# HANSARD

## NOVA SCOTIA HOUSE OF ASSEMBLY

## COMMITTEE

## ON

## PUBLIC ACCOUNTS

**Wednesday, November 2, 2016**

**Legislative Chamber**

**Department of Health and Wellness and Nova Scotia Health Authority**
**Re: Long Term Care Funding**

**Printed and Published by Nova Scotia Hansard Reporting Services**

# Public Accounts Committee

Mr. Allan MacMaster, Chairman
Mr. Iain Rankin, Vice-Chairman
Mr. Chuck Porter
Ms. Suzanne Lohnes-Croft
Mr. Brendan Maguire
Mr. Joachim Stroink
Mr. Tim Houston
Hon. David Wilson
Ms. Lenore Zann

[Mr. Chuck Porter was replaced Mr. Stephen Gough.]
[Mr. Brendan Maguire was replaced by Mr. Terry Farrell.]
[Ms. Lenore Zann was replaced by Hon. Denise Peterson-Rafuse.]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Nicole Arsenault
Assistant Clerk, Office of the Speaker

**WITNESSES**

Department of Health and Wellness

Dr. Peter Vaughan,
Deputy Minister

Ms. Carolyn Maxwell,
Director - Liaison and Service Support

Ms. Paula Langille,
Acting Director - Finance

Nova Scotia Health Authority

Ms. Janet Knox,
President and CEO

Ms. Susan Stevens,
Senior Director - Continuing Care

House of Assembly
*Nova Scotia*

**HALIFAX, WEDNESDAY, NOVEMBER 2, 2016**

**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 of the Public Accounts Committee to order. This morning we have the Department of Health and Wellness, along with the Nova Scotia Health Authority, with us to discuss long-term care funding.

We'll start with introductions, beginning with Mr. Farrell.

[The committee members introduced themselves.]

MR. CHAIRMAN: If our guests could introduce themselves, starting with Dr. Vaughan.

[The witnesses introduced themselves.]

MR. CHAIRMAN: Thank you. Just a quick reminder for everyone to make sure their phones are on silent so we don't have interruptions.

Dr. Vaughan or Ms. Knox, whomever would like to go first.

DR. PETER VAUGHAN: Good morning. We are very pleased to be with you again today to discuss long-term care in Nova Scotia. It may be useful to underscore the different roles both the Department of Health and Wellness and the Nova Scotia Health Authority have in the management of the Nova Scotia long-term care system.

The department oversees the governance of the system, sets policy and standards, and is accountable for the quality and integrity of the system through licensing, investigation, and auditing programs. The Health Authority is responsible for intake, assessment, placement, and coordination of continuing care services. The Health Authority also delivers continuing care services in some other facilities.

The NSHA's care coordinators work with individuals and families to make sure they have the right services that they receive when they need it. Other coordinators support providers to care for residents who exhibit difficult and complex behaviours.

We know our population is aging. This presents our province with opportunities; however, we cannot deny it also presents some significant challenge. Today there are about 180,000 people over 65 in Nova Scotia. If trends continue, almost 30 per cent of the population of Nova Scotia will be over 65 in 20 years.

We know many aging Nova Scotians will need some form of assistance to live fulfilling lives. In the past our answer was to build more nursing homes and provide more long-term care beds, but Nova Scotians have told us clearly they want to age in their own homes and communities - province-wide consultations by the Department of Seniors has confirmed this. Those consultations are helping to inform a new action plan for an aging population. Many Nova Scotians spoke about the importance of being able to age in place, as we've said. Research shows that older adults have better life satisfaction when they stay in their own homes. Seniors have spent their lives working to support their families and contribute to their communities.

Over the past three years, government has directed $59 million additional dollars towards home care - including nursing care and home support services - bringing the total investment to $255 million a year.

We recognize that moving resources to support home care means transitioning from our traditional long-term care model. Our investment in long-term residential care itself is substantial. In 2016-2017 we delivered $565 million to this sector. This year we asked a number of long-term care homes to manage a 1 per cent budget reduction. This measure represents a reduction of $8.1 million in a total continuing care budget of $820 million.

Many have already found ways to increase efficiencies and reduce costs, things like group purchasing, shared administrative services, and joint contracting. This is not to minimize the challenges that many face. We are committed to working with administrators

to ensure that the quality of care is not compromised by these changes. We appreciate that they recognize our fiscal realities and share our commitment to making improvements.

