HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, May 13, 2015

LEGISLATIVE CHAMBER

Department of Health and Wellness
Long-Term Care and Continuing Care Policies

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Mr. Allan MacMaster, Chairman
Mr. Iain Rankin, Vice-Chairman
Ms. Margaret Miller
Ms. Suzanne Lohnes-Croft
Mr. Brendan Maguire
Mr. Joachim Stroink
Mr. Tim Houston
Hon. Maureen MacDonald
Hon. David Wilson

[Mr. Bill Horne replaced Ms. Margaret Miller]
[Mr. Eddie Orrell replaced Mr. Tim Houston]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Mr. Karen Kinley
Legislative Counsel

Ms. Nicole Arsenault
Legislative Counsel

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Mr. Kevin Elliott, Chief Financial Officer
Ms. Carolyn Maxwell, Director, Liaison and Support
Mr. Perry Sankarsingh, Director, Monitoring and Evaluation

HALIFAX, WEDNESDAY, MAY 13, 2015

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Good morning everyone, I call this meeting to order. Today we have with us the Department of Health and Wellness to speak to us about the long-term care and continuing care policies of the department.

I would like to begin with introduction of members of the committee.

[The members introduced themselves.]

MR. CHAIRMAN: I would like to remind everyone to place their phones on silent so we don't have interruptions during the meeting today.

DR. PETER VAUGHAN: Good morning, bonjour tout le monde, thank you very much Mr. Chairman. Thank you for inviting us to speak with you today. Here with me today is Carolyn Maxwell, Director, Liaison and Support Services and Perry Sankarsingh, Director, Monitoring and Evaluation for Continuing Care Branch and of course, the department's Chief Financial Officer, Kevin Elliott.

This morning our team will update you on the work underway in the Department of Health and Wellness, particularly as it relates to providing Nova Scotians with continuing care choices. Allow me to start with a short overview of the Continuing Care Branch. Continuing Care serves Nova Scotians who require ongoing care either on a long-term or a short-term basis. Continuing Care Services include a range of home and community-based care and long-term care.

Some examples include: home support and nursing services, support for caregivers, home oxygen services, adult protection services, bed loan program, and long-term care. These services are administered by the new Nova Scotia Health Authority and delivered through funded providers such as home care agencies and long-term care facilities. Over the years, the Continuing Care Budget has continued to grow. We now spend over $800 million - $808 million - on continuing care services. This investment represents about 20 per cent of the overall Department of Health and Wellness Budget.

With the oldest population of any province in Canada, demand will continue to grow. If the province continues under the current model, costs will continue to rise and services for seniors could become even harder to access. The province must look for better ways to expand home care at home and reduce reliance on long-term care, a new model that is person-centred, efficient and sustainable into the future.

In 2006 a 10-year Continuing Care Strategy was released. At that time, the strategy was based on the best research methods available. It was, in essence, a building strategy. The province added over 1,000 new, long-term care beds, replaced aging infrastructure with new facilities, and introduced numerous new home care programs and services. Yet, wait-lists and budgets continued to grow at an unsustainable rate. Nova Scotia has the highest number of long-term care beds per capita yet those who need support remain on wait-lists. Today, placements are based on when a client was put on a list rather than based on the needs of the individual. This makes an inefficient and, frankly, unfair system.

Nova Scotians want choices and options including choice to stay at home. We know that with access to care and services when needed, people can stay in their homes longer. Our services must be designed to help them do exactly that. The province is changing the way things are done to better meet the needs of people as we all age. We have to; our population is aging and today's system will have trouble meeting the needs of the aging baby boomers. A more modern, innovative system is needed and planning is well underway.

The province recently announced changes to our long-term care policy to make sure those with the greatest need will have more timely access to long-term care beds. These are sound and absolutely necessary policy changes, to ensure long-term care is there when people need it.

Learning from the past and looking at what is working around the country and internationally, the province is developing a new Continuing Care Strategy set for release

in 2017. We know other provinces are doing better with less. Tomorrow's seniors deserve to have the dignity to make choices related to their care. With the help of their family and a little extra professional support, they can stay in their own homes longer delaying the need for long-term care or from entering hospital.

The province is looking at the options for sustainability of home-care services including the feasibility of an RFP. For example, how best to streamline administration, support continuity of care and most importantly enhance the quality of care through more flexible and consistent service across the province. This avenue for exploration is also in line with the Auditor General's recommendation in successive reports that government comply with the province's procurement policy and practices, and secure home care providers through a more accountable process.

The budget also included additional funding to support 385 more families through the Caregiver Benefit Program. We know the reality of 6.1 million people, employed Canadians, who must balance their personal commitments, their caregiving duties and work-related responsibilities. The time and physical demands are often equivalent to two full-time jobs. We know that much of the care for seniors and vulnerable adults is done by family and friends and we have to do a better job at supporting our caregivers. This additional funding is just a start.

We need to continue to pose the important questions like what role can families play? What role can government play and what can communities do to help guide the future development of continuing care services?

In closing, I would like to reiterate how vitally important it is that we have effective, quality services that are efficiently delivered and person-centred. We will continue to evaluate our services and programs to ensure they are delivering value for money. With our demographic reality we need to make wise and strategic investments to meet current and future continuing care needs. I would now be happy to take your questions. Thank you.

MR. CHAIRMAN: Thank you, Dr. Vaughan. We will begin with the PC caucus, Mr. Orrell for 20 minutes.

MR. EDDIE ORRELL: Mr. Chairman, thank you, Dr. Vaughan for your presentation. Early on in your presentation you were talking about support for caregivers. What supports are available for caregivers and how difficult is it for them to access those supports?

DR. VAUGHAN: Mr. Chairman, it's an important question. The Caregiver Benefit is a benefit that people can access. It's never enough, we appreciate that, but it's an important beginning to allow families to be able to tap into resources that allow them to provide the services they need to do that for their loved ones at home and it really is about supporting the care of the individuals at home.

MR. ORRELL: Mr. Chairman, I guess the question I have is not personal as much as - the person who is caring for their loved one at home. They take them home. They apply for the Caregiver Benefit. They are denied because they're told the person doesn't have dementia, a mental type of illness that would require a person to get someone to fill in. I guess a person is disabled, but they don't have a screaming, difficult person at home and can't access that benefit and I'm told it's because there's no mental health aspect to that person's care. Is that being changed because most people who take a loved one home with a physical disability need the help as much as a person with some kind of mental disability?

DR. VAUGHAN: There are challenges across the spectrum of care so thank you for that question. We're always looking to improve the access to programs like the Caregiver Benefit program. The reality is there isn't the resource available. We live in a time that does have fiscal constraints and we're looking to focus as much as possible on the needs and the evidence of needs of the patients and the citizens who are living in their homes with many difficult challenges. We don't have the resources, always, to commit to all the areas but it is something that we would be looking at going forward.

MR. ORRELL: Thank you again because people who take their loved one home and have a challenge, who need the rest or need the support that way, is as important as someone who has a person with early dementia. I've talked to people in my constituency who, when they took their loved one home, knowing it would be a lot of work, thought they were going to be able to access the Caregiver Benefit and couldn't. Those people usually, because they are older, end up either needing care themselves or putting their loved one back into care, which is really costing more money than if it was the benefit itself. Thank you for that.

I guess my next question is, you said the budget for home care has grown to $808 million. How much has that grown to get to that stage? What percentage of the budget or what percentage of money is the difference there?

DR. VAUGHAN: Thank you for that question. We - the government - have put more into the long-term, over $262 million of new funding since the strategy was developed in 2006. That doesn't include capital investment, which is somewhere estimated to be around $450 million, in terms of replacement beds. We have invested significantly, around 71 per cent increase in that 10-year period.

MR. ORRELL: You also said that in 2006 you had a 10-year plan and in 2017 you will be coming out with another - you didn't say a 10-year plan - with another plan as such. Who is being consulted on this new plan and is it going to be done before the plan is introduced or would it be done after the fact, as we've seen over the last little while with other certain aspects of health care?

DR. VAUGHAN: Thank you for that question. It's a great and important question. The Continuing Care Strategy as we have noted, has been in place for almost 10 years and it has been mostly a build strategy, as I outlined in my preliminary remarks. The minister

has committed to a refresh of the Continuing Care Strategy by the Spring of this year and as we all know it was a long winter so we're looking to the astronomical date of June 21st when summer begins, so we have a bit of time and are working on that strategy as speak. The strategy will look at how we begin the short-term, medium and longer term options going forward. Consultation will then take place after that but we will be looking at a draft by the end of June, by the middle of June, at which time we will begin the conversation with stakeholders in terms of how do we roll out a plan for continuing care for the future.

It's important, I think, to understand that we have invested a significant, we, as a government, successive governments, as a people of Nova Scotia, have invested a lot of money in the build of facilities, in particular, over the past 10 years and we have now a situation where we need to think about what the future opportunities are to look at providing more services in the home.

Necessity is the mother of invention and we're on a track that is not sustainable continuing to go down the road we're going down. The new continuing care refresh will look at what are the options going forward? What are the short-, medium-, and long-term options that we need to have a conversation about? It won't be just coming out with a plan, it will be coming out with a plan to have conservation, and what can we do in the short-term as well.

MR. ORRELL: Thank you Dr. Vaughan. My next question is - in your statement you said that Nova Scotia has the highest number of long-term care beds per capita. My question is how does that compare to the amount of seniors, per capita I guess, in the province, is that comparably the same or is different than other provinces?

