HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, January 9, 2013

LEGISLATIVE CHAMBER

Department of Health and Wellness
Long-Term Care

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Hon. Keith Colwell, Chairman
Mr. Howard Epstein, Vice-Chairman
Mr. Clarrie MacKinnon
Mr. Gary Ramey
Mr. Mat Whynott
Mr. Brian Skabar
Mr. Andrew Younger
Mr. Chuck Porter
Mr. Allan MacMaster

[Ms. Becky Kent replaced Mr. Brian Skabar]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Mr. Jacques Lapointe
Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara, Deputy Minister
Ms. Ruby Knowles, Executive Director, Continuing Care Program
Ms. Linda Penny, Chief Financial Officer

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, JANUARY 9, 2013

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 call the meeting to order. We're going to start the process with introductions so I'll start with Mr. Ramey.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you very much. I see that Ms. Kent also just joined us.

We'll start with the presentation from Mr. McNamara.

MR. KEVIN MCNAMARA: Thank you very much, Mr. Chairman. Today we are pleased to be here to discuss the good work of the Department of Health and Wellness in serving people who need ongoing care outside of hospital, on either a long-term or short-term basis.

Specifically today we are here to discuss government's response to recommendations on long-term care made by the Auditor General in 2007 and 2011. Both of these audits are very helpful as they identified areas for improvement and, as a result, helped direct our work. As a department, we have worked hard to implement the recommendations of the Auditor General and we are pleased with the progress we've made to date. We have completed a great number of the recommendations and we have made significant progress on others.

As many would know, here in Nova Scotia and across Canada, our population is aging. In fact, in 2011, the baby boom generation has begun to turn 65. A December 2011 report from the Canadian Institute for Health Information showed that while Canadian seniors age 65 and older are living longer and are healthier than ever, they are still frequent users of our health care system. It is important to remember, though, that the overall pressure of aging on the health system is projected at approximately 1 per cent annually increase in cost over the next five years.

By 2031, the CIHI projects that almost 30 per cent of Nova Scotians will be age 65 and over. With that change in demographics, we encounter new health care challenges; specifically, how do we adapt to the health system in order to provide the best possible care for people as they age. Part of this adaptation no doubt has to do with building and replacing long-term care beds. That is why in 2006, government embarked on a Continuing Care Strategy. Under this strategy government committed to creating 1,595 new long-term care beds by 2016. An initial 1,121 beds were planned to be opened by March 2010 and an additional 47 to be open again by 2016.

As you can imagine, building these new beds is no small task. The average construction cost per bed for an RFP nursing home bed is $196,900, based on 2009-10 dollars. A replacement nursing home bed's average construction cost is $370,600 based on 2010-11 dollars; that's almost double, as you can see. In 2012, the average daily gross operating budget for a new RFP nursing home bed is $287 and for replacement beds is $306. That is why I'm very pleased that 987 of the initial 1,121 beds are now open and 13 more are expected to open in the summer. A further 16 new beds have been allocated to facilities, but the forecast occupancy date is yet to be determined. Indeed, Nova Scotia has one of the highest long-term care bed per capita ratios in Canada. I believe we're number two, right behind Manitoba.

Our department will continue to invest in new and replacement nursing homes in communities throughout Nova Scotia. We are, in short, still working to implement the 2006 Continuing Care Strategy. Here in Nova Scotia, many of our continuing care facilities are meeting or exceeding national accreditation standards. Accreditation Canada recently released a report detailing an overview of the accreditation results in Nova Scotia. In this report, it was noted that the standard compliance for long-term care service for the four independent organizations surveyed is higher than the Canadian average for long-term care. But building beds is only part of the solution.

As I stated above, seniors in Canada are healthier than ever and we know from talking to seniors and their families that people want to stay at home as long as possible to achieve care. We also know in some cases, people just need a little additional support to get home from hospital, or enable them to stay in their own facility or own home. It only makes sense, therefore, that we invest in providing these supports. The result is better for the person, better for our health care system and it is also much cheaper to provide. That is why

the province recently announced a $22 million investment to improve and expand home care services for Nova Scotians.

Our department works with district health authorities and almost 200 continuing care providers across the province to deliver the Caregiver Benefit and Supportive Care Programs, Adult Protection, Personal Alert Assistance, HELP - Bed Loan Program, Self-Managed Care, Home Oxygen, home care and long-term care. This $22 million in funding will make home care more affordable, support caregivers, strengthen community solutions and add more care providers across our province.

As part of this investment, we are helping more people get faster access to services like personal care, meal preparation, caregiver respite and housekeeping. Part of the $22 million investment is $2.5 million annually to help about 265 people now waiting for home care support in the Halifax area. An additional $1.5 million over the next two years will ensure Nova Scotians receive home care services and get more support that is better suited for their needs.

Providing financial support to encourage the vital role of caregivers, the Caregiver Benefit offers $400 per month to eligible caregivers to recognize their valuable role in providing care. Through the Supportive Care Program, we provide resources for some clients with cognitive impairments to hire additional support when needed. We changed the home care fee structure to reflect cost of living increases over the past seven years. While pensions like Old Age Security and Guaranteed Income Supplement have increased each year, our fee categories have not been adjusted since 2005. Beginning this year, we adjusted our fee structure annually for inflation to prevent seniors paying more simply because their pensions have increased. Many home care clients who pay fees now pay less for home care, home oxygen and self-managed care.

More low-income Nova Scotians who need services such as Caregiver Benefit, Personal Alert Assistance and Supportive Care now qualify based on these changes to the income levels. We are providing $2 million in funding for district health authorities to develop supports for seniors and low-income individuals who can’t fulfill the instrumental activities of daily living - things like driving, picking up groceries, housework, cooking, yard work and more. This funding will help district health authorities harness local resources, volunteer groups and non-profit organizations, for example, to deliver supports for home care clients. In addition, our 1-800 number is available to all Nova Scotian families seeking information about home care - this number is 1-800-225-7225.

At Health and Wellness we are excited about these recent initiatives in home care and we are gaining kudos from outside organizations as well. On April 20th, the Health Council of Canada released a study on home care in Canada that supported the Canadian Association of Retired Persons’ position on the key role home care and caregiver support play in helping seniors stay at home. The report points to Nova Scotia’s Home Again program as a pilot program worth following.

You will recall that this program provides up to 60 days of intensive home care support to enable clients to return to their homes and receive the care they need instead of remaining in a hospital bed waiting to go to a nursing home. We know most Nova Scotians would prefer to be at home to receive the care they need, that's why we are taking steps to strengthen home care resources and improve accessibility to home care supports across our province. In the coming year, Health and Wellness looks forward to working with our system partners and home care clients to develop and introduce even more ways to help seniors stay in their homes. Our goal is to ensure more Nova Scotians can receive the care they need safely and affordably.

As I mentioned above, in the coming years Nova Scotia will be home to more and more seniors and this is a huge opportunity for our province. Typically, seniors are interested and engaged individuals who have a tremendous amount to contribute. Indeed, 44 per cent of seniors in Nova Scotia volunteer in any number of organizations. As a province we must work to capitalize on our good fortune to be home to so many seniors. It is also important that our seniors receive the appropriate support from our health care system.

Providing the support remains a priority for the Department of Health and Wellness, whether that be through home care services or to the building and replacing of long-term care beds. Thank you.

MR. CHAIRMAN: Thank you. We will start with the first round of questions. Mr. Younger, you have 20 minutes.

MR. ANDREW YOUNGER: Thank you, Mr. McNamara. I guess the 2007 report was never looked at by Public Accounts Committee, it just never happened. As noted by your comments, we are reviewing to some extent both the issues - I guess long-term care in general and also the items that are brought forward in both the two Auditor General Reports. There are a number of areas I want to cover. I want to start by just asking generally about the June 2007 Auditor General's Report.

In the status update that we were provided by your department today, I'm not going to be able to find the page on which it said it, but it notes in the response that the department recognizes many of those recommendations have not been addressed and then the Auditor General's Report goes on to note this time around that there's a feeling that had some of those recommendations been addressed by now, they wouldn't be making all of the recommendations they are making in their 2011 report.

I just wondered if you could give a further update on where your department is in terms of addressing the 2007 recommendations, whether there are any that you simply don't plan to address at all and I guess what the status is of any of the others?

MR. MCNAMARA: The key one that we are addressing is the legislation around the Homes for Special Care Act. As it was noted, this has not been addressed since it was brought forward a fair number of years ago, through a number of governments. When this government came into power, one of the things they asked was to look at all of our legislation which is their responsibility to make sure we move things forward. We started with the Hospitals Act which was some 30-plus years out of date and that was just passed in the last session of the Legislature. As you know, any major piece of legislation requires a lot of work, a lot of consultation.

The next major piece we are working on is the Homes for Special Care Act. Staff have been given the go-ahead to do the work, the consultation, and probably I would say it will be next Fall before all of the consultation will be completed to bring that forward so that is something that is a major piece of work that is being worked on now. As mentioned, our commitment to the Auditor General is to work our way through the numerous recommendations, not only from this report but numerous Auditor General Reports that were never addressed in the past and we're working hard to move from last to first.

MR. YOUNGER: I guess on the legislative side, I would wonder - that recommendation has been around at least since 2007, maybe earlier but let's say 2007 because that's when it came in that report. If the consultation is wrapped up in the Fall of this year, it's almost certain that - obviously none of us know the timing of an election but it's almost certain that by the time the legislation would make it to the floor of the Legislature and then if we look at, I think it was the Hospitals Act or one of the other Acts that we had recently from the Department of Health and Wellness - by the time even if after it has passed the implementation time, you'd actually be past the five-year point of the last June 9th election. That means that you're into a new government, whether it's the same Party or not, so it's almost like a reset again. That takes it six, seven, eight years yet, at the same time, you are replacing long-term care facilities - which is needed, you're trying to address beds and you're trying to address changes that are coming along.

I understand you are also doing the Hospitals Act, but it's also a big department. I'm just wondering why it wasn't able to do that faster.

MR. MCNAMARA: I only have so many staff and particularly in the legislative branch, so I have to prioritize the work that we're going to do and what we're going to do in what order. Quite honestly, if the work had been done under previous governments to make it ready to move forward, it would have been a lot easier. We had to start from scratch and none of those things had been addressed.