That's why we and the Health Authority are full partners in a working group established with the Health Association of Nova Scotia and its members. Together, we are working to understand the fiscal challenges faced by operators, share information, and propose viable solutions. Our shared objective is to protect sustainability and the fiscal health of our long-term care partners. We know that this is not a problem money alone can fix. We need to communicate better with clients and improve how our services are delivered.

The Health Authority and home care agencies have been doing that and have already demonstrated significant success. Within the last year, they virtually eliminated the wait times for home support in most areas of the province. More than 14,000 Nova Scotians receive home care services every single day. Those services include personal care, respite care, housekeeping, meal preparation, and nursing. Today, there are just 147 people waiting for home support services in all parts of our province.

This is a testament to the hard work of many home care providers, of the unions, of the Health Authority, and of the Department of Health and Wellness employees. In addition, there are no wait-lists for home nursing care in any part of Nova Scotia. Wait-lists for Nova Scotia's long-term care have been cut by 52 per cent in the last year-and-a-half. Of course, we all know that there is much more to do, but I believe that we are in a much better place today than we were even just a few years ago.

At this time, I would like to turn it over to Ms. Knox to say a few words.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Good morning. I welcome the opportunity to be here today, along with our senior director for continuing care for Nova Scotia Health Authority, Susan Stevens.

Today, some 20,000 Nova Scotians will receive care and support they need through our continuing care services. Over 8,000 hours of personal care, respite for family and friend caregivers, assistance with meals, and essential housekeeping will be delivered by continuing care assistants across the province today. Nurses will make over 2,000 visits to homes from Neil's Harbour to Yarmouth and in between, providing wound care, IV therapy, and a range of nursing services once only offered in a hospital setting. Last year, we delivered over 3 million hours of home support and 1 million nursing visits.

Another 3,000 people will receive supports and services through the many other home-based programs we offer, like the Caregiver Benefit Program, Supportive Care Program, and Seniors Community Wheelchair Loan Program. We know Nova Scotians

want to live at home as long as possible. Whether it is helping them take a bath or get dressed, providing a family break for family caregivers, or changing a dressing, the programs and services we offer through continuing care can help them live safely in a place they call home.

We also know that sometimes people need more care and support than can be provided at home, and then long-term care is needed. Every year, more than 10,000 Nova Scotians receive the care and support they need in a residential care facility or nursing home. With an aging population, more and more Nova Scotians will need these supports. We are working with the Department of Health and Wellness, with service providers, with employees, with unions, and with others to improve the care people need, to make it available sooner, and to ensure services will continue to be there when people need them.

We're seeing some promising results. For example, over 50 per cent fewer people are waiting for long-term care, and wait times are down by 11 per cent; 160 more people were able to receive care in a nursing home last year than the previous year; and at the same time, 84 per cent fewer people are waiting for home care.

There are many things that have contributed to this. We are implementing policies designed to ensure people who need nursing home beds the most get them, while others get the support at home first. There are more consistent approaches to how we assess and support people's needs, and there is better communication with, and between, care coordinators, caregivers, clients and families, continuing care assistants, and home care nurses. We also now have a provincial structure which allows us to share information, best practices and resources across our programs and services quickly and effectively.

We know there is more to do. For example, people currently living in a nursing home in this province are there an average of three years. This is higher than many other provinces in this country. If we were able to support people to stay at home longer and reduce their stay in a nursing home by one year, we could provide care to over 1,400 more people in our existing long-term care beds without building any new beds.

By using data and evidence, and engaging our staff and our physicians, the clients and their families, we can continue to improve access, ensure we are making the best use of these valuable resources and improve the quality of care in an informed and compassionate way.

This is a challenging time for the long-term care sector; indeed, the entire health system. As we know we're one of the oldest populations in the country with a heavy burden of chronic disease and a high usage of nursing home beds. As we support people at home longer, their care needs will be higher when they enter long-term care. There are inflationary costs and, in many cases, aging buildings and equipment. All of this is certainly putting more pressure on resources.

Investments in home care, in policy changes, and more consistent and efficient practices are helping to meet the growing demand and ensure that our programs and services are there when people need them. More people are receiving home care, fewer people are going on wait lists for long-term care and wait times are coming down. It's encouraging and we know we must move on.

We look forward to working with the Department of Health and Wellness in the coming months to develop a new Continuing Care Strategy by using evidence and engaging with individuals and their families who need and use our services - our care providers, employees, our unions, and Nova Scotians in general. We will ensure our programs and services meet the needs of the population now and into our future. Thank you.