DR. VAUGHAN: That's a good question. We like to look at comparative standards across the country. On a per 1,000 population basis, the national average is 86 per 1,000 population. Nova Scotia currently runs about 113 point something per 1,000. Our goal - and has been our goal through the Continuing Care Strategy we currently have, and continuing to look at the replacement bed option - would be about 115 per 1,000. So we're still well up, but we can't continue to grow.

I think the important point is there are many options that are becoming available to improve care within the home. Technology is certainly improving to allow us to do that. It's being done in many countries. It's being done around the country. There are many options that allow for innovation and care delivery within the home that allows for people to have a long-term care option when they really need it, so they're not seeking long-term care options as a first option, but a home-first philosophy is really what we're trying to achieve.

MR. ORRELL: So the 86 per 1,000 is the number of beds nationally?

DR. VAUGHAN: Nationally.

MR. ORRELL: And the 113 is provincially?

DR. VAUGHAN: That's our provincial rate currently.

MR. ORRELL: What is our percentage of seniors per capita compared to other provinces, I guess is the other question I have - if it's 86 per 1,000 for beds and 113 per 1,000 - what does that compare? Because Nova Scotia is an aging province - we have a higher number of seniors per capita so it would only make sense that we would have a higher number of seniors' beds or long-term care beds per capita. So how does that compare to the amount of seniors we have in the province?

DR. VAUGHAN: Are you looking for the total number of seniors we have in the province?

MR. ORRELL: No, per capita. If it's 86 per 1,000 capita for beds, which is low, the high for 113, but we have a high per capita of seniors as well so it would only make sense we'd have to have the same number of beds to accommodate for that.

DR. VAUGHAN: We're 17 per cent of the population currently.

MR. ORRELL: Also, in your opening statement, you're looking at the feasibility of an RFP to deliver home care services - could you explain to me what the feasibility of the RFP means?

DR. VAUGHAN: Sure, thank you for the question. Three successive Auditor General Reports recommended that there needed to be a more accountable value-for-money approach to the home care purchasing. We looked at what the options are and one of the options certainly would be an RFP, but one of the things we've learned in this period of time that we've been - we've had a consultant engaged in looking at what the parameters and the elements of an RFP might look like, talking to a lot of people, talking to unions, talking to the service providers, both the for-profit and the not-for-profit, that there may be opportunities in a collaborative way to bring people together to work on and achieve many of the same kinds of elements that an RFP might achieve without necessarily going to an RFP in the first stages, such as achieving performance or service agreements. Service level agreements could be achieved by bringing a collaborative approach to work with the service providers. Standards could be improved - service standards in particular.

There is wide variability across the province now with home care availability. Some areas have virtually no wait times and others have very long wait times. So there are opportunities to collaborate with the service providers that, in the short term, may not lead to an RFP. It may be something that could be considered down the road, but may not in fact be necessary in the short term to achieve our goals.

MR. ORRELL: Is the department conducting an analysis of how this could benefit or harm the quality and the delivery of health care - especially in rural Nova Scotia where

the geography is a lot larger than it is, say, here in the city area? Because not only can the health care system be - I won't say "flawed" in rural Nova Scotia, but difficult to deliver. Because someone who is delivering home care in Sydney who has to go out into East Bay or out in Louisbourg, or somewhere like that, and come back, there is an inefficiency involved there and it has to be factored into the time frame. Has that been looked at by the department and have they been conducting any analysis on how this is either going to benefit or harm the system?

DR. VAUGHAN: Great question again. That's one of the benefits that taking this time to work with the consultant and talking to the providers, unions and others - there would be apparently a great interest in looking at a collaborative approach to try and develop some standards; to look at what opportunities are there to use technologies such as GPS, for example; to look at how things can be standardized across the province. Standardization is an important first step in improving quality of service.

There is a great opportunity having had the time with the consultant to go out, and speaking to providers and others, to look at other ways of achieving the results without necessarily holding the RFP out as the only option, still an option, but it is not necessarily the only option. I think, keeping our goals in mind, the department has been very clear that we're about improving the services to individuals who absolutely need those services and that those services need to be standardized throughout the province so there is accountability as well.

There are ways to achieve what the Auditor General laid out in terms of performance without necessarily an RFP.

MR. ORRELL: We've heard in media and in questions that we've asked in the House here that the department is going to ensure that there is a high quality of care. Can we get that commitment from the department that there will be the same quality, or better quality of care, when a new strategy is introduced or when a new RFP is put out or when there is another alternative delivery to the system? Can we get assurance that that standard and quality of care will be met and maintained or even higher?

DR. VAUGHAN: I think the most important question is around quality of care. We are absolutely most committed to improving the quality of care. This is the reason that Nova Scotians entrust their most important care to us because they believe that we're going to deliver that care in a quality and safe manner. We absolutely need to ensure that the processes and the systems are in place, the accountability measures that are put in place.

In the coming year the accountability framework that will be developed that will outline the targets to achieve the performance that is required to deliver that quality care is a new way of doing business for Nova Scotia, in the health area, but it's absolutely essential to be able to know, all of us, including the patients receiving the care, that they're actually getting not only the value for money but the quality and safe care that they absolutely want and need.

MR. ORRELL: One of the questions and concerns that I'm getting from constituents and people who do provide home care is if they go to a lowest bidder system, we'll say, that the workload of the employees would be such that they would not be able to deliver that quality of care.

The other question is, if there are standards in place for the care and the quality care delivery, we'll say a CCA or PCW has to have first aid, has to have training in lifting, training in back care, training in whatever, this would be included in the process of the bidding so that employers, or the bidding people, would be on the same ground when they are providing services. One of things I've heard is that some of the home care providers now, who are contracted to some of the other providers that are there already, just have to ensure that their employees are either enrolled in a course to upgrade or plan on taking the training that would all them to provide that quality care to our clients.

The fear is that there is no follow-up on have they actually completed it, so a company can come in and employ someone at, we'll say, $12 an hour that says they're going to get the training and they'll be bumped up to their regular rate of pay and never do so they never change that. So the concern of the people delivering the care is that they're all operating on the same level playing field. Can we ensure that that's going to happen and that everybody who provides the care will have equal education so that the care provided is the same across the board, the same in Sydney as it would be in Yarmouth, and in anywhere in-between?

MR. VAUGHAN: Thank you for that question, I think it's important to recognize the value that we place on all of the health care workers who are providing these services. We absolutely depend on the education, training, and the quality of the health care workers who do a tremendous job on a daily basis, sometimes in challenging weather and difficult circumstances, to achieve what they're tasked to achieved and what we're asking them to achieve in the interests of Nova Scotians every single day in this province.

One of the opportunities when we sit down in a collaborative manner is to develop a performance standard around training. We're looking at ways to be able to measure and monitor that – whether it is policy or legislation is yet to be determined, but ways to be able to ensure there's consistency. As I said, standardization is the foundation of quality.

MR. ORRELL: I guess I have a couple of minutes left, so I will ask a quick, hopefully easy, question. The current wait-list for long-term care is around 2,500. That trend, I assume, is increasing. Could you tell us, is there more emphasis being placed on keeping people at home and decreasing the amount of need for long-term care and, if that's the case, are we going to inject more money, financial need resources, into the home care system to allow that to happen?

DR. VAUGHAN: I think it's important to understand that over the 10 years that we've had the Continuing Care Strategy we've had, consistently, a wait-list. The wait-list has consistently been in the 2,000 area, plus or minus. In the past six months we've moved

to reduce the wait-list for the in-hospital, and particularly from 303 to 186 as of May 6th - so a significant reduction of those patients in hospital waiting for long-term care beds.

That's an important part of the system because as we're trying to improve the wait times in emergency, we need to improve the throughput and the flow through the hospital and the patients in those beds to ensure that they're getting the care they need in the appropriate place that they need it – whether it's in the home or whether it's in the long-term care facility. The continued pressure for long-term care beds is a symptom of a problem that needs a different approach. That approach that we are taking is a home-first philosophy, which has been successful in many jurisdictions and in other international jurisdictions as well who also have aging populations, to look at providing more care in the home.

That's the journey that we are on. There are great opportunities to introduce innovation and technology in particular.

MR. CHAIRMAN: Order. I'm sorry. Thank you for the answer. We will now move to the NDP caucus and Ms. MacDonald.

HON. MAUREEN MACDONALD: Good morning everyone. This is such an important topic that we could be here for more than the time that's allotted.

I'm going to focus on the long-term care piece of the Continuing Care Strategy, and I want to start by asking you, as of today or the last time that you have information for leading up to today, how many people are on the wait-list waiting for long-term care in the province - what are the numbers today?

DR. VAUGHAN: As of May 6th, there are 2,126 people.

MS. MACDONALD: Can you break that down further by region or zone in the province?

DR. VAUGHAN: I would have to get you that specific information later on today.

MS. MACDONALD: Thank you. Could you tell me how many of those folks are at home and how many are in hospital?

DR. VAUGHAN: Yes, 1,940 of those people are in the community, and 186, as I mentioned earlier, are in hospital - for a total of 2,126.

MS. MACDONALD: Thank you. How many people will be added to the list in a day in the province?

DR. VAUGHAN: Approximately 20 people a day.

MS. MACDONALD: How many people will leave a bed in a day in the province?

DR. VAUGHAN: It would be consistent with that same number, the inflow and outflow would be the same. We have reduced the wait times, on average, about 13 per cent.

MS. MACDONALD: Since?

DR. VAUGHAN: Over the past year.