MR. YOUNGER: There are a number of areas I want to cover. One of the ones that I think I'll go to now, just because I want to make sure we do have time to get to it - one of the changes that it strikes me you're now going to face that wasn't on the horizon in 2007 are federal changes regarding how they fund long-term beds through Veterans Affairs. It is my understanding that Veterans Affairs has announced that changes will be coming in

terms of how they fund this. I'm wondering, my understanding is there are 341 beds funded to the Department of Health and Wellness by Veterans Affairs currently, is that roughly accurate?

MR. MCNAMARA: The number is approximately correct. They do fund through two ways; one is through beds that are located in a number of existing hospitals. For example, the Veterans Centre in Halifax, Fishermen's Memorial Hospital in Lunenburg and a number of others. There's also some contract beds in existing long-term care facilities. You are correct, they are getting out of the business of funding in the normal way and will be expecting those individuals to participate in the normal long-term care system that we have, if necessary, and they would pay at that time. But they will be getting out of operating their own beds on a contract basis.

At the same time, I should mention that Aboriginal Affairs is also getting out of funding Aboriginals in nursing homes. There are not as many but effective April 1st, we will be picking up the payment of those individuals, as a provincial cost. It's about an additional $2 million, if I'm not mistaken, annually, to the cost to the province.

MR. YOUNGER: Do you know approximately how many beds that would be in Aboriginal Affairs?

MR. MCNAMARA: About a dozen.

MR. YOUNGER: Okay, and that's roughly $2 million. My understanding is that Veterans Affairs is probably about $41 million?

MR. MCNAMARA: That is correct. There's two issues with the Veterans Affairs beds. One is the cost of providing the service; second, because they've been operating in existing hospitals, they contributed to the overhead cost towards those facilities. That's going to be a loss of revenue to the province, in terms of those existing facilities, so we have to look at what we're going to do in the future.

The third thing to recognize is that Veterans Affairs operate their beds at a different standard than we do in Nova Scotia for our long-term care facilities, and they offer different services. So it is going to have an impact on staffing, it is going to have an impact on how we provide those services and we're going to have to look at which of those ones we would convert to long-term care beds or which we may convert to other services, depending, so we have to look at that over the next number of years and decide how we're going to move forward.

MR. YOUNGER: Has your department been in any negotiations with the federal government on how this reduction in veterans, and I guess Aboriginal ones, I was unaware of the Aboriginal cuts, and how that will roll out?

MR. MCNAMARA: Yes, we've had some interesting discussions. On the Aboriginal Affairs, they had mandated that it would occur in the existing fiscal year. I refused to accept that, so we have a date now of April 1st so at least it's in our business plan going forward, rather than happening during the middle of a year.

With Veterans Affairs, we've had a number of meetings to look at timelines to understand what they were trying to do. There is only so much we can do as a department, but we've done our best. We've also made sure it's advanced through IGA and I'm sure there will be a discussion of all Premiers at some point with the federal government.

MR. YOUNGER: So if I understand you correctly, with the beds that were funded by the federal government for Aboriginal Affairs, those will cease to be funded on April 1st of this year, 2013.

MR. MCNAMARA: That is correct.

MR. YOUNGER: Is Veterans Affairs being done the same way or is that a phase-out?

MR. MCNAMARA: It's staged in over a number of years. It's over roughly a five-year period. As the existing veterans that they determined were qualified under the First World War, Second World War, the Korean War, et cetera, the new veterans that are coming on stream will not be afforded those facilities for care.

MR. YOUNGER: So, will the federal government provide funding if you have a veteran from Afghanistan, Cyprus - there are all kinds of conflicts that we've had veterans involved in - will they be provided services that match whatever province they're in, if I'm just a senior and I end up in long-term care?

MR. MCNAMARA: My understanding is that they will provide home care and other services. If they require a nursing home bed, then they will be on the same waiting list for a long-term care bed as an average Nova Scotian and if they do qualify for a bed or get into a bed, then I believe they will be paying for that veteran at that time.

MR. YOUNGER: So what the federal government is doing is moving these future veterans to the general waiting list in Nova Scotia.

MR. MCNAMARA: That is correct.

MR. YOUNGER: And how many people are on that waiting list now?

MR. MCNAMARA: Our provincial waiting list?

MR. YOUNGER: Provincial waiting list, yes.

MR. MCNAMARA: The waiting list we have right now is about 2,400 individuals. One of the difficulties we're struggling with on the waiting list - it's not what I would call a true waiting list - since we've built the new beds, there has been an increase in individuals wanting to get into new facilities first. So even if you looked at facility-by-facility, there's a lot longer waiting list for new facilities versus the existing ones that were there before because people are gravitating to facilities that have a single room and other amenities.

We also know that people become aware that there is a waiting list so they put their name on the list now in case they need it in a couple of years because they know it takes a few years to get there, so we have to go back and rework. That's one of our difficulties with coming up with a secure waiting list that we can publish - it's because we need to understand what a real, true need is.

Also, and Ruby can talk to this better than I - when we've done a profile of the individuals on our long-term care waiting list versus our individuals on the home care waiting list, there is very little difference in the needs. That tells us that the waiting list is probably not appropriate in many cases. There are some true ones, I would admit that, but we don't know the exact number at this point. That's something we have to work our way through.

MR. YOUNGER: I want to ask you a bit more about the waiting lists in a minute so I'll get back to that. Do you know which districts are likely to be the hardest hit by the changes in Veterans Affairs and Aboriginal Affairs?

MR. MCNAMARA: The Aboriginal Affairs, as I mentioned, is a dozen; it is not a big issue province-wide. In terms of veterans, obviously the largest number of beds are in Halifax at the Veterans' Memorial centre. Fishermen's Memorial would have a 22-bed unit, if I remember correctly from my days there.

MS. RUBY KNOWLES: Pictou has 20. There are smaller amounts across the province.

MR. MCNAMARA: So the Halifax, Fishermen's and Pictou are the three big ones.

MR. YOUNGER: As you noted, part of that cost helps cover the overhead costs and then, for example, the nurses at Fishermen's Memorial Hospital or in Halifax obviously work with non-Veterans Affairs' patients. The heating bill obviously applies to everybody and all that sort of thing. Have you looked at what the financial impact to those DHAs will be? Because obviously even if it's a five-year phase-in for the Veterans Affairs, that's actually a reasonably short timeline, and it would appear in reading the Auditor General's Report that the long-term care strategy is already under financial pressure.

MR. MCNAMARA: I don't have the cost here, I can get it for you, but I know it's a significant amount of dollars that would be a cost to the province.

MR. YOUNGER: So we're talking millions of dollars.

MR. MCNAMARA: Yes, we are.

MR. YOUNGER: Take the 22 beds at Fishermen's Memorial because that's an easy number - has the department decided yet what they will do with those beds? Will you continue to offer those as long-term care beds? There's no decision?

MR. MCNAMARA: No, that's part of what we're looking at for the rest of the Continuing Care Strategy on beds, which beds we would utilize, how we would utilize them, or they might be used for other uses - that's what we are working through. I don't have the answer today.

MR. YOUNGER: So say, for example, that those do not become long-term care beds, whether because the province can't afford it or just because you decide that's not necessary, obviously . . .

MR. MCNAMARA: Or there's another priority.

MR. YOUNGER: Yes, for whatever reason that happens. All of those people are not going to go to, or be eligible, or be able to be served through home care, obviously, so does that not - all the people who would otherwise fill those beds because you already have a waiting list, so do you not have a fear that that would increase the waiting list?

MR. MCNAMARA: It depends on . . .

MR. YOUNGER: I realize you're not kicking people out of beds, I realize it's a phase-in.

MR. MCNAMARA: Existing and the rest of those will still have a bed. It will depend on what the federal government does on the home care provisions that they provide which they are, as you know, currently working through. I understand that they're still finalizing what services they're going to provide to veterans. We have to know that full story before I can give a conclusive answer of the impact.

MR. YOUNGER: But at the end of the day between the two departments - mainly Veterans Affairs, and to a smaller extent Aboriginal Affairs - there's a fairly significant impact coming down.

MR. MCNAMARA: The Aboriginal one is a funding issue only because those individuals are already in their own beds.

MR. YOUNGER: Well to some extent then the Aboriginal one, although it's a smaller number, sounds like the funding is gone so now you're responsible for them.

MR. MCNAMARA: That's correct, it's a funding issue only with the Aboriginals because they are already in our existing facilities. In terms of the veterans, they're in beds that were particularly on a contract basis with Veterans Affairs Canada.

MR. YOUNGER: So on April 1st you are going to have Aboriginal seniors in nursing home beds, costing you $2 million that suddenly will become a $2 million cost to the province?

MR. MCNAMARA: That is correct.

MR. YOUNGER: Okay. You started talking about the waiting list and how that's hard to determine and I understand that - people come into my office who want to switch, they want to be closer to their partners. I'm sure every MLA and every staff person in your department can talk about the different reasons why people move. What are you doing to try to address that? I can tell you from my office we try to call and find out where someone is on the waiting list and as you kind of alluded to, it's pretty hard to get an answer sometimes and it's because nobody really knows because of all kinds of other factors.

MR. MCNAMARA: I'm going to ask Ruby to speak to that point.

MS. KNOWLES: The wait-list is managed through a chronology, so first on the wait-list, first off the wait-list. The two exceptions to that are Adult Protection clients - those are people in need of immediate, safe residence, so they go right to the top - and the second priority is people returning back to their home facility if they had a hospital stay, for example, and they're going back to a long-term care facility, or if they have an immediate family member in a particular facility then they become on this priority too, as well.

By far the majority of people are on the third priority listing in the wait-list and that is managed by chronology, but there are exceptions, as I said, with the first and second. You could be very near the top of the list in the third category of priority and then there may be a number of Adult Protection clients that get placed ahead of you. It's very difficult for the placement coordinators who are in place at the district health authorities to give a precise listing of where an individual is on the waiting list and even more problematic is the length of time it will take you to actually get a bed because that, of course, is dependent on turnover.