MR. CHAIRMAN: Thank you, Ms. Knox. We will begin with Mr. Houston for 20 minutes for the PC caucus.

MR. TIM HOUSTON: Thank you, Ms. Knox and Dr. Vaughan for your opening comments. You both mentioned the reduction in the wait lists for long-term care by 50 per cent. I would like to ask Ms. Knox, what is that reduction - from what to what?

MS. KNOX: We're very pleased to be able to describe the process that we used . . .

MR. HOUSTON: For now, I'm just asking from what to what. We'll get to the process stuff.

MS. KNOX: I'm going to ask Susan Stevens, who has these numbers at the ready, to answer that question.

MR. CHAIRMAN: Ms. Stevens.

MS. SUSAN STEVENS: So we picked the date of February 25th, 2015;hat was the week before the policy changes were implemented. At that time, there were 2,446 people waiting in their own homes and in hospital for their first placement into a nursing home or a residential care facility. There were 1,423 people who were already in a facility that were waiting to transfer to a different facility. Our wait list consists of those people waiting for their first bed, and the people in a bed who want to move somewhere else. So the total on February 25th, 2015 was 3,869 people.

On October 14th of this year - so approximately three weeks ago - there were 1,306 waiting for their first bed. They were either waiting in hospital or waiting in their own home. There were 1,079 people waiting in a facility to transfer to another facility. So there were a total of 2,385 people on the wait list on October 14th, 2016. So the difference is 1,484 people - an overall reduction of 38 per cent.

The reference in both of the opening remarks to the 52 per cent reduction was based on more recent numbers as of October 21st - the wait-list, the people waiting for their first bed. The number was 1,292 people, and it has been around a 50 per cent reduction for the people who are waiting for their first bed.

MR. HOUSTON: Sure, yes, that's great, I really appreciate that - it gives me some perspective.

Let's talk about the 1,500-ish people who are no longer on the list. I'm curious as to where those people went. In the opening comments there was some reference to policy changes and the new Health Authority - all this helps, but the people went somewhere or they sadly passed away. Can you tell me how many people passed away during that time frame that would account for which part of the reduction?

MS. STEVENS: In the fiscal year 2015-16, so a slightly different time frame than the numbers I just gave you, 852 people passed away and were removed from the wait-list as a result.

MR. HOUSTON: Thank you. So half of the wait-list reduction came from people passing away?

MS. STEVENS: Well no, not quite.

MR. HOUSTON: Well more, actually - 800 and something part of 1,500 is more than half.

MS. STEVENS: I can't speak to the percentage; we'd have to do the calculation. The number of people on the wait-list is dependent on how many people are put on the wait-list and how many people are taken off the wait-list. Again, in the fiscal year 2015-16, 3,106 people were actually placed, so they came off the wait-list because they received a bed in the system; 852 people came off the wait-list because they died; and then there are a number of other reasons that people are removed from the wait-list. In that same year we put fewer people on the wait-list than we had in years gone by.

MR. HOUSTON: I do want to touch on the fewer people, but I found it significant that a lot of the people who are no longer on the wait-list is because they sadly passed away waiting for long-term care. I guess we'll never really be able to know whether that had an impact on their passing or not, right? I guess we won't know that, which is unfortunate. I think it's important to understand why the list is coming down and how, and some of it is that people are passing away and some of it is policy changes.

I do hear that a number of people, hundreds of people, are taken off the list for whatever reason. Ms. Knox, in your opening comments you said if we can defer people's entrance into long-term care by one year that opens up a lot of spots, but obviously there

are ramifications to that. It just made me think when I was hearing the Health Authority say if we can defer people's entrance into long-term care by a year, let's call it a benefit to the system - it made me wonder, is the list going down because people are being removed from it in the hopes that they can defer their entrance?

In other words, you are on the list and you only get on the list when you've been approved that you need it, but we have a new policy now and we no longer think you should be on the list, so we're going to take you off the list.

I think what disturbs me is I oftentimes hear the Liberal members boast and cheer loudly about reductions in the list and, at its face value, a reduction in the list is a good thing. But when the reduction in the list comes from people dying because they didn't get the long-term care they were waiting for, or when it comes because they've just been taken off the list because of a policy change, that's not helping people's lifestyle and, in my estimation, that is not a reason to boast and clap and cheer.

I'm trying to understand how much of it is with deaths of people and policy changes. How many people were on the list who are no longer on the list because of a policy change, who will eventually show up on the list again - do you have a number of that? I see some nodding there, maybe we can get that number for some perspective.