MS. MACDONALD: You indicated that the people who are in hospital - in a hospital bed - that number has been reduced considerably. Could you explain what process was put in place to achieve that reduction - not necessarily the process, but the elements that achieve that reduction, so I guess my question is: If you're in a hospital bed and you require long-term care, do you move to the top of the list, for example, in your area? Is that one of the things that occurred - how did that decrease occur?

DR. VAUGHAN: I will ask Carolyn Maxwell to answer that level of detail that I think would better answer your question.

MR. CHAIRMAN: Ms. Maxwell.

MS. CAROLYN MAXWELL: One of the elements that has occurred since March 2nd is that we changed our long-term care policy. Phase one was to ensure that we removed the deferral process, which meant that a person who was actually on a long-term care wait-list - no matter where they were waiting - had to accept a bed. We have seen a decrease, as the deputy has said, certainly in the last three months of our wait-list because of that.

We can support removing the deferral option because what we do know is that there are a number of people on the wait who were receiving no home care services or, in fact, were receiving less than 20 hours of home care services a month.

The second thing that we've looked at is obviously the response time standards of everyone in the system. We know, on average, it takes 10.7 days to fill a long-term care bed and we're actively working with all parties to decrease that number to six.

The other aspect that we've implemented since March 2nd, and are working with the new Health Authority on, is an oversight committee to ensure that all people who are on our long-term care wait-list, whether they're in hospital or in community, are actually - there is a sober second glance to make sure that's exactly where they need to be.

One thing that the deputy talked about was our new approach to a home-first philosophy and that's really where we're striving to go with all individuals. We know that most individuals want to stay in their homes as long as possible.

Phase two of our long-term care policy, which I think will be very helpful and supportive for Nova Scotians, is that we are moving towards a needs-based admission to long-term care, which means right now we have individuals on a wait-list because they've been assessed before the person, perhaps, behind them. What we're looking at is making sure that we place individuals based on their care need, and so all of those elements will hopefully see a further decrease in the number of people either waiting in hospital or in the community for long-term care.

MS. MACDONALD: Thank you. That may be something I can return to a bit later, but I want to get a bit more of the data - the numbers. I want to know: How many days, on average, will an individual or a family wait for a long-term care bed?

MS. MAXWELL: It could be up to nine months. One of the variables that we have to take into account is the area or the facility that they want to be admitted to and the wait-list for that facility. Some areas are more popular than others, so we know that some facilities have longer wait times.

MS. MACDONALD: What is the minimum amount of time? If the maximum is up to nine months, what is the minimum wait for a long-term care bed, on average?

MS. MAXWELL: Nine months is the average, and it could be anywhere from 30 days to one year.

MS. MACDONALD: What is the daily operational cost of a long-term care bed? I suppose there is a range, but what is the cost to operate a bed?

MS. MAXWELL: The average is $250 a day per bed - recognizing that the actual individual contributes an accommodation rate.

MS. MACDONALD: So of that I know there's a sliding scale based on somebody's income in terms of how much they actually contribute to the shelter allowance portion, I believe. Let's say you were an individual who fell above the ceiling, what is the per diem you pay for board and shelter costs and what is the health care component of that $250?

DR. VAUGHAN: Mr. Chairman, I'll ask Kevin Elliott to answer that question.

MR. CHAIRMAN: Mr. Elliott.

MR. KEVIN ELLIOTT: Mr. Chairman, the maximum for a nursing home is $107.75 per day and for a residential care facility it is $64.25 a day for the accommodation costs.

MS. MACDONALD: Okay, thank you. Now you've indicated, deputy, the situation is not sustainable in terms of the finances and I'm curious to know more about this. In 2006, you indicated there was a 10-year plan and it resulted in the addition of 100

new beds, but I think the plan intended to put more like 1,400 or so beds in, is that correct - how many beds were intended to be built under that plan?

DR. VAUGHAN: Sure, thank you for that question. There were 1,595 new long-term beds and replacement of 1,744 long-term care beds by 2016. To date, 1,018 new beds have been opened and 898 beds have been replaced. An additional 79 long-term care beds are forecast in the fiscal year 2015-16. The total bed count, which is really what we're talking about here, is 7,824, which represents our metric that is problematic from a sustainability perspective. If we continue to focus on that one area alone then we have a sustainability problem going forward with our aging baby boomer population.

MS. MACDONALD: I understand the issue. I guess the difficulty I have is that the demographics are the demographics. This is a matter we, as Opposition members, need to take up with the members of government, the Minister of Health and Wellness, and the Premier. It may be the case that this is a very expensive proposition, but the truth of the matter is that there are quite a high number of people in our province in need of long-term care.

As you, yourselves, point out, the data demonstrates that the wait-list has been consistent over a very long period of time. That tells me that you can do tinkering to try to squeeze more efficiency out of the system, but you still essentially have those demographics to deal with. And I know it's challenging because I sat in the seat. But I think at the end of the day we have to come to grips with the fact that we have a higher proportion of our population who are aging than many other provinces in the country, and we need to ask ourselves whether or not it's acceptable to off-load care on to families who have already a lot of burden and challenges around care.

I know that you indicated that there's not going to be a new comprehensive plan until 2017, but there will be a refresh of the existing in five weeks. I have some concern that we have to wait two more years to see a comprehensive plan to deal with our aging population and this whole issue. It's very far out and I'm not sure that we can afford to wait that long for a new plan. Having said that, I want to know what analysis the department has done - cost analysis, cost-benefit analysis - of adding additional bed capacity into the system to ease some of these wait-lists.

In the news I've seen the minister say that the wait-list could be cut in half by going to a different kind of an assessment, where people who don't really need long-term care are provided with other options in the home. But that still leaves 1,300 people on the wait-list, as far as I can tell from the media reports. Are those people in need - without options - having to wait anywhere from 30 days to nine months or a year for long-term care?

What number crunching, in terms of what it would cost to add capacity to the system, has the department done to look at what it would take to reduce those wait-lists of 1,300 people or so?

DR. VAUGHAN: Just let me comment first, and then I will get Perry to drill down on the specifics of that. I think it's important for all of us to understand that we had a system where people felt they needed to simply get on the wait-list to get in the queue. We know from other jurisdictions and internationally that when we bring a more evidence-, needs-based approach that people are determined to be placed on the list based on their evidence of need, then that in itself changes the parameter of the wait-list. That is what has happened in other jurisdictions.

So when we look at our costs - and I'll let Perry answer your question specifically in the detail - we know it's half the price or less to have people in their homes than it is to have people in a long-term care facility, and ten times cheaper than people in an acute-care facility.

It serves everyone's interests to be treated in the home as much as possible with the appropriate supports.

I haven't answered your question.

MS. MACDONALD: I know, and I want to make my question a little more succinct, if I could please, so that the answer becomes a little more succinct.

I want to know how many beds would be required to clear up the wait-list and at what cost. That's what I really want to know. Has the department done that analysis - how many beds would be required to clear up the wait-list and what would the cost be? It seems to me to be a fairly straightforward proposition.

DR. VAUGHAN: The analysis would let us believe that we have sufficient resources in terms of long-term care beds if we have a different approach - a needs-based approach - to assessment of clients who are on the wait-list.

MS. MACDONALD: So that means that we have, let's say 1,300 people out of the 2,000-or-so whom the department would see as really needing a bed, like today - the day of their assessment - but you don't have the capacity to give all of those folks a bed today. Only 20 people could get a bed today. So there is something that needs to happen.

I guess what the department is saying - the government is saying - that you accept that people will have to wait. They can't get a bed in 24 hours and there will be a wait time. So then my question is: What is a reasonable wait time? What standard is the department working toward that is a reasonable wait time to get a long-term care bed in the province?

DR. VAUGHAN: Going back to the national metric of 86 beds per 1,000 - we currently have 113.1 beds per 1,000. Our goal is 115 beds per 1,000. That's well above the national average. So a better system to evaluate who needs to be in those beds is really the national/international approach to placement.

Ontario has a standard of around 90 days and that's a benchmark that's reasonable, but we first have to put in place a better assessment tool that allows us to be needs-based, focused on the patient's need for long-term care, and there may be other options within the home and the community.

There are many things we can do as communities to improve the environment - communities of excellence where we have much more physical activity. We are bringing out a dementia strategy in June, which will help us address that major area of concern as well. But the overriding answer to your question is that we really need a different approach and not put all of our eggs in the basket of more long-term care beds, as we have done over the past ten years.

MS. MACDONALD: I have no difficulty accepting the fact that we need a variety of options for families, including better supports for people to remain in their homes. I had an aging father who was very ill at the end of his life and he was assessed by home care, and with a gerontologist. My dad didn't want to go into a long-term care facility. The gerontologist, the specialist, said to me that there is a point where your mom isn't going to be able to provide support and neither will you, and the time has come now to have an assessment because we can't predict what's going to happen to your father in the next two months. His health is declining very rapidly and his care needs are getting really high.

Our family fought like anything to keep my dad at home because that is what he wanted, but he was on a wait-list for long-term care and I suspect that there are many families in the province who are pretty similar. When I was the Minister of Health and Wellness I heard from a lot of families who were desperate, waiting and trying to get their loved ones into long-term care because they couldn't provide the care, and home care was important but it only went so far.

I mean, all of the people you're going to move off the list have been assessed, they've received an assessment, and that assessment included medical information and documentation. It's not like people just decided - jeez, I'd really like to get on this list. I think that . . .

MR. CHAIRMAN: Order. We have gone over the time. We'll now move to the Liberal caucus. Mr. Rankin.