That said, the staff are pretty good at estimating and they do try to give family members a heads-up when they are getting close to the top of the waiting list and that is our wish, of course, and their wish so that people can make ready the plans to transition into a long-term care facility. The turnover rate in longer-term care is 30 per cent to 35 per cent per year, so there are a lot of placements in the course of a year. We have more than 7,000 beds, so that continually is managed over the course of the year.

The other complication with the wait-list is we also have people waiting for transfer, so somebody may be in a facility that isn't of their first choosing and that often happens when people are placed in a long-term care facility directly from hospital because in hospital an individual doesn't get to wait for the facility that is their preferred facility. They are obligated, because they are using an acute care bed, they are obligated to take the first suitable bed that meets their needs within a 100-kilometre radius. So if that isn't a facility they wish to remain at, then they stay on the wait-list, maintaining their place on the wait-list until a bed comes up in their preferred facility. Then they're offered a transfer to that facility. So that's another complexity in the wait-list.

The third complexity is we do allow individuals to defer their placements, so if somebody is at the top of the wait-list and they get a call that a bed is available in the facility they have selected, if they feel they can continue to remain in their own homes with the services and support they have now, they are able to defer their placement into long-term care facility. Then, in a few months time, in three or four months time, we recontact them or they are recontacted to see if they need a bed. That's an added complexity in managing the wait-list, clearly. We try to balance that complexity of allowing people to defer with - we don't want individuals prematurely going into a long-term care facility if they have an adequate care plan in the home because most people do want to stay in their own homes and communities, really, as long as possible.

MR. YOUNGER: I'm wondering how early can somebody get on the list?

MS. KNOWLES: Well there are criteria to get on the list, there's care criteria to get on the list. But we do know, particularly for some homes that are favoured amongst some people, that they know that there's a lot of interest in these homes and they get on the wait-list fairly early, even though they are perfectly safely being provided care . . .

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

MR. YOUNGER: We'll come back to it.

MR. CHAIRMAN: Thank you for the answers. Mr. Porter.

MR. CHUCK PORTER: Thank you, Mr. Chairman. I'll start and probably hand off to my colleague from Inverness as we go through.

I want to get to a few different things here but I want to talk mostly about the single-entry system. I thank you, first of all, for being here today. It's probably no secret to any of you, nor the minister, my comments - both in the current government and past - with regards to my thoughts on the single-entry system. I've stood in my place in this very House and I've called it a failure. I've quantified that by being a former health care provider and being someone who has transferred these patients from a variety of hospitals or wherever they're waiting for care, into these long-term care facilities.

The process used to be very simple. I'll give you an example; someone was in the local hospital and it was determined by the physician and their family that mom or dad needed to go into a long-term care home. Dr. Enright, I'll use as an example, would pick up the phone and he would call Emily or somebody over at one of the homes, at Dykeland or where have you, and he would say, hey, I have Mr. Jones here, he needs a room. Very quickly this process would be completed, very quickly. The finances would be done sometimes before and/or after - it was still determined. The biggest thing that stood out here was that Mr. Jones needed a long-term care facility, he met the requirements and it was taken care of very, very quickly.

Now having moved to the single-entry system, what I have seen is a great change in how that happens. At the same time I want to say that I know that our needs are growing, we're living longer, as a rule, generally speaking, and I am sure that has helped create part of where we are today.

My first question to you would be, how many people - and you can break it down provincially, if you want, or perhaps by district health authority if it's easier for you. How many folks are working in, at any given time, the single-entry system, proceeding through the paperwork and processing and doing what needs to be done, to get the example I use, Mr. Jones, from, say, Unit 500 at Hants Community Hospital to a facility?

MS. KNOWLES: Just to make sure I understand the question, how many people are on the wait-list or are in process of wanting to apply?

MR. PORTER: No, that's fine, I'll clarify that for you, thank you. What I'm asking is how many employees - and I'm not blaming employees here - what I want to know is how many people are working in the single-entry office, shall we say, processing people who need to get into homes? One, two, three? You can break that down for me, if you want, say you know the Cape Breton area, the western area - however you have it set up - but provincially how many people are working through this massive list of paperwork that needs to be processed?

MS. KNOWLES: I would have to give you approximate numbers. We have approximately 380 care coordinators; those are employees of district health authorities throughout the province. The role of the care coordinators is to do the assessment and then provide people with guidance through to home care or long-term care.

We also have a significantly lesser number - I believe there would be less than 20 - referral assistants, or more typically you might know as intake workers who would answer that 1-800 line and they would kind of start that process.

MR. PORTER: With the wait-list and those numbers, do you see that as an accurate figure to manage what is coming and going by way of processing that paperwork and getting the intakes done? I'm very familiar with the process. We deal with it sometimes

more than weekly in my office and I'm sure others are dealing with it too. You would only need to go back to your department and look at the records from the conversations back and forth with the different care coordinators and so on and inquiries and status checks on any number of patients who are waiting - some who have waited a very long time. I'm just curious as to your opinion, as somebody who is obviously overseeing and part of this - is the number adequate or do we need to figure out something else here?

MS. KNOWLES: We had a look at that this year and we added some additional staff for the district health authorities this year - both temporary staff - to the end of March 31st because a number of new initiatives were introduced, and then a number of new FTEs were added to the district. About a $1million went to new staffing this year.

MR. PORTER: I'll just go back to Unit 500 again because I know it well. It's always full and generally speaking, it's full with folks who are waiting to get into a long-term care facility. Most want to be local, of course, as we know and that would be the same with any area where they are waiting, but some are very open to Halifax, Dartmouth, the Valley or wherever - not many. Most want to be in their home communities and that's reasonable to think; their families are there.

With Unit 500, I'm looking at a cost factor here. We talk about the cost of staying in hospital and that sort of thing versus the long-term care and maybe the answer will matter as to how that is paid for, whether it's privately or otherwise. What is the cost difference between the two? So, Unit 500 at the hospital costs, and we'll use Dykeland Lodge as an example because it comes to mind, cost - what are the differences between the two? More at the long-term care facility or more at the hospital, do we know?

MS. LINDA PENNY: When we looked at the per diem costs - and it's in your package, the financial sheet - it shows you daily rate at the hospital ranges from $579 to $1,100 versus a nursing home at $235 or less.

MR. PORTER: Or less, depending on who is paying the bill actually. Whether they're paying it privately and eating up their savings, which some people do - they have set themselves up to do just that to take care of themselves. I have known a couple of patients in the past who have paid their way.

I've also been aware of folks who have gotten letters who are actually on Unit 500, saying, you must begin paying. Now generally speaking, I'm not sure if they ever actually ended up paying before they get into the nursing home. Once they were assessed, they were getting the documentation saying, your per diem rate will be this.

I think most of the time it may have been very similar to the nursing home rate that they would have billed at that time. Even though they may have been in Unit 500, the rates wouldn't have been the exorbitant in $500 or $600 or $700 or $1,000. They would have been based on the nursing home rate and we have seen that. Sometimes that has been

argued and resolved, based on where they are. Not that they're not getting great care at Unit 500 because they are. It's very much a nursing home in and of itself. Right down the hall is Haliburton Place and sometimes I wonder if we shouldn't be thinking about that because most of those beds there are taken up with folks who are waiting, but I guess that's a discussion for another day as we continue to think about the ever-growing need.

We do know that need is there and we do know that people are living longer and it does create a longer wait-list, but it's very difficult to explain to people sometimes when they come in that there is only one way generally that somebody leaves a long-term care facility and that is upon their death and that is what creates the openings. Once you explain that clearly, people say, oh, I didn't really realize how the process works. Some do, some don't. Some are very willing to travel, as I said. Some are willing to pay their own way as long as they can, and they have because they've set themselves up through their life to make sure that they're cared for, whether that's privately or in a private nursing home or what have you.

As I said early on, I've been very critical of the single-entry system because it does seem to take so long. I just wonder, are there other plans, other reviews - I asked the question about staffing and you said we've added some staff - are there other plans to review and make any other changes in this process to help speed this up? I know it would be easy to say, just write a cheque and print some more dollar bills and we'll build another 20 nursing homes if that's what we need. I realize that's not a possibility when we think about budgets and so on, but there has to be a better way of reducing the sometimes very long wait-lists, which can be many months and creates numerous stressors on families that are trying to help care for them.

We talked about the figures a few minutes ago; Ms. Penny, you gave the figures of cost difference. When we really look at the math and we compare that $500 or $1,000 versus the $200, we're still paying, as a government, as a taxpayer, the $500 or $1,000 value at $500 versus maybe even the $200 we're still paying for the value of the nursing home or less. Is there a plan somewhere here to say, okay, we know this doesn't really work well, where are we going?

MR. MCNAMARA: Mr. Porter, there's a tremendous amount of thought being given on how we move this forward. As I mentioned in my opening remarks, we've been concentrating on home care as a start because we believe, when we look at the profile of the patients, that we can do a much better job and a much cheaper job of having more people looked after. As a matter of fact, if we looked at what we've been paying in long-term care facilities - forget the hospitals, just look at the long-term care facilities - if we used some of that money we could provide a Cadillac home care service and provide a better service and save money and look after more individuals, so that's one of the things that we've started concentrating on. Does it mean that institutional beds will not be required? No, it doesn't, but I think what we have to do is say, how do we move upstream first and help people be

happier staying at home as long as possible and we have to start somewhere, so we have started down that road.

I just wanted to clarify, you mentioned about private nursing homes. Nursing homes as such are not private, there are residential . . .

MR. PORTER: I guess that's what I was referring to, those other facilities that are private and providing the same care too. Sorry to interrupt, but . . .

MR. MCNAMARA: Not the same care. If they're in a nursing home and getting nursing home care, the province subsidizes regardless of your income and the individual only pays what we call the hotel costs, so just to separate. There are individuals, yes, in facilities who are probably very wealthy individuals who can look after themselves in a different way, but that's their individual choice. But if it's licensed and under us, we subsidize - just to clarify that for everyone - regardless of income.

In terms of home support we're paying about $33 per day for individuals, to try to help individuals in their homes. We have to spend, I think, more time seeing how we can help more people stay at home because if we look at the demographics, if we build a bed, we'll fill it, regardless of whether it's . . .