MS. KNOX: I'll ask Susan to actually give you the numbers, but what I'd like to say, Mr. Houston, is our whole process is not about deferring access to a resource. It's about helping the individuals and their family have the right resource. So it's a whole combination, and the strategy must be multifaceted.

We have had a history of, we need to eventually go to long-term care. We need to really think about how we support our people whatever their stage in life is, based on what their needs are and then determine the best resources. So, there's a whole combination of strategies that are required including policy, including how we use it, but the most important part is really working with that individual and his or her family and assessing their needs. So, I'll ask Susan to give you the numbers.

MS. STEVENS: So I can give you the number in terms of who was removed from the wait-list. Just a couple of comments on the people who have passed away. That happens every year and we can get numbers - we can go back and get numbers from previous years before the policy change - but that hasn't changed. That occurs every year and occurred before.

In fiscal year 2015-2016, we did remove 377 people from the wait-list. When we called them to offer them a bed, they said no thank you, I'm not ready, we don't need it now. And so as a result of the policy changes, we took those people off the wait-list and told them that when they did need it, we would be there and we would get them to a bed. We would get them back onto the wait-list and we would get them to a bed.

Also, in that same year, we had 228 people call us and tell us they wanted to be taken off the list. They did not want to pursue long-term-care placement at that time. So as Janet indicated, we had in the system a practice of getting people for all kinds of good reasons - for all the right reasons, people were getting on the long-term-care wait-list before they needed to be there which meant the list was getting longer and the wait times were getting longer. We would have situations where we would call, and it would take 15 or 20 calls to 20 different families before we would find somebody to accept the bed. All the while, that bed was sitting empty.

MR. HOUSTON: Is it true that a patient cannot be admitted into long-term care unless they have a family doctor? Maybe Dr. Vaughan - is it true that you need a family doctor before you can be admitted into long-term care?

DR. VAUGHAN: You need to have a medical oversight within the facilities. It doesn't necessarily mean a family doctor; it could be a nurse practitioner or someone to look after your care in the facility.

MR. HOUSTON: Okay, so the facility provides that.

DR. VAUGHAN: Historically, that has been the case.

MR. HOUSTON: Okay, and what is the story on the new nurse practitioners that have been announced? I think it was 22 in total between nurse practitioners and family nurse practitioners. Have they been allocated? Would any of those be headed for long-term-care facilities?

DR. VAUGHAN: I'm not aware of that, but Ms. Knox could answer the specifics about their relationship in terms of the long-term-care facilities.

MR. HOUSTON: Sure, maybe Miss Knox - have they been allocated, and are any of the new positions headed for long-term-care facilities?

MS. KNOX: Thank you for that. The whole process for those 22 new positions is to help us increase access to primary health care, and so we are going through a process of asking for expressions of interest from physicians who would be interested in working in collaborative teams, and then those resources will be part of that. A collaborative care team will be looking at how we use that team to support an entire community, which would include support to the nursing home in that local community.

MR. HOUSTON: Okay, so . . .

MS. KNOX: So they wouldn't be allocated perhaps directly into the nursing home, but it's part of the primary care support to that community.

MR. HOUSTON: Okay, so you're looking for expressions of interest for people who want to engage one of these new nurses. What's the time frame for that?

MS. KNOX: That has already been let out and we've already received much more interest than we would ever have anticipated. We're just going through that process now.

MR. HOUSTON: Okay. Okay. Now, I do want to talk about the budget cut. Dr. Vaughan, you referred to the $8.1 million budget cut this year; it's a 1 per cent cut. The first thing that kind of bothered me about that cut was the timing of it. The cut was communicated to long-term care facilities in particular around the June time frame, and we know that that's a couple of months into the fiscal year. So even though you already had a couple of months of spending - so if you get notified of a cut and you only have 10 months it automatically becomes more exacerbated.

So what's the story there? Why wasn't that part of the budget that was laid down? Why did it come during the fiscal year?

DR. VAUGHAN: As you know, it's part of a budget cycle. We have a budgetary cycle which is April 1st annually. It takes some time to make the necessary administrative processes to put those in place. We have had conversations with facilities in preparation for that, but we weren't able to actually give them their actual budgets, if you will, until after that time frame. I'm happy to have Ms. Maxwell answer any specifics in terms of that process.