MR. IAIN RANKIN: Thanks for coming in today. I'm curious - with the number you gave, which is 2,126 on the wait-list currently, since May, how does that compare to prior years? You can just give a rough order of magnitude - if it's relatively the same or if this is a new number that has grown significantly or if it has been roughly the same over the last two to three years.

DR. VAUGHAN: We have a trend line here that we would be happy to share with you, it goes back to 2004. Since about somewhere in the past ten years, the trend line has been pretty consistent, up and down with a small degree of variability, but not a huge

variability change, hovering around the 2,000 to 2,500 line, consistently almost throughout that period.

MR. RANKIN: I want to ask a question around whether you believe this is simply tinkering with the system or if you believe it is actually structural change that the government is undertaking here. I appreciate the statement that going forward with the status quo and the same delivery of services is not sustainable. I guess, could you just explain what type of change you believe will help streamline care and better coordinate front-line care?

DR. VAUGHAN: Mr. Chairman, there are a lot of things we can do to improve the care, streamline it, make it more efficient and more value for money, and better quality for individuals who are receiving the care. The variability, as has been discussed here this morning already, is one area we can deal with in the sense of the performance metrics that we can bring into place so that we can have a conversation with the service providers. We can do things to improve the consistency of training the staff and put metrics in around that.
We can put metrics in terms of GPS and service delivery times.

There are a variety of things that we can do to deal with that. There are a variety of things that are being done in other jurisdictions to improve the use of technology in particular, in the home-care environment, that allows for monitoring and measurement of many factors that will allow for people to stay in their homes and be treated in their homes - and this is not fantasy, this is being done in other jurisdictions in Canada and the United States today, so there are many other options that can be done.

MR. RANKIN: I appreciate that and I guess the question would be: If we don't do this, what is the alternative? We know that in the 1980s the budget was 20 per cent of the entire budget and in the 1990s it moved up to 40 per cent, and we're now very close to 50 per cent. If we did nothing and we continued on the path without trying to keep people in the home longer, alternative system deliveries, preventative care methods, do you see that trend going up toward 60 per cent, 70 per cent over the next decade?

Has the department conducted any specific projections on those values? Because if we do get close to $6 billion, $7 billion, then we don't have funds for community services or education, so I think it's important that people understand the alternative.

DR. VAUGHAN: Mr. Chairman, I believe the Finance and Treasury Board Department has done those projections over a number of years. It's not recently, but even ten years ago there were projections that looked at the cost of continuing the health expenditure on a trend that has been set out for a number of years.

We are looking at the last ten years - we've spent a 4.3 per cent increase in health just in the past ten years. There are many of us who believe that we spend a lot of money on health care; we spend $4.1 billion on health care and we know from research and

evidence in other jurisdictions that the money isn't necessarily spent where we need it most. One of the important challenges that we face is developing the analytical capacity within our department to be able to know really where the value is, and where we're not achieving that value, and where we can reallocate.

What we have done this year is really hold the line with a small increase in health, which is historic in and of itself, in an effort to take the opportunity to look at reallocating within the money we have to better focus. We have invested in home care services in particular - the government spent $30 million last year and another $3.8 million this year, in very difficult times when the province is facing fiscal challenges that everyone has to contribute to. We are investing in home care in difficult times, including the 385 new people who will have the home benefit, so we are doing that in difficult times. But we can't continue on the path we're on without making those structural changes.

MR. RANKIN: Right. I appreciate that answer and just one more question and that revolves around the whole RFP process that people are asking me about. I think it's important to know when you're evaluating applicants for the request for proposals are you simply looking at the lowest bidder or do you have strict guidelines - what is the criterion around the chosen applicant?

DR. VAUGHAN: Thank you for that question. It's an important one to explain as well.

We haven't begun an RFP process - it's important to be very clear about that. We have an RFP for a consultant who is doing the work around what that might look like, and what we're learning from that consultant's work and talking with people, including meeting with unions in February, and a variety of stakeholders, is that there may be alternatives because of the receptor capacity, the interest in the home care area, particularly among the service providers, to be able to come to a different place without necessarily going to an RFP.

So it's not just about money - it cannot be just about money. First and foremost our concern is around quality and safety, to deliver the best possible care for the value for the money to Nova Scotians. It's not just about money and that's why we're looking at the process in terms of maybe there is a different way than an RFP. We haven't set out an RFP yet. We intentionally spent time doing the consultation with the consultant to go out and talk to people. Is there a different way? There might be a different way.

MR. RANKIN: Okay, thank you, I appreciate it.

MR. CHAIRMAN: Mr. Stroink.

MR. JOACHIM STROINK: Thank you very much for coming today. Where I want to go, I have a few questions regarding the new nursing strategy and how that fits in to this whole process. Last week, we heard, when your department was in talking about the nurses

in and out, it is pretty equal to that and part of this whole long-term care and home care is that we need the support because more and more people want to stay home versus long-term facilities are more of turning in and out. People aren't staying there as long; they're passing on.

There are a lot of moving parts to this whole equation, so with that mind, with the new nursing strategy, how is that going to play into the home care piece of the equation?

DR. VAUGHAN: Nurses and other health care providers are the backbone of our health care system, whether it's in acute care, primary care, or home care - the nurses, the doctors, the other health care workers, the other paraprofessionals all working together are delivering the best services that Nova Scotians need.

The nursing strategy is about ensuring that we have enough trained nurses to work across the health care sector, and that includes the home care and continuing care sectors. It's not just about acute care, but we do need to ensure that we have the nurses who are going to be able to deliver those services and the trained nurses with the skills to deliver those resources in the appropriate place, no matter where it might be. The skills are very different in critical care, very different in the operating room suites, very different in the primary care and the continuing care sector.

The nursing strategy is about the replacement of the nurses who are going to retire at some point over the next number of years. We've known this for a decade or more and we've had increased nurse enrolments. With the nursing strategy I think the important thing is to reduce the amount of time nurses have to spend going to school, from four years down to two years, to accelerate that to allow for more nurses to come through faster.

Yes, we absolutely need nurses as a part of that nursing strategy and they're critical, along with other health care providers, to our strategies in a number of areas in health care.

MR. STROINK: I guess that leads me to what I'm hearing from long-term care facilities is CCAs are a huge component of the whole nursing strategy. I'm just wondering where we are with them because there seems to be a shortage there, or not enough CCAs coming through the system. I understand that about 400 are graduating this year. What's the plan forward with the CCAs?

DR. VAUGHAN: We have seen an increase. There were problems with recruitment of the CCAs. We now have more this year coming through, 19 per cent I think - sorry, a 29 per cent increase this year and, as you mentioned, 400 coming out in June. We are now seeing the benefits of that strategy.

MR. STROINK: Excellent. I have just one more question. Out of this whole equation of long-term care and short-term care, palliative care and hospices also play a huge part of this equation, so I want to know where we are headed in that direction. For me I see that as a very integral part of this whole piece of the puzzle.

DR. VAUGHAN: Thank you for that question. Hospice care is an important element that is fairly new in the Nova Scotia context. It fits within our palliative care strategy which is in development, so it nicely fits within that. There's a lot of palliative care that takes place within the home currently, especially in the South Shore which has a fabulous palliative care workforce and service delivery in the home. So the hospice is another element which is a home-life setting for those folks who aren't able to stay in their home; they don't have that ability to do that. We are currently putting forward a model for hospice care across the province that is founded on the good evidence of research from other jurisdictions. So we're bringing that through and in the very near future we'll be having an announcement on our hospice model.

MR. STROINK: Perfect. I look forward to that. Thank you very much for your time.

MR. CHAIRMAN: Mr. Horne.

MR. BILL HORNE: Thank you for coming today. I think it's very important and timely that you're here talking about home care and long-term care, and it reflects back to every family in Nova Scotia.

I just want you to talk a little bit about the inefficiency in present home care from the side of how it's delivered and how do you see this to be changed so that it will be more efficient - and maybe talk a little bit about how you monitor that and how you evaluate home care delivery.

DR. VAUGHAN: Sure. We have 25 service providers currently providing home care services across Nova Scotia. I think the intention of those service providers is to provide top-quality care; I don't think anyone sets out to do anything but. However, there is a wide variability that we have seen, which is one of the reasons that the Auditor General, in three of his reports, mentioned that there needed to be a different way to account for the resources being spent on home care. We have some jurisdictions that virtually have no wait for home care and there are other jurisdictions in Nova Scotia that have wide variability, and they tend to be a couple of areas clustered in the Valley and Halifax in particular. In other areas, doing much better.

The opportunity is bring people together, our service providers, and say we need a new way of organizing the services. There may be requirements to even move between service areas. Remember, these service areas grew up organically under the previous structure of health authorities in many ways. Now we have a new foundation, one Nova Scotia Health Authority and the IWK going forward, we have the opportunity now to sit down with these service providers and say how can we provide better service across boundaries, how can we provide multi-service?

So it's nursing and home care, home support across various boundaries. We have a new beginning to have an opportunity to have a conversation with them and see what the art of the possible is, first and foremost. If that doesn't work then the heavy hammer of the RFP becomes the only option that we have going forward down the road, but it may not necessarily be what we want to do today. There may be other options to achieve our same results.

MR. HORNE: One area that I hear from home care workers is on the idea of travel time and sometimes it's inefficient because they're driving a long distance and then coming back to the same place they started from, and it's difficult to do that but there has to be better coordination in trying to keep travel time down to a minimum - I don't know, do you have any comments on that?