MR. PORTER: That's right.

MR. MCNAMARA: So we have been working with our DHAs to try to move more people out into the community. We also are starting a program of looking at individuals and the type of medications they're on because we know that's creating many problems for individuals in the community and they end up in our institutions because of that. Polypharmacy is a problem, so we're starting to develop programs to deal with that province-wide; we're starting in the Cumberland area, we've had great success at some of the facilities, so we have to do this as a province-wide program. It's a lot of work, it's going to take a lot of time, but we have to start somewhere.

The emphasis has been on building institutions for too long, rather than looking at the other side of the coin; we have to do both in order to make it work.

MR. PORTER: I agree with that wholeheartedly, I think you're right, as soon as you build a bed, it's full - it's full before it's even built, we know that. We know that the problem is not going to get better and we know that the numbers are not going to go down in all likelihood from what we're seeing, just based on our aging population that we spoke of.

It's interesting that you mentioned the home care piece. I think you're also right because many people who come to my office would love to stay at home and there are a variety of factors of why they don't or can't, one being care. Family has a very difficult

time sometimes, depending on the needs, looking after others and sometimes it's medical, sometimes it's preparing food, you know - all the things that can go along with providing health care to folks. I could see a considerable cost-saving by way of that method when I compare it to the Unit 500 example and/or the Dykeland example, the regular fee of a couple hundred bucks a day, you could do very, very well.

Two things with it, though, I would say. Although there is a home care program, most will tell you it's very difficult to get someone out to their home, there doesn't appear to be enough in the way of staffing. That is certainly an issue that appears to be most important to people because some are told you're going to wait many weeks, a month or more before we can get it lined up. That's a staffing issue, we realize what that is. And you talk about, you know, we're looking at this.

This is not a new problem, this has been around for some years. With all due respect, when are we going to stop looking and start doing, I guess would be my question to you?

MR. MCNAMARA: I would suggest that we have started doing. We put $22 million into home care and other amenities in the past year and we have other plans that we're working on. I think we've also come up with programs to help people hire their own individuals to help with some home support. That has made a difference, in terms of getting individuals.

We also looked at one of the things that can help. For example, snow shovelling, we know that can be an inhibitor for some individuals. One of the interesting parts - that program you would think is fairly simple to put in place, say, you can get some money to look after that - we found in going through it that we had to work with Revenue Canada because if we went above the $500 threshold, individuals are going to have their supplementary Old Age Security pension reduced, so that became a bigger problem for them than the solution. I'm really interested - I saw that Veterans Affairs are now coming out with an allowance to veterans so I want to see how that's being treated tax-wise. We might be able to emulate some things that we can do that may make it better and be able to provide more funding to individuals to look after themselves at home.

I think sometimes, too, when we use agencies, there are much cheaper ways of doing things if people have their own resources. So we're looking at how we can expand that type of program but we have to do it in a way that we don't impact their GIS.

MR. PORTER: Yes, I agree with that and it's one of those things that we may have to go to Ottawa and battle - I mean it's a worthy battle, there's no question about that. They shouldn't be affected by that, through their OAS or whatever it might be, as you've just suggested, that should be free and clear of that because there's a true need there. If they really looked at it seriously and the savings that could be had and the benefits, in all honesty, to provincial and federal governments and dollars being spent and invested, I

think they would probably see the reality of it versus the income and the revenue that they're looking for perhaps on the other side, to do many other things.

Yes, I agree, it's very big. We know the Department of Health and Wellness is very complex, both provincially and federally. It's a major issue and there are many, many roads to travel yet and I think there's a lot to be done.

I would argue that it can be done. I think we've seen a lot of success - and I just use the ambulance story in the Province of Nova Scotia, although it has taken - it's still evolving - a number of years. I can remember when it was not much of a place to work but we worked in it and I mean we're one of the top in North America. So when you look at the ability and the people and the ability to make that happen, it's there.

I also agree with your comments with regard to maybe allowing people to set it up themselves because there are a number of individuals - I think of LPNs and others out there - who are looking for work, who aren't working, and other health care providers within their scope who are not working, who could be working in the private sector and being hired for whatever the fee might be. I think that given how there is such a lack of jobs right now and times are tough, there would be a lot of interest.

I'm looking forward to seeing something change here because as I said, this is a weekly occurrence in my office - at least once, sometimes two or three times - and I'm sure in others, where we are dealing with long-term care issues. It creates a variety of stressors on that family, outside of the actual health needs. I know you know that, as someone at your level in your department, as deputy minister, and others and you've been around it for a while and I know you know that.

I can't stress enough the importance of figuring out something better than what we have and that the single-entry system just does not work in a way that - not just me, I guess, it's easy for me to say, but the people who are waiting will tell you that this does not work, there is something wrong. They remember back when maybe their parents were going into a facility and it was the example I gave when I started, of how easy it was in those days and they have a hard time sometimes understanding how something so simple could be so difficult. It is difficult to explain to them sometimes. Now these people are very reasonable and they do understand, although that doesn't help their situation much.

As I said, I do look forward to seeing a variety of changes in this and sooner, hopefully, rather than later. Whatever that education is or letting people know we're being part of trying to assist with that, I think that our offices - as MLAs or people who are there on the front lines taking care of some of this stuff and dealing with it - we'd be there to help make this thing flow smoother however we could because we do deal with it so much.

In closing this, I want to say that I guess dealing with a lot of people - we deal with care coordinators and such at the Department of Health and Wellness - I will say on the

record that I want to thank those people for what they are doing to help me, in my office, and my CA and others who deal with them, they are doing what they can do and they are very helpful. It's amazing how much gets done with that little bit of extra - I don't want to call it influence but having the ability to call the right people and get things rolling.

How much time do I have left, Mr. Chairman?

MR. CHAIRMAN: You have approximately two minutes.

MR. PORTER: Just a quick question then. I'm dealing with one right now, an interprovincial. A lady in Prince Edward Island wants to come to Nova Scotia, there's the three-month window of funding, you have to be in the province three months and have your health card number or you're not funded. Are there any programs in place that say, okay, we know this is an issue; she's formerly a Nova Scotia resident in a home in Prince Edward Island - we're trying to work through that, but family can't bring her so she may never get here, based on the fact they can't pay what would likely be somewhere between $15,000 and $20,000 over the course of three months at private care to make that happen.

MS. KNOWLES: We don't have a lot of requests for interprovincial, so sometimes it's necessary to work through them case by case because circumstances are a little different. If you would provide the details to our Continuing Care office, we would certainly be happy to work with you and your staff and the family on what could be some options for them.

MR. PORTER: I am working with Ms. Miller and that is moving along. I just wondered if there was anything - I do know that there is nothing there I don't think currently and we're just wondering - the question really is, knowing that we don't deal with a lot of them - either Prince Edward Island is paying or we're paying or another province, this happens throughout the country. I was just curious as to whether or not there is some thought about the cost of covering, bringing people back who want to be home with their families, closer to their families and such, whether there is an interprovincial agreement maybe somewhere in the future that might address this unique situation.

MS. KNOWLES: To my knowledge there is not current work going on, but we do try to problem-solve case by case.

MR. PORTER: Thank you very much. I think my time is just about up.

MR. CHAIRMAN: Mr. Epstein.

MR. HOWARD EPSTEIN: Deputy, my thanks to you and your staff for coming here today to try and explain what now appears to be a very complicated system. I've appreciated what you've had to say. At the same time, I'm probably left a little baffled

about some things so maybe we can sort them out. Maybe we can start by focusing on the Auditor General's Report that we're here to discuss and you're here to respond to.

As I read this chapter, it's essentially quite complimentary to the department about how issues around long-term care have been dealt with. At the same time, there are perhaps two exceptions there - two points that they focused on. One was the need for some revised legislation and the other was the choice of priorities for building and replacement of the beds. I don't think there is any point in ducking those so could we just have a quick look at both of those points?

I want to start with the legislation. The suggestion from the Auditor General was that the Homes for Special Care Act had not been revised in some time and there was a suggestion that it might need revision. I heard you agree with that and I'm wondering if you could just remind us of exactly where that stands, particularly flagging the consultation process and what process you anticipate going through in order to move ahead with changes to the legislation.

MR. MCNAMARA: Just after the completion of the Hospitals Act, I met with our legislative staff and also with Ruby and talked about the fact that we need to get this legislation as next priority. I know both of them - their faces blanched a bit with the volume of work that is going to be required to make it happen, but we did agree that we would proceed and do the necessary draft legislation and then go through with it because we always try to do consultation on major legislation whether it's with Doctors Nova Scotia, with the industry, and also it will be posted for the general public to make comments.

We know it has to be updated - there's no question about that - and it is out of date, but there is a tremendous amount of work to change legislation and we hope to have it ready for this Fall, regardless of what happens to other circumstances. The plan that we're trying to do is to have legislation that is updated. Also, part of that is to review what goes on in other provinces so that we understand - are there good things we can do that we can borrow from others to build into the legislation and try and get the best legislation we can while at the same time, providing enough flexibility that in the future we can change things by regulation where appropriate, rather than bringing everything back for legislation. As you know, legislation is much more cumbersome.

MR. EPSTEIN: Could you give us some examples of what points have been identified as needing updating in the legislation?

MR. MCNAMARA: We're in the early stages of looking at it. The legislation is so old, I think, the whole thing has to reviewed and quite honestly, I haven't sat down and gone through the review myself. What I have done is said to the appropriate folks on our staff, start the work, look at what is going in other places and then bring us back something that we'd go forward.

MR. EPSTEIN: That's fine, I'm sure we'll see this in due course. I gathered from what you said that the consultation will extend to all obvious stakeholders. Did you also say that it may involve an invitation to the general public as well to comment?

MR. MCNAMARA: Usually we put it on the Web site for people to have comments like we did through the Hospitals Act because individuals have a lot of interest in legislation around these things, so we try to give the general public an opportunity to make comments.

MR. ESPTEIN: Okay, so the new target date is next Fall, is that right?

MR. MCNAMARA: That's correct.

MR. EPSTEIN: Good, thank you. What about the other point that the Auditor General focused on, which is the question of choosing priorities when it came to the new or replacement beds? Did you have comments to make on that?