MR. HOUSTON: Just saying 1 per cent is a little bit misleading in the sense that at a long-term care facility you have fixed costs and you have variable costs and you just can't reduce your fixed costs. You can't just tell your bank, I want to give you 1 per cent less on my mortgage payment. So it's not really 1 per cent. It kind of amps up when you get into the variable expenses and that's why we hear the types of sad stories that we hear - the impacts of the cuts.

Did somebody decide that 1 per cent would not impact the quality of care? I've heard the Premier say, well, it's just a per cent, it's not going to impact care. But I'm sitting here saying of course it is - if you take money away from a system that's already in desperate need of money, there's an impact. It would be foolish to think there's not. Who came up with the 1 per cent?

DR. VAUGHAN: The 1 per cent was a part of a budgetary process that goes through in government, looking at the fiscal health of the province. I think everyone knows that Nova Scotia has significant fiscal challenges. The 1 per cent was perceived to be a reasonable contribution to that from the long-term care sector.

MR. HOUSTON: So it was as simple as that: it's only 1 per cent, they should be able to handle it.

DR. VAUGHAN: One per cent is - as anyone who has been involved in large enterprises knows, no one likes to receive any budgetary reductions. The fact of the matter is that we have 134 organizations that are all independent, all in various degrees of ability to address those. So we've worked with them and we've been talking to them. We've talked to over 83 per cent of those facilities to say, how's it going, what can we do to help you? We've been working with them to look at administrative efficiencies and they were not to impact patient care.

The reality is that some of those facilities will hire people over what we would approve, for example, within our world for administrative positions. We can't control that. That's not within our control. That 1 per cent is in some ways an opportunity for those facilities to look at how they can start to do things differently.

The ad hocery that we see across the sector is long-standing over decades and decades and decades. As we look to our Continuing Care Strategy to bring new ways - to modernize that sector - that's what we're trying to improve. We're trying to look at getting them to think about how we can work together differently.

MR. HOUSTON: I'm going to come back to that, but you mentioned the Continuing Care Strategy. That's something that was a campaign promise from the current government - that they would come up with a Continuing Care Strategy within 100 days of being elected, which would have come out sometime back in 2013. We sit here today, we're pushing 2017. I haven't seen a Continuing Care Strategy, but you refer to it there. Is there a Continuing Care Strategy?

DR. VAUGHAN: We've been working to improve efficiencies through the 1 per cent incentive reduction, if you will, to how we can work together better across the sector. We are looking towards 2017, and we've been saying that for some time, 2017 would be the year for the continuing care - new continuing care - strategy, and it would be delivered by the Fall of 2017. So it's all within the planning cycle.

MR. HOUSTON: So the Fall of 2017 for a Continuing Care Strategy, which would be years late. Even the minister last week in Question Period, when asked about the Continuing Care Strategy, said it's on its way and it will be in the Fall. I guess we should have asked a follow-up - which Fall - because now we know it's 2017.

In terms of the budget cuts, first you characterized it in your opening comments as an opportunity for facilities to look, and then you characterize it as an incentive. Both are positive spins, but we're not particularly seeing positive ramifications of the budget cuts. We can talk about the meals, and I've talked to many people around the province who say, we'll just have to do without something. Whether it's a small piece of equipment, whether it's haircuts, or whatever, they're doing without something because you have less money, you're doing without something.

Would you say that the facilities, on balance - there's room for 1 per cent, plus more, if they were properly managed? In other words, is it the position of the department that there are inefficiencies in these facilities and we're going to keep squeezing until it's gone? Would you say there are inefficiencies there, and it is no problem to find 1 per cent, and it might not be a problem to find another one down the road? Is that the outlook of the department?

DR. VAUGHAN: Through you, Mr. Chairman, that's not what I said, of course, that we're having any conversations around that. I think the conversation around the 1 per cent is an opportunity for organizations to come together, as many of them have. We have to give credit to those organizations that have come together, that have consolidated some administration amongst their ranks. There are opportunities around consolidation around human resources, there are opportunities around consolidation around insurance. There are many efficiencies that can be achieved, and I think many of those organizations are actually doing that.

We've made no discussions around going forward. I will mention that in the Throne Speech there was conversation around strategic investment in long-term care and I'll leave it at that.

MR. HOUSTON: Thank you for that. I guess my concern is that the system is very tightly-wound right now. I'm worried about the quality of care that the budget issues are forcing down on them. It just seems to me that if you keep tightening that, and tightening it, that it's going to spring at one time, and I don't know how far we are away from that springing, when I hear some of the stories that I hear from family members who are concerned about their loved ones.