DR. VAUGHAN: Certainly, I think that's an excellent example of an opportunity when sitting down with service providers. Some service providers are already using GPS technology to be able to look at where people are going, and that is a well-used tool in many industries that are delivering services to the home. So there are lots of things that we learn, and they can learn from other industries to improve the efficiency and to improve the service ultimately and the cost and value for money at the end of the day.

MR. HORNE: The only other quick comment - just the fact that you may have many different service providers, how will they coordinate with each other if they do that?

DR. VAUGHAN: I think that's a great question. I think that's for the service providers to come together to see the opportunity to be able to work together. They may see that there are great opportunities to work together. If they don't see those opportunities to work together then you know the only other option down the road is an RFP to change the playing field, and I think that kind of a concept could have some incentive for individuals to at least to try and work together, otherwise it could be a very different environment for some.

MR. HORNE: That incentive isn't there right now, I don't think. Anyway, I'm going to pass it along.

MR. CHAIRMAN: Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: I'll start. I know I have very little time. My mother lives with dementia, she will soon be going on three years in a long-term situation. We could not keep my mother at home, she was a wanderer and she needed to be in a locked facility. As difficult and challenging as it was, we had to make that difficult decision to put my mother in long-term care - I'm very happy with the care she is receiving, by the way.

How does it fit into phase two of the plan where you're anticipating one-year stays in long-term facilities – my mother, I don't' think, is near at the end of her life?

DR. VAUGHAN: We have, as we mentioned, a dementia strategy which will be released very soon. That will lay out the kinds of activities that we need to do as a province. Nova Scotia is one of the first jurisdictions developing a dementia strategy based on the very need that you articulate very well. That strategy will detail the kinds of opportunities and investment that we will be making over the number of years. It's not a one-year plan but it is a multi-year plan. There is a lot that we need to do to prepare individuals, communities. Again, the opportunities for prevention - you know there is compelling evidence, the experts will tell us, around physical activity. You don't have to wait until you're a senior citizen to be physically active; in fact, there is compelling evidence that the earlier you start, the better it is to prevent dementia.

We have to focus on the areas of prevention even in the seniors' population. There's tremendous evidence around the opportunities for physiotherapy. So we are doing many of those things already in the home care environment, but the dementia strategy will help us to focus, it will allow other organizations as well to participate in some of the short-, medium- and long-term plans - a very important element going forward.

MR. CHAIRMAN: There is just about 20 seconds remaining.

MS. LOHNES-CROFT: We'll turn it over and I'll wait for the next round. Thank you.

MR. CHAIRMAN: Thank you. We'll move to Mr. Orrell and the PC caucus.

MR. ORRELL: I want to continue where I left off and ask a couple of simple questions; they shouldn't take too long to answer. It seems as though the government is interested in promoting the increase and use of home care rather than long-term care facilities - is that accurate, is that the way we're going?

DR. VAUGHAN: I think it's clear that the strategy of just continuing to build without any end in sight is a problematic strategy, and that is the road that we've been on. Certainly there is a need for some, but it is about where this strategy takes us, this endless build strategy. The strategy that we're embarking on is a home-first philosophy, what can we do within the home, the appropriate resources within the home including the opportunities to be innovative in that regard.

MR. ORRELL: So if the government is making changes, as we heard, to the person if they refuse a long-term care bed, they're taken off the list but they can't apply again until three months later unless there's a drastic change in their health condition. My question is: Are we not just shuffling the chairs around the deck - is that just another way to say we reduced the wait-list for nursing home care, but increased the home care list?

DR. VAUGHAN: A fair question. I think the answer to your question lies in the history of the wait-lists and people feeling the need to get on a wait-list. The better we can

get at determining need, and a lot of that is the condition that you've articulated - the individual's need to be on that wait-list, and if they don't truly need to be on that wait-list, based on the evidence of need, then they may be better off treated at home as long as possible. Down the road they might end up in the long-term care, but for a shorter period of time.

One of the challenges that we have as well from our data is that we have longer times in long-term care facilities in Nova Scotia than many other jurisdictions. So yes, the opportunity to do things differently in the home is a real phenomenon. If people get sicker, they don't have to wait longer to get into the long-term care facility; that individual's evidence of need becomes the determining factor for their placement, and it's important to remember that. It is the individual's condition that will determine their placement - whether they're at home or in the long-term care facility.

MR. ORRELL: So I guess the evidence of need - right now there are 2,500 people on the long-term care wait-list. We're saying that probably only half of them actually need to be in a nursing home. They've all been assessed by health care professionals and determined to have that need. My concern is that if the person who has a little less need than the person who has more need refuses, they're going to need a little more assistance at home if the family members - or if some situation changes at home, someone loses a job and they end up having to go away, the need then is not a physical need, it's not a medical need, it is a need of the family to have more service. With that would be a cost to either increase the cost of their home care or being admitted to a nursing home.

My fear is that families are going to get together when that call comes in and they'll say, well if something changes and it's not a medical change we still have to wait three months and we can't do that. Do you think we're going to see more people going into the nursing home who really don't need it as much compared to someone else, and having healthier people in the nursing home and sicker people at home because some of the healthier people are planning for their future because they've all been assessed as having need? If the need changes or if the assessment part changes, how are we going to communicate that to the people who are doing the assessing? Are we going to make sure that if it is a complicated need, that that's accurately done?

DR. VAUGHAN: The evidence of need is evolving. We use various international tools to assess the individual's need. But that assessment really determines what will be the appropriate option for that individual. I think, historically, people got on the wait-list just in case because the wait-lists were so long and even when their ticket came up, they didn't necessarily need that long-term care facility, but they took that option. So there were many examples where people were in long-term care options who just took that option because it came up, for fear of not having it when they needed it.

I think the focus on home-first philosophy is about how we keep people in their homes as long as possible. So the assessment is important in that there may be many options

to keep people in the home and adding resources to the home environment, than to uproot people from the home and put them into the long-term care facility.

We can't forget that that's a pretty disruptive change for many seniors. To move from their familiar surroundings of their home into the long-term care facilities can be a pretty dramatic change and it does have significant impact on some people's ability to operate, to get around, to see the world in a way that can be quite challenging for many, many people. So the longer we can keep people in the home - it's their choice ultimately, but the evidence of need is really going to be that tipping point where they're going to have that requirement to go to long-term care or they may choose to be at home at that period anyway.

It's really about what we can do to develop resources and systems to provide the best quality care for individuals to keep them home as long as they can, moving into long-term care when it becomes the right option. We need to focus on that solution rather than continuing to build beds in long-term care facilities, as we have been doing, on an endless basis. We need to stick with our metric, stick with our plans in terms of 115 per 1,000 - that's still very high compared to the national average - recognizing some of the comments of our aging population but not putting all our eggs in that basket.

MR. ORRELL: Thank you for that answer. Still, all those people who were on the list were assessed by medical professionals as needing home care, maybe not as much as the other person but they still had assessment as need. I'll use my mother-in-law, for example, who lived with my wife and my family and me, who was assessed as needing nursing home, long-term care, but we could handle her care at home until it got to the point where she was as scared to be at home as we were, although she could still be handled at home. She was assessed as that, relatively healthy except for a lot of different things that we couldn't provide, but home care could. But we had to increase the amount of home care for her to stay there, so the need was there.

She was relatively healthy going in but there are other people who are less healthy than she is who are at home waiting as well. My fear is that she went to a nursing home not healthy but healthier than someone across the street who did need it. They were all assessed as need, so if the assessment requirements have to increase, if that is the case and we have to, then you are going to have more people, as I say, concerned that that might happen.

I'll get off that for now. I guess the next question I have is: Earlier we talked of the cost of a long-term care bed as $250 per day, per bed. What is the cost of that person waiting in a hospital per day, per bed?

DR. VAUGHAN: It depends on the hospital bed they are occupying, to be perfectly honest with you. If it's a critical care bed it's much higher than the number I'll quote, but the average cost is about $1,100 a day.

MR. ORRELL: So $1,100 a day, 186 people actually waiting in hospital. To do the math quickly - I couldn't figure that out - but it's probably $1 million a day to keep people

in hospital waiting for a long-term bed, $30 million a month, probably $360 million a year. Construction costs are high but I don't think they would be that high that it wouldn't be worth their while to construct a few more beds and have the people who are in hospital actually enter a long-term care bed that way. Has that been considered as in the long-term, not necessarily tomorrow or next month or next year, but in the long term it is saving $360 million a year from people waiting in hospital; I think it would be more cost effective. Has the department done any analysis on that to see if that is cost-effective - keeping them waiting in a hospital?

DR. VAUGHAN: Thank you for that question. There are the capital costs and there are the operating costs of expanding an already high proportion of our population, compared to the national average of 86 per 1,000. We're already way above that. To continue to go down that journey to think that it's cost-effective because of the acute care environment is probably a false economy when the real strategy is about having those people who are in hospital beds flow as quickly as possible to the appropriate place. That is what we are working on, and that's what we are achieving.

It may not be in long-term care beds where you are seeing the $260 a day, it could be at home where it may cost $100 a day and that may be better off for that patient. So it's not all about more long-term care beds, it's about what is the right option and choice for individuals, and that includes home. That's what we're trying to do in the acute care environment.

MR. ORRELL: I agree with you, it's not all about long-term care beds. But if we have 1,300 people actually assessed as needing that care, unless someone vacates a bed that is already there, those 1,300 are not going anywhere. So from 25 to 1,300, as we're saying a need, it concerns me the fact that there are still 1,300 people who are assessed as need or sick enough to need who don't have that facility to go to unless one of the beds is vacated.