MR. MCNAMARA: When the last initial strategy was developed on beds, there was a tremendous amount of work done looking at the number of beds per thousand throughout the province. Through that a system was developed, of the number of beds that should be developed by a district health authority, for example, so that we knew the number per thousand - which counties were high and which counties were low. Part of it was to try to bring an equalization of that province-wide and that was part of the work. For example, if I remember correctly the Colchester/Pictou area was very low, where Queens County was extremely high, so Queens County got no beds, but there were a number of new beds built in the Colchester/Pictou area to be able to bring them up to more equally distribute the number of beds we had. So that was part of the work that was done.

A decision was made by the government of the day to do two things. One was to go out to an RFP for new beds province-wide, which I referred to in my talk were much cheaper. They also made a decision - and it was their decision to make - that in some areas for the replacement beds, because of the small communities they were in, that they should be replaced by the existing organizations, many of those were non-profit or municipal facilities. Because of where they were located, because of the numbers, because probably not having the same expertise as some of the private sector builders or the RFP, they became much more expensive to build. That's one of the things we'll have to examine when we're going forward: do we continue to allow that choice when it costs you almost double to build the beds? So that's one of the struggles that government is going to have to face when we get to that point.

Currently, we have also gone out and are doing a review of all existing structures that we have to answer, should they be replaced now or are there other avenues we can use to try to shore them up? Also it should be mentioned, even though we've gone through this part of replacement and building new beds, we do spend a fair amount of capital money

each year for existing facilities so they can be updated as much as possible within the limits of the facilities. I'm not sure the exact amount, but it's not cheap, I know that.

MR. EPSTEIN: So if I followed that correctly, one of the points you seem to make is that the department and the Auditor General focused perhaps on slightly different criteria on assessing where the priority ought to be? As I read it, the Auditor General's Report focused on their assessment of the state of the physical plant and what needed replacing or updating. The department focused, among other things, on the overall need for beds in particular communities or parts of the province. Is that right?

MR. MCNAMARA: The first part was the overall needs province-wide. Secondly was there was also a review done of existing facilities at the time and the ones that were in the worse shape were the ones that were replaced, whether it was private or non-profit, so that did occur. There were also some changes made looking at priorities, for example, if you may remember there was a facility out off the Armdale Rotary and when it was replaced, it was split into two facilities in two different parts within the municipality to better serve the municipality, rather than being one facility located in one location.

So there were decisions made that I believe did use priorities. It may have been different in the criteria of the Auditor General, but at least there was one the department followed to come up with the decisions that were made at that time.

MR. EPSTEIN: Does the department now have a working set of criteria to assign priority for the funding of new or updating beds?

MR. MCNAMARA: We're still working through that, to be quite honest. I mean to be very fair, in the department three years ago there were not a lot of criteria for a lot of things, in terms of looking at replacements. For example, we went through that issue with equipment in hospitals or replacements. A lot of it was based on the decision of individuals of the day, rather than looking at a - so we put a system in place to be able to identify where the greatest needs were. It's not perfect but we're working our way through that, to become better at it.

We'll be doing the same thing as it relates to long-term care. We're also, particularly in the higher-cost facilities, working with Transportation and Infrastructure Renewal management to make sure that when we go forward, we don't end up with situations like what happened in the Colchester hospital. So we're trying to put greater controls in place to control costs, to make sure we do it right.

MR. EPSTEIN: Just to be clear, I certainly was not meaning to imply any disagreement with the Auditor General's criterion about safety of the physical plant. It seems to me that that's important. Can I just ask whether that's one of the factors you're taking into account now?

MR. MCNAMARA: That's correct, we will.

MR. EPSTEIN: All right, that's good. Thank you. Can I move to a slightly different part, which is maybe a bit of a general picture as to the number of beds? There has been some discussion about the 2006 target that was established when the Continuing Care Strategy went into effect. That target was just under 1,600 new beds but I think I heard reference to another number when we were hearing the testimony earlier. I heard the number 7,000, which I gathered was the total number of actual beds, so I just want to see if I understood this: 1,600 beds was an addition to the number of beds was it, based on what things were in 2006? And the current number of beds, is that the 7,000 number?

MS. KNOWLES: Right, the number of 7,000 and a few, is the current number, so that's the additional almost 1,000 beds that have been added in the last recent years.

MR. EPSTEIN: Okay. One of the things I'm led to wonder is whether the target that was set in 2006 is still a number that the department thinks is appropriate. The reason I ask about that, of course, is the emphasis I heard in the comments about trying to support the people at home, rather than see them move into short-term or long-term care facilities. I'm wondering if programs to support people at home were in place in 2006, when that original 1,600 number was generated, or whether they've been added to in the intervening years. Can I hear some comments about the perspective of the department now when it looks back on the continuing care plan that was adopted back in 2006?

MR. MCNAMARA: I think as I mentioned earlier, we know that we're going to have to build new long-term care beds. What we're doing, though, is saying what can we do more immediately to deal with the long waiting lists that we have for individuals in hospitals? Home care is a much faster way of being able to deal with that.

We're trying to move the upstream first, then we would back that up with what beds do we really need in order to be able to serve the population of Nova Scotia? One of the things I'm going to do is ask Ruby to talk a little bit about the profile of the patients waiting for long-term care beds, as well as for home care. I think when we hear that, you can see that the strategy we're looking at makes some sense. Ruby, do you want to speak to that?

MS. KNOWLES: We had a look at the profile of clients on the long-term care wait-list and the profile of clients receiving home care. In many circumstances there are not very many differences. I'll just give you a couple of examples. Two of the things that we look at when we go through assessments with individuals and their families is how able an individual is to maintain their activities of daily living - so that is feeding themselves and bathing themselves and that kind of thing.

When we look at those two groups, people who are home care clients and those who are waiting for long-term care, we see that home care clients, 83 per cent of them are

independent or require very few supports, and 78 per cent of people are on the long-term care wait-lists. That's just a few percentage points difference.

The other example is people who need help with what we refer to as the instrumental activities of daily living. What we mean by that is people who need help with meal preparation, housekeeping, laundry, transportation, shovelling the walk, yard work, and those kinds of things. Again, the numbers are very similar in terms of those two populations and particularly that latter group - transportation and the help with housework. That often is what makes the difference for people being able to stay in their own homes. When we look at what interventions are required - and we've had a look across the country and the literature is telling us this as well as our own conversations here in Nova Scotia - for not very much investment, it really can make the difference for someone being able to stay longer in their own homes and that is what they want.

MR. EPSTEIN: Can I tell you what I think I just heard from both of you? It sounds to me as if what we're being told is that given the hard demographic facts of an aging population, we're going to need both systems. We're still going to need all the beds that were projected in 2006 to be added to the system along with an expanding home care system. Is that the picture that you have in mind?

MR. MCNAMARA: I'll respond to that. If we don't do the home care, we'll be doubling the number of beds that we have to build in this province, and that wouldn't be the appropriate way to go - both for what people want to do and what's affordable, and also providing a much better service to individuals. But we know that with the aging population, yes, we know we're going to require some more beds. What we're looking at is whether we would use some of those beds - for example, the veterans' beds that are going to become available, are there other opportunities rather than going out and rebuilding between the cost per bed that we spent over the past? We have to go back and revisit and see if there is some opportunity, but we want to put our concentration on home care first to see how we can mitigate the number of individuals who require - or the length of time they may require in a long-term care facility.

As Ms. Knowles said, the turnover in long-term care is about one-third a year because individuals who go into it are usually quite elderly, but maybe we can extend, we can change the demographics a little bit of those going in and allow individuals to stay longer in their own homes.

One of the things we also have to give some thought about is that when the government changed the policy a number of years ago so that individuals could keep their assets and not be used towards paying for their long-term care needs, regardless of what they are - some individuals like to keep their home to pass on to their son or daughter - we may want to start talking to some of those individuals, if they live in a two-storey home that maybe they want to consider selling that home, buying an apartment. Your investment could still be left to your son or daughter, but if you could go into a place that has an

elevator and wheelchair access, you probably could stay home longer. So we have to start exploring new ideas to help individuals to stay at home than we have in the past. I think we have to be more aggressive in educating individuals in what the opportunities are.

It's amazing - I was talking to a couple on the weekend who thought they still lost all their assets in Nova Scotia; they tried to go into a nursing home. So we have to do a better job of letting individuals know what the opportunities are and how they can maximize their side of the equation, while at the same time providing for themselves in the longer term.

MR. EPSTEIN: This actually moves to the next point I wanted to touch on. My colleague, Mr. Porter, asked some questions around the financial responsibility of individuals as they move into some care facilities. Can you tell us what the general picture is in terms of what is looked to from individuals as they move into care facilities? I have in mind particularly whether you could update us about the issue around security deposits and income splitting and so on, but generally, could we start with the overall picture as to the financial responsibility of individuals when they change their circumstances?

MS. KNOWLES: In long-term care, for a number of years government made the decision that government would pay the cost of the care component of long-term care and individuals, residents of long-term care would pay the accommodation charges, kind of room and board. That cost is about 50 per cent for health care and about 50 per cent for the accommodation charges.

When someone enters long-term care and . . .

MR. EPSTEIN: Sorry, can I just interrupt? This is what Mr. McNamara referred to earlier as the hotel costs, is that what it is? That's the internal, shorthand term, is it?

MS. KNOWLES: Right.

MR. EPSTEIN: Okay, sorry, please continue. I'm sorry to interrupt.

MS. KNOWLES: When someone enters long-term care, we do a financial assessment because your ability to pay the accommodation charge - we look at that ability based on income so there is a subsidy available depending on your income. The health care costs . . .

MR. EPSTEIN: Sorry, I'm going to interrupt again. Meaning that although normally the approximate 50 per cent that would be attributable to room and board would be borne by the individual patient, in some circumstances that full amount is not charged. Is that what you're saying?

MS. KNOWLES: Correct.

MR. EPSTEIN: Okay, please continue.