Obviously staff - they are all afraid. They are afraid of the government, they don't want to speak out against the government. I find when you hear the stories from families, it gives me real cause for concern. I'm sure we'll take up more on the budget issue in the next round.

MR. CHAIRMAN: Order, the time has expired. We'll move to the NDP caucus and Mr. Wilson.

HON. DAVID WILSON: Thank you for being here today. It's definitely a topic we've spent quite a bit of time on over the last year to year-and-a-half, around long-term care. I think it stems a lot from what MLAs hear from their constituents. I deal with long-term care issues on a weekly basis in my constituency office, and not only from my own constituency office, or people from my own constituency, but people from across the province - it's a challenge.

Dr. Vaughan mentioned a new action plan around long-term care, and you're working towards how we move forward. Is that something that will be finalized? Is that

plan something the government is going to announce - and here we are - or is that part of the Continuing Care Strategy that we hear will now be released in the Fall of 2017? Is there an action plan specifically on long-term care, and how we move forward with meeting the needs in long-term care?

DR. VAUGHAN: Thank you for the question; it's an important one. There is work going on today. I don't want to leave anyone with the impressing that it's being pushed out, but it will be delivered by 2017, and that's when we will start, in 2017, with consultations. We've already been in early discussions with many in this sector. To the point earlier with the member's comment about quality, that is absolutely the driving force behind a renewed Continuing Care Strategy in 2017.

We have this ad hocery that exists, we need to focus on the quality and the standards, and what's the appropriate investment, based on our needs. That's all part of the strategy, that's part of the consultations that will occur, beginning in January.

MR. DAVID WILSON: But this has been a commitment from the current government. We're in the third year, going into the fourth year of this government. Why the delay? Now we're hearing 2017. This is an issue, and you mentioned the statistics on the demographics of our province and I wrote it down here - in 20 years, 30 per cent of our population will be over the age of 65. I'll be hitting 65 in 20 years, so I'm concerned. The demographic, we know that; we've known it for a number of years. The government and previous government recognized it and tried to move in the direction of trying to come forward with a way to address it.

Why the delay? Is it because of the time this government took to amalgamate the district health authorities? Did projects like this and initiatives like this have to be put off until the amalgamation finished? That's the obvious reason why we're seeing such a delay in such an important area of providing services to Nova Scotians.

DR. VAUGHAN: It would be a mistake to try and to do too much at one time. There are great benefits, as Ms. Knox has alluded to, in the consolidation of health authorities around standardization. We're now just reaping some of the benefits of that. The 1 per cent budget reduction in many ways was an opportunity for organizations to come together to look at how they can improve their own efficiencies, how they can in some cases modernize - more money to do the same thing. You know the old adage around that. It's not like it's been pushed out without reason. It's not been pushed out in fact, it's been part of a plan, the consolidation of the health authorities. The standardization that we're now reaping the benefits of in this sector is real. That allows us to now have conversations, as we are, with the sector to talk about the future of long-term care in Nova Scotia.

MR. DAVID WILSON: The challenge I think facilities have is the approach this government has taken to managing the costs. As my colleague mentioned, the cuts were

after the fiscal year started. It's very challenging if you're the administrator of a facility here in the province to figure out how you're going to operate for the next 10 months.

During Question Period and throughout the summer, our caucus asked the department to provide us with the actual cuts that each facility received. The minister continued to go back to the 1 per cent, and I know we were provided with some figures some time ago, but the reality is that they don't match with what the administrations of some of the facilities had indicated their cuts were. When I questioned the minister on it, the minister indicated that there were different streams of funding to some of the facilities. Again, I asked the minister, which he said he would provide to the Legislature, the actual cuts.

I'll give you an example with St. Vincent Nursing Home. The information that was provided to this committee, the information that was given to me in the early Fall, was that they were cut by $65,000, when actually we were told that the cut was around $128,000. The minister committed to me to provide me with the total cuts to each facility in all the streams that are there. Are you able to provide that for us today? That was a couple of weeks ago, and the minister hasn't provided it. Are you able to provide that to the committee today?

DR. VAUGHAN: We're happy to give you 2016-17.

MR. DAVID WILSON: The frustrating part is when the government is challenged on the cuts to long-term care, it's almost like they respond in a dismissive way - it's only 1 per cent, don't worry about it. But, actually, when you look and dig into it, it's more than that. It's 1 per cent this year and 1 per cent last year. Over the two years, we think there's somewhere around $14 million in cuts so far.