Anyway, I'll get off that for now. We talked about the home care process and the department's bidding or potential RFPs or some other form of acquisition of home care. Has there been a determination of the potential savings that may happen and, if there are savings, will those savings go back into front-line care to hire more individuals to make sure that we can continue to provide that quality care?

DR. VAUGHAN: With an escalating cost in health care - and you heard me talk about the 4.3 per cent annual increases in cost in health above the rates of inflation - it's about what is the most efficient and effective way to allocate those dollars. It's not necessarily saving money to put it somewhere else - it's about being as efficient as we can with the resources we've got to be able to reallocate the resources we have. That's efficiency based on need. It's not about here we've saved a bunch of money, let's increase a particular area. But there is a lot of demand in health care across the sector and so it's about becoming increasingly efficient with the resources that we have across the entire sector.

We have to stop thinking about just little silos because people aren't in silos. People quickly move between primary care, acute care, and long-term care, so we need to think of that and operate as a unified whole.

MR. ORRELL: The concern is we're moving more people towards home care. We're looking at efficiencies of providing the service because we want to keep people out of long-term care facilities, so if there is money to be saved and we're going to need more money in the system, I would just hope that would be diverted back into front-line care, because ultimately it's the front-line care and the care of our people - our seniors, our sick at home, no matter what their age - that's ultimately our goal as a province and as a health care system. So I would just hope that if there is potential savings to be had, that we make sure the quality of care and the quantity of care necessary to provide that is there and that the system operates as efficiently as it can, but to make sure our seniors get the best quality of care possible.

MR. CHAIRMAN: Order. We will now move to the NDP caucus and Mr. Wilson.

HON. DAVID WILSON: How many people were moved from the long-term care wait-lists because they declined placement?

DR. VAUGHAN: Around 200.

MR. DAVID WILSON: How many people were removed from the wait-lists when they were assessed and it was deemed that their needs could be met with home care?

DR. VAUGHAN: We'll have to get back to you with that specific statistic.

MR. DAVID WILSON: But there have been people - the new policy is in place but there have been people who have been assessed and their requirements were deemed to be able to be met under home care - right? So they were moved to the home care list - is that correct?

DR. VAUGHAN: Yes.

MR. DAVID WILSON: How many people are currently waiting for home care services in the province - could you break that down by region?

DR. VAUGHAN: I'll ask Perry to answer that.

MR. PERRY SANKARSINGH: There are 862 people waiting provincially for home care.

MR. DAVID WILSON: And that's total, but are you able to provide us with a regional breakdown?

MR. SANKARSINGH: Yes, I can.

MR. DAVID WILSON: With the new Health Authority, will we continue to see wait times for long-term care and home care broken down into region or are you going to go to a zone or is it going to be one wait-list?

MR. SANKARSINGH: Our intention is to reflect whatever configuration the new Health Authority decides, that we are consistent with the operational reality of the health system. Our current reporting hasn't changed over from the old District Health Authority. I can provide you wait-list information by Health Authority: DHA 1 - currently 18 people; DHA 2 - currently 80; DHA 3 - currently 294; 0 people waiting in DHAs 4 and 5; DHA 6 - a total of 119 people; DHA 7 - 97; 44 people in Cape Breton, DHA 8; and Capital Region - DHA 9 to11. Once again, these are old designations.

MR. DAVID WILSON: What timeline is that - is that a month ago, or . . .

MR. SANKARSINGH: These numbers are current as of May 1st.

MR. DAVID WILSON: Okay, thank you, May 1st. When you do transition, maybe I didn't understand this right - you'll be reporting it by zone, is that correct?

MR. SANKARSINGH: Yes. We anticipate that there will be a need for some sort of further breakdown beyond the zone because the zones are a pretty big catchment area and if the intent of the wait-list is to reflect the wait for services in local communities, we would want a more local breakdown. We don't have a sense of what that looks like just yet.

MR. DAVID WILSON: I'm glad to hear that because I think it definitely needs to reflect by community. It will be easier to respond as a department, as a government, if you know exactly where those are. I appreciate that.

With the change in policy for the long-term care wait-list and the move or the shift to get those individuals on home care, the acuity level of Nova Scotians who are going to enter long-term care in the future is going to be much higher, which means there needs to be work and there needs to be a change in the nursing care and the level of care that they are going to receive.

Has the government put aside funds to support that change in acuity level that these health care providers are going to see enter the long-term care facilities?

MS. MAXWELL: What we do know right now is that in the past five years there has been no significant increase in the level of care of individuals who have entered the long-term care.

With respect to your question about what is the department doing to look at that, what we have to do is determine through our assessments and that data that Perry is able to garnish on and what the level of care changes are before individuals entering long-term care - we will be interested to see what that is telling us.

What we do know is that we have provided additional funding for staffing in 2013-14 for our long-term care facilities and we are working with them the later part of this month on recruitment and retention strategies around CCAs. As well, if it does become an issue related to staffing, what we need to understand is what the vacancy rates are with our long-term care providers. The department will be reissuing a second vacancy survey to determine what the vacancy rates are, combining that with work with the long-term care providers in the event that there are vacancies and some staffing challenges.

What we do know is that the quality of care is being met and we know that because of our staff from the department do licensing visits. We make sure that the current providers are maintaining their requirements under policy and legislation, so we're very comfortable with that. We will also be monitoring the Protection for Persons in Care Act, any referrals that come in, which is also followed up by our investigation and compliance staff, and we would be also monitoring any capital incidents or complaints.

MR. DAVID WILSON: So you're going to do the analysis, so you're saying there hasn't been a cost analysis or analysis of the implications of changing the policy yet, that's work that's going to take place - is that correct?

MS. MAXWELL: Right. One of the other indicators that I had said previously was around length of stay. Right now we need to look at what the length of stay is and then look at what our data is telling us about the individuals who are actually placed in long-term care.

MR. DAVID WILSON: I'm a bit concerned that the government has made such a shift in policy. You've indicated over five years there hasn't been a change in acuity level, but over five year there hasn't been a change in the policy that will keep people from entering long-term care, which will increase the acuity level. There is no debating that. I'm concerned that that analysis hasn't taken place yet.

The standards that you talk about when you do your inspections, when were they last updated? Are you able to indicate that?

MS. MAXWELL: They're done biannually, our inspections.

MR. DAVID WILSON: But the standards you use to go in to evaluate if the care is appropriate, when was that standard last updated?

MS. MAXWELL: I'll ask Mr. Sankarsingh to take that question.

MR. SANKARSINGH: The current standard that we audit long-term care facilities to the program requirements policy was first created in 2007; we are currently working to update that standard and it is planned for release later this fiscal year. We have a draft that is currently in play and we have, in the last month, socialized that draft, revised policy, with the long-term care sector for their feedback and thoughts on it.

Our intention is to move forward, incorporating the feedback from the sector into a revised policy, anticipating a release of the revised requirements by the Fall.

MR. DAVID WILSON: Okay, thank you for that. I appreciate you being upfront and open. I'm still concerned with the fact that the changes in policy were made before, I think, the work that needed to be done.

Who makes the decision to take people off the long-term care wait-list? We know that they've been assessed by a medical practitioner, so who now is deemed to look at the numbers that you reflected earlier on, removing them from the list - whose authority or who is in the authority position to do that now?

MS. MAXWELL: The care coordinators who work for the Health Authority, their employees do a standardized assessment. So as far as clinical judgment, it's a standardized assessment that all individuals are assessed under. I just want to make sure that that's clarified. They have a variety of different backgrounds, but it is with a standardized assessment.

One of the things we have to understand as well is that those who are on the wait-list, there were 40 per cent who don't have any level of care that is being provided through home care. That's an important variable as to why we would be changing policy.

Now the care coordinators have been fully educated on the change of policy and we will be looking at the Health Authority to do reassessments based on the change in the long-term care policy, but certainly we've had a philosophical shift on supporting individuals in the community.

There may be a number of individuals who are currently on the long-term care wait-list whom we need to re-look at for the possibility of what kind of supports they may have at home.

MR. DAVID WILSON: What work has been done to support the physicians of the province? They are usually the first contact for family members or for an individual. What work has been done? Has the physician been given a new list to look at so they don't tell the family, or that individual, I think you need to go into a long-term care facility?

MS. MAXWELL: Thank you for that because we recognize that one of our key stakeholders is physicians. In 2013-14 we embarked on a communication strategy that

included an update to our website. So not only do we have revised fact sheets on each of our programs, but we have a specific site designated to our physicians.

The Health Authority also has physician leads, funded through the department to help facilitate any questions or inquiries with other health professionals with respect to placements or challenges around that. They would be a key contact for physicians.

MR. DAVID WILSON: So if someone deemed that they are going to be removed from the wait-list, are they told, is a letter provided to them, is someone calling them? If so, what is that process, and is there a possibility or is there an avenue to appeal that decision?

MS. MAXWELL: Certainly. First and foremost, we are very concerned about making sure that people receive the care they need and at the appropriate juncture in their lifespan. One of the things I would say is that individuals we first looked at, with phase one of the implementation, they would have either been on a deferral process or they would have received letters and then a follow-up phone call from their care coordinator.

Say, for example, if they were taken off the lists, there would have been other options discussed with them - do they want home care services or are they fine in the current situation that they have?

So we have that 12-week period where they can reapply. I want to reassure everyone that in the event that somebody did have a crisis health situation or their caregiver in the community, we have through policy a community variance that allows someone to be placed on an urgent basis, based on need.