MS. KNOWLES: So the health care component is paid by government; the accommodation charges, when we look overall at the costs of the accommodation charges, about 50 per cent of accommodation charges are subsidized by government when we look at the aggregate of all of the residents. Individuals do retain a minimum income when they're in a long-term care facility, to pay for incidentals and so on, so it is a sliding scale. There is an assessment that is done annually because people's income does change annually, so the rates could fluctuate annually, as well, for individuals. So that's done once a year.

In terms of the income splitting - this is a situation where we have married couples, where one has to go live in a long-term care facility and one remains in the community - this Fall there was a change to how that income splitting was advanced in terms of the cost of the care for the individual . . .

MR. CHAIRMAN: Order, please. Unfortunately, Mr. Epstein's time has expired for this round. Mr. Younger, you have 14 minutes.

MR. YOUNGER: When we ran out of time last time, we were talking about wait-lists. I know it's hard sometimes to shift back and forth, but I just wanted to finish up what we were talking about on wait-lists.

You had given a fairly good explanation of the complications of the wait-list and how to some extent it's triage, but also there are people who try to get on it early. That doesn't seem to me to be an insurmountable problem, to be able to have some sort of public wait-list - obviously, not with everybody's name on it because then you get into privacy issues - but to get a sense of what are the wait-lists at different facilities, even if it's in different categories.

To some extent that's done in the emergency rooms now. It's on-line after the fact, but you can find out fairly easily what the waiting time is at the various hospitals in the ERs, and understanding if someone comes in with a heart attack, they're going to jump to the front of the list. It strikes me that this would be the same, so if you have a protection client, people understand that's going to the front of the list. What work is being done to try to have a more - I'm going to use the word "transparent", I guess - transparent and open wait-list so that it's very clear, whether it's somebody in a constituency office or somebody from the public wants to know what the status of the wait-lists are for various facilities, if that can be determined?

MS. KNOWLES: Well, there are a number of things we're looking at. It's our intention that the wait-list does become more transparent for individuals because you get calls - we get calls, too, and we do try to explain it. If people have that information in

advance it helps them with their discussions with the staff to try to assist them through the continuing care application process.

One of the things that we're doing is having a look at our facility placement policy, so there are needs-based criteria to get on the long-term care wait-list, but I think we've already talked about similar clients in home care and long-term care. Other than once you meet the threshold of meeting the criteria for long-term care, then it is managed by chronology. Some jurisdictions do more of a balance of chronology and needs-based so that people going into the long-term care facility are those who need it the most. So we are reviewing our policy right now with respect to that.

The other thing we're looking at is the impact of the deferrals part of the policy. We had a situation, very troubling, just anecdotal, a year or so ago where a placement coordinator went through 18 or 20 phone calls to that many different clients on the wait-list before they got somebody who was able to take that bed, willing to take that bed, so a number of deferrals. That obviously delays the placement that many days because you have to give people a reasonable amount of time to make a decision, so we're having a look.

We're doing a pilot in Cape Breton around the impact of the deferrals policy - should it be longer, shorter, not at all - and how that impacts the wait-list.

The other thing is we had a look at the people on the long-term care wait-list about a year ago. It was very interesting to us and we've been trying to drill down on this. Almost half of the people on the long-term care wait-list are receiving absolutely no publicly funded home care service. That struck us as very curious, how you can go from no service to needing 24/7 residential care, so we've been drilling down on that with our colleagues in the district health authorities to help us understand why that is and what offerings in home care we can make to people so they can defer or perhaps avoid long-term care admission.

One of the difficulties with the long-term - and not to repeat what I said earlier because it is complex to talk about all the different factors that influence the wait-list. We think it can be simpler and we can be more transparent to the public and that's what we want to get to, so that individuals can make decisions. If there's a home that has a one-month wait-list versus a three-year wait-list, you might make different decisions as a family, right?

MR. YOUNGER: I think this is an important issue for a number of reasons. I think the home care issue you raise is important; I think there's probably a number of reasons for that. Some of them would be people not even - perhaps not being aware that there are home care services available and that would be a certain percentage. There would be other people - there might be other people who just haven't been able to access it for a variety of reasons.

I think the wait-list issue is important because - and I'm sure it's always difficult to speak for everybody else here but I think I'm safe in saying that the other members of the Legislature who are sitting here with me, regardless of Party, have probably had people call them who are absolutely convinced that if they call their MLA, they will get bumped up on the list and that will put them at the top of the list. They are absolutely convinced and it doesn't matter what you tell them. We write a lot of letters, and others do, explaining the situation to the person, this is why they want to be moved, which is probably a letter they could write themselves - I mean I don't mind writing it - and it would get them the same treatment from your department as if it came from us.

That is a symptom of a problem with a waiting list that doesn't seem to be transparent. There is obviously an impression in the public, the families in particular, less so the clients; often it's the families who believe that it is a politically motivated wait-list - or politically influenced, not motivated, I guess - politically-influenced wait-list or that it's who you know on how you get on the wait-list. That feeling shouldn't be out there because in my view it discredits the entire system.

That ties into another issue, and I know I'm running around but I don't have a whole lot of time. One of the other issues the Auditor General's Office raised was related to, in my view, how replacement facilities are built. They noted cases where there didn't seem to be, at the very least, a transparent process of identifying, okay, this is the one that's most in need of replacement so that's why we're going to do this. They gave the example of the one where the fire marshal went and said, wow, this should have been replaced, and then your department decided to replace it. So fair enough, you decided to replace it.

It strikes me as a very similar problem, that nobody is quite sure. I mean I'm sure they are in the department but outside the department nobody can quite identify - including the Auditor General, as far as I can tell - how a building gets decided, that this should be at the top of the list for replacement versus this one and why it doesn't go out for public tender and why it just goes to those who have done it before. The issue seems to be the same - a different category, but the same - that there doesn't seem to be transparency. I guess on that side, and I'm not sure if it's you or Mr. McNamara - what are you doing to address that side because the issue is the same. It's just one is capital and one is people on a list.

MR. MCNAMARA: Just dealing with the list, I can tell you whether a waiting list is published or not, we get the same belief that if a politician writes the letter it will bump them up, whether it's for orthopaedic surgery or for nursing home. It's amazing to me in getting these letters I think two things: one, if all the people who write in and say who they voted for, there wouldn't be an Opposition member in this House; secondly, the Premier has more relatives than he ever knew. (Laughter)

MR. YOUNGER: You learn very quickly after getting elected, everybody has voted for you in your riding. (Laughter)

MR. MCNAMARA: But we get that regardless of whether the list is published or not that individuals think it is political - and it is not, I can assure you. Every individual is treated equally regardless of who the request comes from. As I think many of you know, your responses are dealt with sometimes - in some places you have legitimate reasons and we are able to respond to it.

In terms of looking at going forward, we have gone through and are doing a review of existing facilities. That work is being reviewed right now and there will be a report that goes to the minister and can go out so people do know what the existing state is of existing facilities and what we plan to do on a go-forward basis. We're trying to be as transparent as we can, but we have to make sure we do the due diligence work first before we publish it.

MR. YOUNGER: I agree that you need to do due diligence, but I assume the due diligence was done before they were placed. For example, the Admiral Long Term Care Centre opened. It's a great facility in my riding and in all honesty I'd been talking for 20 years about building a long-term care facility there. We've gone through all three Parties now and it has moved along at different stages in each of the three Parties and so now it's open and it's great, but that replaced another facility - I think the Glades Lodge. So fine - maybe the Glades was at the top of the list, but I assume that due diligence was done to determine which facilities actually did need to be replaced.

MR. MCNAMARA: That was done the last time there was a review of existing facilities. There was a determination made of which ones had to be replaced and Glades is a good example.

MR. YOUNGER: So why couldn't the Auditor General's Office seem to be able to determine from the records they looked at - I don't remember their exact wording.

MR. MCNAMARA: I'm not sure and my memory is such right now that I don't remember that exact recommendation, but I'm not sure why the difference, but I'll discuss it with them and clarify for the committee.

MR. YOUNGER: There are a couple of minutes, Mr. Chairman, maybe if I could ask Ms. Colman-Sadd or Mr. Lapointe - I don't know who would be best to respond to that. Maybe I'm misunderstanding what they felt they did or did not find.

MS. EVANGELINE COLMAN-SADD: My recollection from when we looked at that is that the department had done a needs assessment of facilities. They had - I think they're called facility-conditioning assessments and they had ranked facilities based on that, but the facility that was ranked first wasn't necessarily the first facility that got funded and the second wasn't necessarily. So there seemed to be other things that came into play as well. The department seemed to have some concerns with the validity of where things maybe ended up on the needs assessment at the end of the day.

The bottom line for us was that when we looked at the facilities that were selected, it wasn't clear and obvious that those were the most in need of replacement. There were others that appeared to be sometimes in greater need or in equal need of replacement and we just couldn't figure out, based on what was available, why the specific ones that were selected were selected.

MR. MCNAMARA: I can now respond to this, as my memory is refreshed. All I can say is the government of the day made decisions and the department acted on them.

MR. YOUNGER: Okay, so it was a political decision.

MR. MCNAMARA: You take it as you wish.

MR. YOUNGER: So is what you're saying from your comments before, that it is now starting to be looked at and addressed? You said there is a report before the minister now?

MR. MCNAMARA: No, it hasn't gone to him as yet. We're still doing the due diligence to bring it to him.

MR. YOUNGER: All right, because you obviously . . .

MR. MCNAMARA: The report would be done by our staff, but we also want to make sure that we have the fire marshal to see where they are, those types of things are tied into it, so it isn't just a single report going in and then you get a surprise a few weeks later by somebody else saying something different.

MR. YOUNGER: Okay and that's fair. Regardless of the fact you want more people on home care, more people at home, you're going to need more beds at a certain point. Is it your expectation that will be implemented before you start with the construction of new facilities?

MR. MCNAMARA: As I had mentioned earlier, one of the things we have to do is review the veterans' beds, to see what uses - because we don't want to construct a bed if there's another way of being able to provide it. If we can save that $300,000 to $500,000 a bed in building construction, then that would be an obvious way to go for the taxpayers of this province.

MR. YOUNGER: Absolutely, but I suspect that even if all 341 beds were available that's probably not going to solve the entire waiting list in perpetuity, and as you noted, we have an aging population.

