACMASTER: But I guess the government chose to leave that 1 per cent, obviously that was part of the bargaining process.

MS. KATHY MACNEIL: As we went into our business planning, that was the amount that we were including in our business plan for mitigation, yes.

MR. MACMASTER: Would you say there are nursing shortages right now?

MS. KATHY MACNEIL: When we look across the country, I would say there is no province that's experiencing high levels of shortage or extreme vacancies as we may

have seen in the past. That said though, there are definite needs in every province. As I mentioned here, we have, today, almost 50 registered nurse positions posted. As Ms. Regan had pointed out, many of them are proactively posted for a special care area. It's those specialized skills that I think we see that we have a need and are most vulnerable if the people in those areas chose to exercise their retirement options because there are many in that demographic who are eligible to retire.

MR. MACMASTER: What could help to fix that shortage amongst the specialized-skills employees?

MS. KATHY MACNEIL: I think what we're doing is the best we can do. So proactively planning . . .

MR. CHAIRMAN: Order, please. We've run out of time again unfortunately. Mr. MacKinnon.

MR. CLARRIE MACKINNON: Mr. Chairman, I'm going to try to make my questions very short today because I hope to save some time for Mr. Skabar. How helpful has the Change and Innovation Fund been for Capital Health?

MS. POWER: We're in the planning stages, certainly, now but I think it will prove to be extremely helpful for us as we move forward, having the ability to have our scheduling on-line, understanding the utilization of beds throughout the province will be a huge step forward for us as a province in health care.

MR. MACKINNON: Capital Health has gone below the national average in relationship to overtime. How does it compare with the other health authorities in Nova Scotia?

MS. KATHY MACNEIL: The other health authorities that participate in the HRBN, the benchmarking exercise, have a percentage of overtime rate at 1.5 per cent. So we're a little below the provincial average.

MR. MACKINNON: Capital Health has nine hospitals. Which ones have the most overtime and why?

MS. KATHY MACNEIL: I would say the two highest uses of overtime would be the emergency departments at the Halifax Infirmary and the Dartmouth General and primarily those are because the emergency department - I think we've spoken to that already this morning - the unpredictability and the stresses that are in the emergency rooms.

MR. MACKINNON: We have spent the morning talking about nurses' overtime. Is there a difference between the RN overtime in actual overtime rates and LPNs?

MS. KATHY MACNEIL: There is a higher utilization of overtime by RNs than the LPNs. I'm just going to, I have a note here. The RN overtime hours, I think, per employee is about 32 hours per employee and overtime for LPNs is 42, so about 10 hours more in the LPN group.

MR. MACKINNON: There are a lot of people out there who say that overtime dilemmas here and elsewhere could in fact be minimized by the hiring of more nurses. It's not really that simplistic, is it?

MS. KATHY MACNEIL: No, the requirement, the contingent nature of overtime is the difficulty. It's the need to be able to access people with the skills when we need them based on the patient population needs or other needs. So if we were to increase the complement overall, we would then have another inefficiency in our system. It's really about balancing efficient and effective use of those human resources and the patient needs and the contingent nature of when we would need them.

MR. MACKINNON: We have spent, again, most of the morning talking about overtime and we haven't, of course, talked about sick leave. It has been a real concern of mine and Health and Education for a long time. I'm wondering if there's any correlation between those who are using a lot of overtime, or are being called upon, not using, are being called upon for a lot of overtime, is there any study that has been done in the amount of sick leave those individuals are actually using? Somebody who is being overworked, so to speak, may need what they term as "mental health days".

MS. KATHY MACNEIL: Back in 2007 we wondered the same thing so we underwent some research and looked at the group that was working higher numbers of overtime, so I think we've spoken to that 25 per cent number that are over. Now it has gone down to 18 per cent that are over 50 hours per year. We correlated their experience, as individuals, of the sick time and we did not see on an individual level, a relationship. So those who worked high overtime did not have higher use of sick leave.

However, when we aggregated it and looked at a department or a unit, units that had high levels of overtime also had high levels of sick time. So you are absolutely right, there is a relationship at a collective level but at an individual level, there may not be that same relationship.

MR. MACKINNON: Thank you very much. I'll pass the remaining time to Mr. Skabar.

MR. CHAIRMAN: Mr. Skabar.

MR. BRIAN SKABAR: Thank you very much. I've got a couple of my own but I'm kind of intrigued by that one. So it sounds like you've got your chicken and you've got your

egg. Are people taking sick time because they work overtime or are people getting overtime because people in their unit are sick? It sounds like the latter is more likely.

MS. KATHY MACNEIL: This whole issue is a very complex issue. The relationship between overtime and sick time, the numbers of factors that cause people to miss work is complex. Some of the complexities are the fact that it's shift work, 365 days a year, and a predominantly female workforce, a very physical workforce, so there are a number of factors that play into sick leave and why people might not be able to attend work.

I think you're right, what you're pointing to. There could be the use of overtime to fill those absent shifts is a phenomenon that we know to be true.

MR. SKABAR: Now not to belabour the point but it was brought up a couple of times that a number of people seem to think that just by hiring more people full time, that would mitigate the need for overtime and frankly, up until today, I was one of them. So I did learn something today and actually modified my own opinion on that.

That being said, you have roughly 3,500 staff and you're only looking for, I understand, like 57 postings for more staff and many of those are anticipatory. That suggests to me an extremely low rate of turnover, is that the case?