When you look at 1 per cent, if I just look at the figures that were provided - Northwood was cut by almost $236,000 - that might be only 1 per cent, but that's a large amount of money, and there has to be some impact on those facilities. I know they're trying to streamline procurement, and other things, but were there any warnings given to the government of potential impacts that this type of cut could have to facilities in the province? Are you able to share any of those with us today?

DR. VAUGHAN: We had many discussions with the sector, with the individuals and that institution in particular. They were aware of the coming trend - not specifics around the dollar impact.

MR. DAVID WILSON: So was there any concern potentially of that impact on, say, employment, staff levels? Facilities may not fill a vacant position, for example, because of those cuts. Is that where you perceive the administration of these facilities to look for savings, or is it in a different category that you thought they could come up with the amount of money that was being cut from their budget?

DR. VAUGHAN: Each facility is going to make its own decision; they run independently. We do not run those facilities, so each facility has to look within its own operation. We made it clear that we did not expect any - in fact, we did not want any impact on patient care at all. So they're looking for what opportunities there are around efficiencies of administration. There are many opportunities around efficiencies for administration, and many of those organizations have reaped the benefit of that. As I indicated, there are other opportunities around insurance and HR.

So, in the particular example you cited, very large organizations have a greater opportunity and a greater amount to mitigate, obviously, but they also have opportunities to consider how they're going to improve their efficiencies within their organization.

We are doing that right across the health sector, by the way, and we have seen significant benefits. So, we're asking that long-term care sector to look within their own world and what they can do.

MR. DAVID WILSON: So, one of the initial statements out of the government was that they didn't want to see any impact on care in the facilities. Are you confident, and are you able to state today, that you feel that has not happened across the province in facilities, and that care, in your opinion, is the same as it was two years ago, prior to the cuts?

DR. VAUGHAN: That's a very important question. The quality of the care is the driving force for everything we are doing across the health care sector, including long term care. We inspect every single facility a minimum of twice a year. If there are complaints, if we hear about any issues, we send in inspectors unannounced. We look at every single item within our purview, and there are many indicators within that Act that we look at. So we are totally focused on the quality of care that those residents receive.

MR. DAVID WILSON: But we've heard more recently that some facilities were laying off staff. You indicated in your opening statement the shift, and the population of growth of people over the age of 65 that is happening on a monthly basis. We can assume that will lead to a greater need.

I know there is a focus on home care. There always has been; it's important. I was a strong advocate when I was minister to improve home care services. It's a key to hopefully having people stay in their homes longer. But there is a point when those caregivers at home who are unpaid, for example, reach a breaking point. There is a point when home care services will no longer meet the needs.

We talk about the number of people on the wait-list, on long-term care wait-lists, but we often don't talk about the length of time that people are on that list. That hasn't changed significantly from what I'm seeing. I'm wondering if you could provide us with the amount of time people are waiting.

In my opinion, if it's 100 people waiting 1,000 days, or if it's 5,000 people waiting 1,000 - it's still a wait. So can you provide us with up-to-date wait times for how long people are waiting for long-term care? I don't know if you have it right now or can comment on that.

DR. VAUGHAN: I'll ask Ms. Stevens to drill down into that level of detail.

MS. STEVENS: The median wait time for nursing homes, and this is on the government wait time website - when we look back to 2014, the wait time was 350 days. Median means that 50 per cent of the people wait less than that and 50 per cent wait more than that. That would have been in October-December of 2014.

The most recent data we have is from April to June of this year, and that number has reduced to 313 days - so a reduction, you are correct, not a significant reduction, but going in the right direction. That's for nursing homes - would you like the wait times for residential care facilities as well? (Interruption)

I can give the same time-frame, if you'd like. It was roughly about 100 days in October-December of 2014. It continued to rise, and again, these are median wait times, it continued to rise until October to December of last year, 2015, it reached a high point of 146 days. More recently, between April and June, that number has come down this year, 2016, to 134 days, so again, we're seeing a reduction in the wait times.

MR. DAVID WILSON: So the drum of victory that I hear from the government on is, look what we've done to the wait-list, we've reduced it by - somebody said 50 per cent or 52 per cent - that's great, I mean that's just a figure. Ultimately it's people who are waiting today that I think we need to concentrate our time on, and concentrate the efforts of the government on and there haven't been significant changes. That's unfortunate, because I don't think that's going to go away. I think the demand is going to increase and the challenge government is going to have is trying to meet the needs.