MR. MCNAMARA: Correct, but when Ms. Knowles was talking about - when we do a comparison of individuals on home care and long-term care, we believe . . .

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

MR. ALLAN MACMASTER: My first question is I'd like to have a breakdown on a percentage basis of the cost per nursing home bed. Now I know in the opening remarks you mentioned that the cost per day in 2012 was about $287 per day. Of that amount, what would be the rough percentage breakdown - if we looked at, for example, there would be a percentage for the real estate or the hotel costs, as you referred to it, for human resources such as nurses, for administration and so on - could you give a percentage breakdown?

MS. PENNY: It's roughly 50 per cent for the direct health care costs and 50 per cent for what we're terming as the hotel or accommodation costs.

MR. MACMASTER: Can you break it down a little more specifically? The hotel cost, as you refer to it, is pretty straightforward but the other 50 per cent, can you break that down a little bit further?

MS. PENNY: It would be made up of direct patient care costs - I'm not sure if I'm answering what you're asking - but it would be the direct health care costs, so salaries, benefits, that type of thing, to look after a patient for their health care needs.

MR. MACMASTER: So that would be everybody from nurses to administration, all costs included?

MS. PENNY: Yes, that are directly related to the health care, yes.

MR. MACMASTER: Okay. And if we compare that to home care, I heard a figure of $33 per day; I guess that's quite a bit less than, say, $150 per day in a nursing home. I know that we're not exactly comparing apples to apples there, but is that one of the reasons why you're looking more towards home care, because it's so much cheaper?

MR. MCNAMARA: No, the first thing is because people want to stay home, that's the first one. So the first priority - we're not trying to avoid building nursing homes, because people need them, but we do know economically we can provide more home care spaces for the same dollar and look after many more individuals and yet still provide excellent care, so that's where the philosophy is coming from.

MR. MACMASTER: Sure and that sounds like a win-win. One of the things about home care - and I did raise the issue in the Legislature - there were some changes made recently where the time spent for things like meal preparation and for hygiene has been reduced. I was told that it wasn't, but over the holidays I did some visiting and discovered that no, it has been reduced. I guess I raise that as a concern today that it's being raised to me from people who are receiving home care that the actual amount of time that the workers are allowed to spend preparing meals has been reduced. That's having an impact

because people who are receiving the care are having to eat pre-prepared meals; they might be preparing meals for the next day. Anyway, I just wanted to bring that to your attention that it is a matter of concern to people out there. I don't know if you have a comment on that, but in fairness, I'll let you comment on that.

MS. KNOWLES: We have heard these concerns before, Mr. McMaster. There have been no cuts; there are regular reassessments of people's needs, though. So home care authorizations for services go up and they go down, as people's needs change. Your example about the meals is quite right - home care doesn't replace what might be available through another means. That said, there's a lot of opportunities for more flexibility in home care to really meet people's needs. Most of our clients in home care are nowhere near the maximum service level authorizations that might be available to them. It can get up to 100 to 150 hours of home care service per month and there's a very small percentage of clients who are at those maximums.

MR. MACMASTER: Okay, thank you. I can appreciate you saying there have not been necessarily cuts - I think you are referring to dollar cuts, in terms of dollars - but there has been a change in the level of service.

MS. KNOWLES: It would be based on an assessment of the unmet need.

MR. MACMASTER: Sure, and I guess in practical terms, I guess what I'm hearing is that people who used to get more service, I guess they're getting less service now, maybe because of a reassessment.

MS. KNOWLES: Possibly, yes.

MR. MACMASTER: Yes, okay. If there was . . .

MR. MCNAMARA: If you have a particular example, maybe if you bring it to our attention and we can look into it for you.

MR. MACMASTER: Yes, you know what? There's all kinds of them, just about everybody I've talked to. But I'll move on from that.

I guess the thing that comes to mind, and I can appreciate that people do want to stay in their homes and I respect that's part of the decision driving the move towards more home care, but is it really working? We see the list growing for long-term care beds, so despite the extra efforts to provide care for people in the home, we're continuing to see the demand for long-term care beds grow. Do you really think it can be solved by moving more resources towards home care?

MR. MCNAMARA: It is my strong belief that yes, we can do that. It is my strong belief based on the profiles that the department has done, looking at the staff in both facilities. It is also based on what we hear from families, what we hear from individuals.

Also, we know that the wait-list to some degree is not totally accurate, because of people knowing there's a long wait-list and putting their names on it in case. We also know that when we try to place people, that we have to make in some instances a number of phone calls in order to get somebody who is willing to accept a facility. Some hold out for a preferred facility. That also tells me that if I'm holding out for a preferred facility, maybe I don't really need it at this point in time. Until we clean up our list, it's pretty hard.

I think in our emphasis of going to home care first - I didn't say we don't do institutions, I said home care first and home first, I think, has to be the main drive that we look at to help individuals get what they want.

MR. MACMASTER: Is that why you are hesitant to accept the Auditor General's recommendation to publicize the wait-list for long-term care by putting it up on the Web site?

MR. MCNAMARA: It's because it's not accurate. Until we can clean it up some, then we will publicize it.

MR. MACMASTER: I can think of an area where it probably is accurate and that's the number of hospital beds that are being taken up by people who should be in a long-term care facility. I mean those are people who are not just putting their name on a wait-list - they are actually consuming resources.

I know you mentioned earlier I think the cost for a hospital bed is somewhere between $579 to $1,100 per day versus a nursing home bed that is roughly $300 per day.

MR. MCNAMARA: That's correct. We also have found out that when we have worked, for example, at Capital Health, to say that when somebody arrives at an emergency room that the concept of home first has diverted individuals from being placed into hospital beds and they've been able to go home with support. So we know that the home care can work. Once the individuals are in a bed, it's much more difficult to say you can't stay in one. So we recognize that there are major opportunities.

That doesn't mean that some of them who are in those beds do not require nursing. I also think we have to be very careful we don't stigmatize seniors who are seen as the reason for hospital beds not being available. We have used those resources strategically, I think over time, to be able to look after individuals.

The other thing - I have been in the health business for many, many years and one of the things, I can remember going back in my earlier days in hospitals, the long-term care

patient was the individual who helped keep our hospital costs down because they helped to lower the average cost of looking after patients. That strategy has never gone out of our system and I think we have to start looking at it differently.

MR. MACMASTER: I appreciate your point about stigmatizing seniors. I don't think anybody intends to do that though, I think we just want to see people placed in the most cost-effective manner and if it . . .

MR. MCNAMARA: I wasn't casting aspersions.

MR. MACMASTER: I know. So I guess there are seniors waiting in hospital beds that are designated for other purposes. Would that include, say, emergency purposes or in-patient purposes?

MR. MCNAMARA: We have designated beds in certain hospitals for those types of patients. For example, there's an alternate level of care centre at Fishermen's Memorial Hospital in Lunenburg, there's one in Capital Health, there's one in a number of places around our province. It was in lieu of - it was meant to be short term at the time. It was a decision of the government of the day and I think it was probably an appropriate one to deal with the crisis they had as they were building beds.

I think when the long-term care strategy was developed it was thought that this would take care of that problem; it hasn't. What we've done is we've created a greater demand rather than fixing the problem we had, because individuals like these facilities; you can go to a facility, you can have your own room, be well looked after by competent and caring staff, so it has made it much more interesting for individuals wanting to move into it. At one time going into a long-term care facility was something you avoided; now it has become an okay thing to do. That has made a difference as well - acceptability.

MR. MACMASTER: In what ways do patients awaiting long-term care placements impact the flow of normal hospital operations?

MR. MCNAMARA: It can have an impact at times when we have an overload. We have a number of issues that are creating the flow problem in hospitals; it's particularly in the emergency departments where the issues are. It occurs for a couple of reasons. One might be somebody needs to see a specialist and if the specialist doesn't show up for two hours, that delays; it's when the test is done - it's not just one factor, there are a whole number of factors. As a matter of fact, it's one of the things we've been talking about with my own staff: what's the strategy we can develop to try to streamline some of those processes to make it a heck of a lot easier and to reduce some of the frustrations for individuals?

As we know many of the issues of individuals, particularly in the rural areas, are because they don't have a family doctor, which is another strategy we're working on. If we

can make some of those things work we can reduce a lot of the frustrations. It may not reduce Halifax, but we can reduce the rest of the province.

MR. MACMASTER: The department had said that planning for the balance of the 1,320 new long-term care beds provided for in the strategy will begin in 2012. What is the status of that?

MS. KNOWLES: We have completed the analysis of both home care spaces needed and new long-term care bed spaces, and I've started also the analysis of the replacement facilities. We reviewed 68 facilities that were older than 15 years, so we're just in the final stages of completing that work, because one affects the other, right? If you invest more in home care our claim is we need potentially fewer long-term care beds, so that is just working its way through approval processes within the government. I think the deputy said we haven't yet presented through finally to the executive committee, to the minister.

MR. MCNAMARA: Just based on that, can you give us some indication of the amount of investment in home care over, say, the last three years? Can you compare the impact and the amount of investment in home care versus long-term care beds?

MS. PENNY: Over the last three years: we had a budget in 2009-10 of $157 million, roughly, in home care and our current budget is $194.2 million; long-term care was $411.5 million in 2009-10 and it's now $529.4 million. So interestingly they've grown at the same percentage rates, home care and long-term care.

MR. MACMASTER: At the same time we've not seen any new long-term care beds constructed or provided other than what was previously planned. Are we going to be able to keep demand? In your presentation you talk about our demographics are showing - we have the first baby boomers retiring in 2011 so the demand looks like it's going to continue. Why isn't the government looking at creating more long-term beds now?

MR. MCNAMARA: As I had mentioned a number of times, the first emphasis is going on home care - what we can do to divert - and particularly when we know that long-term care beds are extremely expensive.

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

MR. GARY RAMEY: I'll just ask one question and then pass it off to my colleague from Pictou East. There were some very positive things that you said in your opening remarks and I just want to point out two of them, and then I want to ask a question. I think you said in here somewhere - and I can probably find it - about 44 per cent of seniors in Nova Scotia volunteer in any number of organizations. I know a couple of times during the discussion there were comments made - not by anybody in a disparaging way but just the

remark that sometimes seniors are considered to be a problem or something like that maybe by society, and they're definitely not. They're actually part of the solution and we have a wonderful opportunity with the seniors we have.