MS. KATHY MACNEIL: Our attrition rate for our nursing staff, as a collective, is around 5.8 per cent, to around 5 per cent attrition, which actually is not a bad indicator. Some of the attrition rates across the country are closer to 10 per cent.

MR. SKABAR: Now the attrition, is that people retiring or again, I believe Mr. MacMaster brought this up, to what extent are we competing with other jurisdictions, with other areas within the province and other provinces? I recall that a number of years back there was an exodus, at least reported, of our nursing staff to the United States, is that still an issue?

MS. KATHY MACNEIL: Again, multiple factors, but I'll go back to attrition which is voluntary separation, so anybody who leaves voluntarily, from resignation to retirement, those are the two big groups that would factor into that rate. There are a number of factors that would influence people to leave. Some of them are workplace related, some of them are personal, some of them are opportunities for advancement.

You'll see that oftentimes and in times like now, where we don't have the positions for full-time, permanent positions to offer new graduates, many of them go to alternate locations in Canada and in the U.S. to find permanent employment.

MR. SKABAR: And this was touched on as well, so when it does come time for a staffing process, for initiative to come, is there a sufficient pool being trained in Nova

Scotia or do we have access to a sufficient pool to meet the needs both current and, well, immediate and mid-range future?

MS. KATHY MACNEIL: Our projections are indicating that yes, there are adequate numbers of registered nurses being trained and licensed practical nurses being trained. The one area of growth that we see in the acute care sector is in what we call our care team assistants. Many of them are coming through community colleges as continuing care assistants. The program was set up for the continuing care sector. Through our models of care work we are developing roles in acute care for the acute care team assistants and we know that as a system that's an area where there's always going to be a need, as we start to shift the model a little bit and develop more people, have more vacancies in those areas, both in the continuing care sector and in acute care.

MR. SKABAR: Cumberland North is in Amherst, basically Amherst is the hospital for the Cumberland North area. When you're recruiting staff do you find it an easier time - I'm thinking, but maybe not - to recruit staff in rural hospitals, or do you have any information on that, any data on that?

MS. KATHY MACNEIL: I'd be speculating and it would be anecdotal. We've had experiences, challenges in recruiting some employees to some of our more rural sites. In particular I'm thinking about Sheet Harbour; we had to do some innovative things to recruit some registered nurses to the community.

In the urban centres it is a little easier because the schools are located here, the graduates have roots here often, they want to stay, they have friends and family often that they've made relationships, they want to stay in the urban centre. There's also a relationship with the university so they have opportunities for continuing education and professional development. The rural/urban challenges can be complex. It does mean that one-size-doesn't-fit-all in terms of a recruiting strategy. We often have to try different things to recruit to rural sites.

MR. SKABAR: Amherst is one thing, but I'm thinking places like Pugwash or Tatamagouche or Springhill would be even more challenging.

As a consequence, many of the rural areas, we're moving into the collaborative emergency care model and I understand from your earlier presentation that the emergency rooms are, by definition, the most unpredictable of areas of how much staff you're going to need, how many accidents are going to happen on any given day. Is there much or any use of nurse practitioners in emergency room care, or any other model for that matter?

MS. POWER: At Capital Health we've used nurse practitioners in many areas throughout our organization and in some of our rural sites we have a nurse practitioner. One of the first in this province, before we ever called it a CEC, had something quite

similar to that in Middle Musquodoboit. In fact, that was held up as a model for the rest of the province where we have a nurse practitioner working.

In our more urban sites, our nurse practitioners tend to be specialists in particular areas like transplantation, dialysis, and different things that we have a significant number of nurse practitioners working throughout. We utilize a paramedic model, as well, and we're one of the first in the country to do that in our emergency department at the QEII and are looking at that in our other areas.

I think the way we're approaching it with CEC and with all of the areas where we work is, who is the most appropriate person to do the work that our patients require? Nurse practitioners are wonderful assets and we're thankful that we have so many of them but there are other care providers, such as advanced care paramedics and others, that I think we need to look at to be sure we have the right people doing the right work.

MR. SKABAR: I have 27 seconds so I would just like to thank you for coming to make this presentation. This is one of the ones - well, many of them I did, but I did learn a few things and, frankly, you were able to change my point of view on a couple of things. Good job, guys, thank you.

MR. CHAIRMAN: Order, please. Time for questions has expired.

Ms. Power, would you like to make any wrap-up comments?

MS. POWER: Thank you very much. Thank you to all of you, your questions were great. We're always thrilled that when we leave people have been educated and have learned new things about our health system. We hope we left with you that we take our stewardship of public funds very seriously. We have been working very hard to be sure that we work within the budget that government has given us, and I think we have a track record to show that, but most importantly, for us, it's about delivering safe quality care and that's what we're all about at Capital Health. This was a good news story for us, our overtime use, and so hopefully you've heard that through us. We will continue to work on it as we do on every efficiency that's before us, so thank you very much for your time.

MR. CHAIRMAN: Thank you very much, your comments have been very informative today and keep up the good work. There were a couple of things asked by Ms. Regan: the number of surgeries cancelled due to staff shortages that you committed to do, and also the number of nurses working in your system, if you could supply that to the clerk we'd appreciate it. She will follow up with a letter anyway asking those specific things.

Next week we are going to meet at 8:30 in the morning as we'll be in lockup and it will be an in camera session with the Auditor General. Unless we have any other business, a motion to adjourn is in order.

MR. MACKINNON: So moved.

MR. CHAIRMAN: We stand adjourned.

[The committee adjourned at 10:56 a.m.]