MR. DAVID WILSON: The deputy mentioned an incentive for the home care providers to work together. Is there a financial incentive or is the incentive the fact that if they don't, the possibility of privatization will happen or an RFP - am I understanding that correctly?

DR. VAUGHAN: Just to be clear, the RFP is an option; it's not necessarily about privatization because they are for-profit and not-for-profit agencies delivering services today. It is about that levelling of the playing field, if the service providers are not able to come together to work together and my understanding is they are interested in being able to do that.

MR. DAVID WILSON: There has been a lot of concern in the area, especially from the workers, from the standard of care to their working environment so I hope that the government is transparent and open in this process not only for the workers but for the patients that they care deeply for. Thank you.

MR. CHAIRMAN: Order. We'll now move to Ms. Lohnes-Croft for 14 minutes.

MS. LOHNES-CROFT: Thank you. I just want clarification here. When you speak of the number of hospital beds that are currently taken up with people waiting to get into a long-term facility, does that include your ALC beds?

DR. VAUGHAN: Yes it does.

MS. LOHNES-CROFT: So, you should be clear that families are paying a fee for those beds as well. It's not purely coming out of government money. I know that I paid for my mother's. I was billed like she would be in a nursing home at that time. So I just wanted clarification on that.

In 2006 the Continuing Care Strategy also said that it would address the needs of those with brain injury. Are you doing that and how does that fit in to - phase two again, such as dementia?

DR. VAUGHAN: Thank you. That is something that we should mention as well, the Acquired Brain Injury Strategy is a separate piece of work and we need to recognize the patients and the stakeholders who are very keenly interested in helping us move that forward. We will be moving that forward over the next number of months to develop that strategy over the next year.

MS. LOHNES-CROFT: So they will be worked with phase two as well - they will be in long-term care for a long time.

DR. VAUGHAN: There's a separate strategy that we're developing for the acquired brain injury piece, so that's in addition to the continuing care refresh.

MS. LOHNES-CROFT: With the new nursing strategy that was released, there was talk about senior nurses mentoring newer nurses. Working with dementia and brain injury patients takes a very special type of nurse and caregiver - will these people also be mentoring in geriatrics and dementia and brain injury?

DR. VAUGHAN: The skilled nurses who have those kinds of skills to work with those needs of people with acquired brain injury, for example, are highly specialized and they will be working across the spectrum. We can't see these strategies as separate entities but when they all come together as options for individuals, those resources, those doors open depending on the needs of that individual person and so the nurses that have those skill sets may be different nurses, may be nurses with multiple skill sets. It will depend very much on the care environment.

We definitely need nurses with those advanced skill sets to work with people with dementia, to work with acquired brain injuries, to work with the complicated cases that we do see today. People are much sicker, multiple comorbidities, multiple diseases, living longer, that's a good thing but there are many challenges, so we need nurses with the advanced skills and the nursing strategy will allow us to do that.

MS. LOHNES-CROFT: There's usually a high turnover of CCAs and whatnot in brain injury institutions as well as in dementia units. They have skills that they can share to help people learn how to cope in those situations. I know some long-term care homes are now asking staff - who wants to work in the dementia units? And that seems to be working out very well. Can you comment on that?

DR. VAUGHAN: Obviously we like people to work where they feel comfortable. One of the challenges sometimes is that people don't always feel like they have the resources and skills that they need. The nursing strategy is about ensuring that the nurses have the skills to work in the environments that are both safe for the patient and satisfying for the individuals who have the skill sets to be able to deliver the care that they want to deliver, so the nursing strategy is about helping nurses achieve that.

MS. LOHNES-CROFT: Thank you for that, and I'll hand it over.

MR. CHAIRMAN: Mr. Maguire.

MR. BRENDAN MAGUIRE: Thank you for coming today, we appreciate it. I guess maybe I'm misunderstanding the tone of the questions here a bit because I feel like there's a bit of a negative tone from some of the Opposition members in regard to seniors staying in their homes. This is not what I'm hearing at the doors; I'm hearing seniors want options. They want to be able to choose whether they go into long-term care or stay at home and live a high quality of life among their friends, families, and neighbours, and they deserve the options.

What are you hearing from seniors with regard to wanting to live a high quality of life in their own homes?

DR. VAUGHAN: Mr. Chairman, seniors, like other citizens, want choices, nobody likes to have only one option. Seniors like to know that the resources they need when they need them are going to be there when they need them. Historically people felt perhaps they didn't have any choices, that they only had the choice of getting on the list for long-term care. As we've talked about, sometimes people took those options because that's all they had.

The option today is we want seniors to be able to choose to stay home with the appropriate resources for their situation. That may mean home support, where you have people who are coming in to help out with activities, which may be all they need; others may need more intensive nursing activities or physiotherapy, as we mentioned before, to keep people active. Keeping people active means keeping people mentally active, so that can help people be productive in their own home environment.

We're seeing many more seniors continuing to be very active not only in their family lives, but in work lives. Many more seniors are continuing to contribute across many

professions, across many sectors, including things that they like to do in their home environment. So it's about choice.

MR. MAGUIRE: Am I right in assuming that if we put some resources into seniors staying at home that we can bring that long-term care list down, that we can take some people off that list who are waiting for a bed and say listen, with these resources you can stay home?

DR. VAUGHAN: That's, in fact, exactly what we've been able to achieve. In the statistics that I quoted earlier, over the past six months we've cut the number of people waiting in hospital in half because we've been able to achieve people being placed back in their homes, where most people really want to be at the end of the day anyway. So it's not just about money, it's about what's the right choice for individuals. Yes, we all have to be conscious of money, but we have put over $30 million in the last budget and, in this last budget, $3.8 million in addition to that. That's close to $35 million in home care alone, and when you add the Caregiver Benefit, it's close to $35 million. We are adding resources in times of fiscal restraint, so we are reallocating resources already to areas of greater need in an effort to give people choice.

MR. MAGUIRE: What I'm hearing is there is major investment being done, but it's not being done how it has been done in the past. This is about allowing for options and not just a bed, which is great, because I think the more options we have the better the life seniors will live.

This is a little bit different here. We know that there are seniors who are the primary caregiver of maybe a son or daughter who needs around-the-clock help. Are you working with other departments, do you have a plan in place for when they can no longer take care of their loved ones or themselves - is there a plan in place so that they are taken care of?

DR. VAUGHAN: Mr. Chairman, yes, we are working actively with the Department of Community Services, in particular, to be able to look at what are the full range of options. The full range of options include, in some cases, support for the caregivers as well.

MR. MAGUIRE: Thank you.

MR. CHAIRMAN: Thank you, Mr. Maguire. Ms. Lohnes-Croft.

MS. LOHNES-CROFT: Mr. Chairman, I'm very interested in your Home Again program - how does that work with rehabilitation? For example, the Patterson Centre that we have in South Shore Health has been key with getting people who would normally have gone into a long-term care facility, straight from the hospital home. I know it's a lot of work. I'm only familiar with this one. Are there other centres around Nova Scotia and is that part of the Home First program?

DR. VAUGHAN: There are other opportunities across Nova Scotia for those kinds of restorative care centres. That's exactly the kind of resource that's needed to get people in shape for going home. Those extra resourced, high-intensity physiotherapy, for example, that patients are engaged in in those restorative care centres, like they are in the Patterson Centre, allow people to go home with a degree of confidence.

One of the challenges any of us might have of having a serious injury or operation is to be sure that I'm going to be okay when I go home - am I really going to be okay? Those kinds of resources help people feel more comfortable, get the resources in place. It's not about kicking someone out of hospital; it's about having the option as soon as they're ready for the option to get back home as soon as possible. Care in those facilities is very individualized, but it is absolutely essential to have the confidence that people are going to be able to safely be at home.

MR. CHAIRMAN: If there are no further questions, Dr. Vaughan, I will now give you a chance to provide some closing comments.

DR. VAUGHAN: I want to thank all of you for your important questions. Nova Scotians want to know that their health care dollars are being spent wisely. The ultimate goal is high-quality, consistent care across the province, a oneNS standardized approach: Nova Scotians want to know that we are planning for the future in continuing care; they want to know that when they need a bed in long-term care, that it will be there; they want programs that will help support them to live well at home longer; and they want to know that we are investing wisely to meet the future needs of Nova Scotians. This is what we strive to do in the Department of Health and Wellness.

We currently spend over $800 million annually on Continuing Care services and have to ensure that we have value for money. We are continuously looking at programs and services we offer and how we can improve them. This is a continuous quality improvement approach to the services we deliver. We know we can improve; we want to improve. We need the information systems to be able to know where we need to improve. We must take steps today to set the foundation to better meet the needs of Nova Scotians today as they age.

We are moving in the right direction. We have a plan. We have several pillars, several strategies in place. It's the beginning but we need to think differently, be innovative in our approaches and not be guided, necessarily, by what we've always done. We are in a challenging financial status in Nova Scotia, and we need to be mindful of that and look at how we can do things differently to improve the care and to demonstrate value for the money. That's our challenge, that's our opportunity, and that's what we intend to do. Thank you.

MR. CHAIRMAN: Thank you for being with us today. We do have some committee business. There were two items of correspondence, one from the Department of Finance and Treasury Board, the other from the Department of Community Services. Those

were both sent to members on May 7th. If you have any questions about that information, please let me know.