You also pointed out near the beginning, you said, as many would know here in Nova Scotia - I'm quoting you - and across Canada, our population is aging. In fact, in 2011, the baby boom generation began to turn 65. So welcome to my world. That's exactly where I am now. As a result of that, I got some stats from the Department of Seniors. I know in 2007, 700 people per month were turning 65. I don't have the updated version of that, but my best guess is that it's higher than that per month now. So we know that there is an issue there.

I guess I'd also argue because when I'm travelling the world, I never cease to be amazed when I get home how lucky we are to live here. I know sometimes when people are here they don't really maybe recognize all the great things that do happen, but we have very good primary care too, which allows us to get older. Some of us probably wouldn't if we didn't have good primary care as well.

Here is my question, based with those few facts at the beginning, most of the seniors in my area would prefer to stay in their homes. I've had a million discussions with many seniors and I know that's what they want because they tell me that's what they want. When did the department seriously look at the strategy for keeping people in their home as a serious option to just building more and more beds in facilities? Can you trace that back for me and update me a little on it?

MR. MCNAMARA: A couple of things - I'll just respond to your first points first. When I'm talking about stigmatizing seniors, we've heard it said by hospitals and others that seniors are bed-blockers. That's where I'm talking about the stigmatization and getting away from using those types of words. They're not there because they're blocking beds; they're there because of a necessity.

When you also talk about the baby boomers, I think Mr. MacKinnon joins you, as do I, and we're all contributing members to society as well, I hope. The younger generation may not agree, but that's okay. (Laughter)

Going back to when did the home care strategy - as a matter of fact, it was first muttered publicly in my last appearance before this committee talking on long-term care. That's when I said that one of the things we have to do is move towards more home care and stop building beds, and I remember going back to the department and Minister MacDonald blanching a bit because I hadn't discussed it with her in advance. But after we went through a lot of discussion, we all agreed it's the right thing to do and so it has become a policy to try and move that forward.

It doesn't mean we stop doing beds, but we have to work hard at helping people stay at home first and that has been thankfully the emphasis of this government in trying to do that as the number one priority and recognizing that we still have institutionalization to deal with as required.

MR. RAMEY: Thank you very much.

MR. CHAIRMAN: Mr. MacKinnon.

MR. CLARRIE MACKINNON: I'd like to follow up on one of the Auditor General's recommendations and Mr. MacMaster touched on it as well, and that was in relation to putting the wait-list for long-term care on a Web site. Do you think there will ever be an opportunity to do that because we know now of how inaccurate the list is and the fact that many people do put a name on the list far in advance of needing the bed?

MR. MCNAMARA: Our commitment is to have the wait-list up; we just want to clean it up first. As I've indicated a number of times in appearing before this committee, our belief is that we want to move from worst to first in honouring the AG's recommendations. That's a mantra that I know staff in my department know we're trying to live by and to make sure we can implement the recommendations that were not implemented for many years. So yes, it is a commitment, it will happen; we just have to get it cleaned up first.

MR. MACKINNON: Thank you for that. I understand why it isn't being done now and I appreciate the fact that you are looking at it and so on.

I want to talk about service delivery agreements. On service delivery agreements, the Auditor General was okay with the new long-term care facilities and the agreements that have been signed, but there were some concerns with existing service agreements and the providers there. Is that something that you're looking at down the road?

MR. MCNAMARA: Well, to start with, in terms of service agreements, first there was one between the department and the DHAs, and that took a considerable amount of negotiations. Then we moved on to doing one with the long-term care sector and the DHAs, but we became the negotiator - I'll use that word - in the middle. That took a tremendous amount of work by our staff and by others. There was a lot of resistance to it and, in fact, some of the facilities had hired lawyers to try to water down the agreements. I think we stuck to our guns and I think we got a decent agreement.

Yes, there has to be more work done and we have to build on our accountability. But we have step one done, and as we go and redo them, then we can start increasing the accountability and increase the work and get a more global agreement on what it looks like. The other thing in moving from the individual facilities was dealing with the Department of Health and Wellness and moving through DHAs. There was an initial distrust in some

cases, so we have to build that. What we're finding is now that they're working together that trust is building, and as trust builds it is much easier to build an agreement that everybody can live by and in a better way.

MR. MACKINNON: One of the areas the department rated very well on was inspections. There have been so many new facilities built and the inspection process, the pre-occupancy inspection - I think there are more; there are several inspections or at least two inspections, it's my understanding. I think those inspections have rated very well. Can you comment on that?

MS. KNOWLES: Yes, I concur. We were able to hire a few more staff, as well, with all the new facilities. Another change in our inspection process is we have added an additional visit, an unannounced visit that occurs in the course of the year, in addition to the regular annual inspection. We have had quite positive feedback not just from facilities, but the deputy mentioned Accreditation Canada has commented on the long-term care facilities that are accredited and that they are above kind of the national average for some of those responses.

MR. MACKINNON: I'm very, very impressed with two new facilities in Pictou County, one in Pictou and one in Trenton, just outstanding facilities, but I have to get a local question in here as well. With the district health authority there we still have about one-third of the beds in the Aberdeen Hospital which are, in fact, occupied by people, good citizens waiting for long-term care. I know there are a number of initiatives and I don't think you talked about the new one with the district health authorities - I'm trying to remember, I think it's called the Home Again program, and so on. Will we, in fact, see that tremendous problem that exists there - because this has an impact all the way down through the system. It has an impact from the ER right through because people in the ER can't get beds oftentimes and so on. I know you're trying to address that with the home care but do you see a solution to that down the road for that facility and other facilities?

MR. MCNAMARA: Yes, I do. As I said, we're working our way through. We had to start somewhere so we started with the home care, and home first is one of the things that we're trying to do. We have to work with our DHAs, we have to work with the polypharmacy issue, how we can help individuals, what can we do to help people maintain or even help families cope with individuals that they would like to look after.

One of the things we sometimes forget is that we have to look after the caregivers too. One of the programs we have put in place and we've been recognized nationally for our leadership in providing support to caregivers, family members. This is something that we - if we can put a bit more resources into that, we can also help individuals to not end up in facilities. How do we provide respite care so individuals can get a break from looking after individuals? That also helps. If you can get a vacation away from looking after your father or mother or spouse, it does make a big difference. So we have to become more aggressive in looking at those types of programs. All of these together will make a

difference. It is a building block and we're keeping to adding to what we already have in place.

MR. MACKINNON: It's also my understanding that you have made monies available to the health authorities for this new initiative, the Home Again program. Is that having an impact, or is it too early perhaps? It might be too early to even assess that because I think those monies are relatively new in relation to the provision of them.

MS. KNOWLES: Yes, they are. In Capital Health there was a pilot program and it has been running for more than a year, so there is information and data that has come out of that program. For the rest of the DHAs, we rolled out that money and that initiative. I think it was just at the beginning of November but there's regular accountability reporting that would come in from the DHAs, so we just haven't received that yet and can't comment on the specifics.

There's a lot of evidence across Canada that this is the way to go, so we do expect it will be successful. At the same time that program was announced, there was a program for additional funding to assist districts with supporting some of the activities of daily living, so money for transportation, for example, if that was a need. That also just rolled out in November, so again, we'll be anxious in the last quarter to see what difference that has made.

MR. MACKINNON: I really appreciate the department coming along with this initiative. I'm anxious for you to keep us updated as time goes on, which I'm sure you will.

Mr. Epstein was sort of cut off when he was talking about the security deposit elimination and the income-splitting rules. What have those two initiatives done for seniors? That's sort of a broad question but I think it has had a fundamental impact on the system and a great provision for the people of Nova Scotia and the seniors of Nova Scotia.

MS. KNOWLES: The income splitting, previous to this Fall, used to be assessed at 50-50, so the income that a couple had, 50 per cent was assessed to pay the hotel or accommodation changes in a long-term care facility. We heard many examples of hardship that created for the spouse left in the community, sometimes with the very same costs - rent for the apartment or whatever. So this Fall the change was made from 50-50 to 60-40, meaning the spouse in the community would retain 60 per cent.

MR. CHAIRMAN: Order, please. Unfortunately, the time has expired for oral questions. I believe that Ms. Knowles answered the question very well, thank you.

I've asked the deputy minister to make some brief wrap-up notes.

MR. MCNAMARA: Thank you very much. I thank the members of the committee for the opportunity to present. Too bad that Mr. Younger has left, there's one correction in

what I had mentioned on the First Nations: there are 16 individuals, not 12; and the cost is $1.5 million, not $2 million. I just wanted to make sure the record is corrected on that. Also, Mr. Porter mentioned about MLAs and I think one of the things we may do is go back and put a package of information together to go to all MLAs. That may help them in talking to individuals who call them and make their life a little easier - on the programs that are available, so we can do that.

I also want to thank the AG for holding our feet to the fire as we're moving this forward. I don't always look forward to his reports, but it does help us provide a better service to Nova Scotians and we do appreciate that.

I just want to make one personal comment. I have a very elderly aunt who is now in a nursing home in Kentville. She lives in Richmond County so with the distance she's not within the 100 kilometres, but it's working out for the moment. She was previously receiving home care and the home care workers used to prepare her meals a day in advance. She was quite pleased with that and it allowed her to live independently an extra five years at home. We all experience it and also, I guess I can say by her living so far from her own home that there is no preference given to anybody in this province no matter who. Thank you very much.

MR. CHAIRMAN: Thank you very much. Indeed, we appreciate the fine work that the department does and a very difficult job you have with the changing demographic in the population, and you will provide us that information for MLAs; I think that's very, very helpful. I know in my case, it will be very helpful.

We really don't have any business. Our next meeting will be January 16th. We'll have a workshop on effective questioning and follow-up for the Public Accounts Committee. That will start at 9:00 a.m. That will be in the Dennis Building, Committee Room 1.

If there is no other business, a motion to adjourn would be in order.

MR. MACMASTER: So moved.

MR. CHAIRMAN: We stand adjourned.

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