We had talked about having a workshop on June 10th. It was tentatively scheduled with the CCAF and through some further discussion with the Auditor General and with the CCAF as well – the vice-chairman would be aware of this – with the blessing of the committee as a whole, I think we will put that off until the Fall. There are a number of reasons: one because the briefing they were going to give us, some of the aspects we already have working for us on this committee in terms of follow-ups with departments; the other item being that of having a researcher and making our own recommendations to departments. I think at this time that without having a researcher in place and with a need to continue to follow up on Auditor General's recommendations, it may be premature to be looking in that direction at this time.

Through conversation I've had with the CCAF, we thought it might be best, after the conference in August of all the provincial Public Accounts Committees, that we would speak again about possibly setting something up for the Fall. Does anybody have any comments on that?

Hearing none, if we're okay with that, we will put that off until the Fall.

Is it agreed?

It is agreed.

Thank you. The next item on the agenda is our next meeting. We have a report from the Auditor General that is coming out on June 17th. What I am going to propose is that we meet on the 24th, one week after, that we have a meeting of the subcommittee at 8:30 that morning where we can pick topics, including topics raised by the Auditor General in that report. We would then hold a briefing from 9:00 a.m. to 10:00 a.m., for the meeting from 10:00 a.m. to 12:00 noon with the Auditor General on that report.

At the end of that meeting we would then take the subcommittee topics to the full committee for its blessing. I will propose that now and that that be our next meeting on June 24th.

Are there any comments on that? Ms. MacDonald.

MS. MACDONALD: Mr. Chairman, does that mean there's no Public Accounts scheduled between now and the 24th, or now and the 17th?

MR. CHAIRMAN: That's correct, now and the 24th. We had the tentative scheduled meeting with the CCAF on June 10th but, as we've just discussed, that is going to be put off until the Fall because a lot of the items they wanted to cover in that meeting, we are already doing as a committee.

We generally do break for the summer months. I have looked at our number of meetings this year and we are hitting at about our average of 22 meetings per year. Certainly if members wish to comment on whether we should be meeting between now and the 24th - Ms. MacDonald certainly if you have any other comments we'd be glad to hear them.

MS. MACDONALD: I do, actually. I recognize we've been through a long session of the House and probably we're all a little frayed and could use maybe a week or so, but I would really hate to see us not have any more meetings between now and the end of June, and then go into recess for July and August.

I think there are a number of items that we certainly could and should continue to pursue. Perhaps a subcommittee meeting with a look at some additional topics would be in order for early June. We could, in fact, meet on the 3rd of June, for example - there's ample opportunity to have a meeting on the 3rd and even on the 10th. I know, for example, that I would really like to have the committee talk to Nova Scotia Business Inc. with respect to the work they are doing and some of the really pressing issues in front of them, such as the replacement of the film office inside government. I really hate to see that deferred until the Fall.

MR. CHAIRMAN: Thank you, Ms. MacDonald. Are there any comments?

One of the challenges for the clerk of the committee when scheduling meetings is that there usually needs to be some lead-up time before the meetings can be scheduled.

We are in mid-May right now, and usually we give departments at least a couple of weeks' notice. We could have a subcommittee meeting after today's meeting, if you wish. Ms. MacDonald.

MS. MACDONALD: Or I could just make a motion right now that we, as a committee, bring Nova Scotia Business Inc. before the committee before the end of June, pending what would be a time that they would be available on the subsequent Wednesdays. We've got one, two, three, four Wednesdays available to us, so it seems to me that that would not be an unreasonable period of time to be able to find at least a time for Nova Scotia Business Inc. to come in front of the Public Accounts Committee. I would make that a motion.

MR. CHAIRMAN: It's not my position as chairman to object, certainly. My clerk has raised the matter that generally topics are brought forward from the caucuses in advance, then a subcommittee meeting is scheduled and from that meeting, of course, there is some agreement on which departments will be brought forward, and then that would have to be blessed by the entire committee.

Practically speaking, if we have four or five weeks, I suppose we could meet in a couple of weeks' time with a subcommittee. The challenge is we could not have a full committee meeting that day unless we have a department scheduled. Suffice it to say it does present challenges. I'm going to open the floor up to the committee.

Mr. Rankin.

MR. RANKIN: We did have a subcommittee meeting in April to set the agenda that was going to go until the summer and then we generally take a break. This committee meets more than in any other province, as I understand after attending the conference last year. I don't see value in rushing in one more meeting with NSBI last minute. As long as we keep to the amount of meetings that we do yearly, which is more than any other province in the country, I don't see a reason why we should be entertaining that motion.

It's not fair to the department to just ask and try to get them in within a couple of weeks, and in terms of the film policy that was talked about exclusively when the Department of Finance and Treasury came in here a couple of weeks ago.

MR. CHAIRMAN: Are there any other comments? Mr. Wilson.

MR. DAVID WILSON: I can appreciate not voting on it today, but I hope we do. We do have five weeks until the 24th of June and then we'll have another eight weeks off throughout the summer. I think it's appropriate for the committee to maybe reconvene, if it's next week, to have a subcommittee so then it gives some time for the caucuses to bring forward a list and that will still give us four weeks, so the department or a witness would have a least two weeks' notice before they come in.

I hope members support the motion my colleague made but, if not, maybe we can reconvene a subcommittee meeting next week and have caucuses present a list of witnesses because that will be 11 weeks-plus that we don't meet, which is excessive, I think.

MR. CHAIRMAN: I believe there is another comment. Mr. Rankin.

MR. RANKIN: I guess the last comment I'll make is I know June we had given the committee dates that we were planning on scheduling an out-of-town caucus, I'm not sure if the other caucuses have that as well, and I don't know off of the top of my head which week that was. We also, likely, have a by-election between now and October, or whenever the next Fall session is, so there are some other things happening in the background. We are by no means taking time off work by not sitting in the committee.

MR. CHAIRMAN: Ms. MacDonald.

MS. MACDONALD: I just want to say that I would okay if we had a subcommittee meeting next week to look at this and to schedule to see who else we could bring in. I have to say I really don't care about how often Public Accounts Committee sit in other provinces compared to ours. I care about our province; I was elected to be a member of the Legislature

in this province and we have expectations for how MLAs work in this province, for MLAs here.

I've been here long enough to know that committees do not go on break in the middle of May, especially the Public Accounts Committee. There's really important work to be done and this is most the most important working group that we have outside the full Assembly, and there are certainly many, many issues to be examined. And we have a full committee staff to provide support to the committee. So I'm aware of what the process is of setting topics and we can use that. The full committee is ultimately the group that sets the topics though, and it always comes here for approval, and there's nothing this morning to stop any other member of this committee from suggesting ideas for witnesses in front of our committee.

I really do believe, given the important role that Nova Scotia Business Inc. have been tasked with now with respect to the film and screen industry, and all of the uncertainty around how that's going to actually work, this would be a very good opportunity for us to have Ms. Broten and officials from her department come forward and talk to us about that particular issue and other issues with respect to Nova Scotia Business Inc.

Again, I would say that it's incumbent on us to continue to do the work of the people of the province whether or not the Legislature is in session. We don't go on holiday until well into July - and by-elections have nothing to do with the work of this committee, nor should they.

MR. CHAIRMAN: Thank you, Ms. MacDonald. Mr. Stroink.

MR. STROINK: Thank you. I guess just on - the subcommittee came forward and put the recommendations forward, you guys picked the topics that we discussed. We're out of topics now, at this point, with some changes that you presented today. My concern is if a subcommittee is reached again next week, or in two weeks as been suggested, then we're going to go back to the department and they're supposed to scramble and put some incredibly detailed documents together to present to the Public Accounts. I'm not sure if that is fair to the departments, or the information that this committee is looking for is going to be accurate because they have been scrambling.

My two cents on this is I'm not sure if this is the right way to go about this to get the information that is forward, that it needs to be the level of detail that needs to be presented at the PAC and that's just not fair to the departments.

MR. CHAIRMAN: Thank you, Mr. Stroink. One of the items mentioned was out-of-town caucus meetings. I happen to know from our own caucus, it is not formalized but on the week of the 27th, which would be two weeks from now, we have an out-of-town caucus. Can any of the other two caucuses offer if they have an out-of-town caucus? Ms. MacDonald?

MS. MACDONALD: Thank you very much. We have no out-of-town caucuses planned at this time, and certainly not for May.

MR. CHAIRMAN: Thank you. Mr. Stroink?

MR. STROINK: Right now we think it's roughly around the first week of June.

MR. CHAIRMAN: The first week of June. So that would be June 3rd. That leaves us with the 20th being next week, and the 10th and 17th of June, before the 24th. There are three separate weeks there. I'm just stating this to, hopefully, help the committee in understanding what's coming up in the next few weeks. Are there any further comments before we vote on the motion put forward by the member for Halifax Needham?

The motion being - and perhaps, member, you can clarify. I'll let you, Ms. MacDonald, put forward your motion just to clarify.

MS. MACDONALD: I think the motion should read that the committee continue to do its work until the end of June and that a subcommittee meeting be convened and caucuses given opportunities to bring forward topics that could be scheduled for the available Wednesdays between now and the end of June.

MR. CHAIRMAN: Thank you, Ms. MacDonald. So the motion is that a subcommittee meeting be held on May 20th with topics being put forward by caucuses in advance of that meeting for the dates of June 10th and June 17th, because on June 24th we'll be meeting with the Auditor General, and that's already set up.

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is defeated.

With that, we will conclude the meeting.

This meeting is adjourned.

[The committee adjourned at 11:06 a.m.]