When we look at that, you've recently indicated a shift of priority to home care, so people are going to stay in their homes longer. To me, when you look at that, it means when they do enter long-term care facilities, they are going to be worse or more frail than we might see today. Their acuity level will be higher, their needs will be higher, so there will be a demand on staff to ensure they can meet that demand.

How is cutting the budget to these facilities, which I would assume - part of what will happen is administrations will claw back additional training to staffing levels, increasing staffing levels. I don't think we're going to see facilities increase staffing levels, which I think will have to happen, if we're trying to keep people home longer, and when they enter long-term care facilities, their needs are going to be much higher. I don't see how the direction of the current government, by reducing the budget for these facilities is going to help meet those needs. Any comment on that, Dr. Vaughan?

DR. VAUGHAN: That's a great question, actually, because it's a one-year reduction. We're asking those organizations to think creatively in the environment that we're all in fiscally, to look at how they can work together to do things differently. As we have conversations with them, we're beginning to have conversations with Nova Scotia about modernizing the whole sector and the facilities, frankly. That means looking at how we finance and the kinds of needs of those organizations going forward. You're right, there will be a different level of care in the future. That's why we absolutely need to modernize. That's why the Continuing Care Strategy is so important, it needs to have the appropriate time to do that.

The one-year reduction is an opportunity for organizations to be creative about how they can do things differently, and many of them have. We have to give credit to those who have done that work. But to just say that the 1 per cent is going to lead to more problems is probably not a real reflection of the direction we're heading in.

MR. DAVID WILSON: But if we're seeing facilities laying off people now - and I had mentioned one just recently, in the Premier's riding - if the people on the wait-list are still there, and they're waiting to go into a long-term care facility, how is reducing staffing going to meet those needs?

Earlier, when I asked about ensuring that facilities are meeting the needs, you had indicated there is not a negative impact on residents of those facilities and that you do an inspection or audit. How often do you audit a facility, and what kind of timeline do you look at for those audits?

DR. VAUGHAN: I'll ask Ms. Maxwell to answer that question.

MS. CAROLINE MAXWELL: Yes, so, under the long-term-care program requirements, these are basically the standards that the administrator has to attain to make sure that their licencing is maintained. We have staff that go in at a minimum of two times, a year. If we hear anything from the public or from families, if anything comes in through the minister's office, the NSHA, or for example the other regulators that are actually going in the facilities as well such as the fire marshal, Environment, Agriculture - we would do another visit. So, we do more than just two. It is a matter on what the response is to what's happening, and to what we're hearing.

MR. WILSON: So, that's for every facility. There's a minimum of two audits, per year.

MS. MAXWELL: Yes, licencing visits.

MR. WILSON: Okay. One minute? I've got one minute. I don't know what question to ask in one minute and get an answer. I think what we'll do is we'll just return back on the next turn around. Okay?

MR. CHAIRMAN: We'll move to the Liberal caucus and Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Thank you for being here today. This is obviously a topic that is concerning to everybody here in Nova Scotia, with our aging population.

I have a few questions that I'd like to put forward. Have you seen any changes to long-term care with the transition to the one Health Authority?

DR. VAUGHAN: Thank you for the question. We have seen efficiencies, as I said earlier. The standardization has been important. Remember, we're dealing with 134 different organizations, and so that sort of level of ad hocery, historically, has led to many of the challenges that we're trying to address today.

I'll let Ms. Knox deal with the specifics of what she's seeing because I know that she's dealing with it every day.

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: Our whole approach with the Nova Scotia Health Authority, in looking at our services across the province, is to really focus on standardizing our policies and approaches, so that's where we get the efficiencies. I'll ask Susan to talk a bit about the work that she has been doing as our Senior Director for Continuing Care for the Nova Scotia Health Authority.

MR. CHAIRMAN: Ms. Stevens.

MS. STEVENS: When the new Health Authority was created, Continuing Care was also created as a provincial program. So as Janet indicated, we have spent the last year-and-a-half in Continuing Care - both home care and long-term care - bringing consistency in our approach, our practice, and our policies to the delivery of home care and long-term care. Some of the advantages of being one organization have translated directly into improvement in the delivery of care. The reductions in the long-term care wait-list has meant people are getting more timely access to nursing-home beds and residential care facilities.

In home care, we've reduced the wait-lists for home care, and we started in certain parts of the province, working with agencies, our Continuing Care team and the Health Authority, and used the lessons that we learned in those areas where we had success eliminating wait-lists, and took them across the province, in other areas where we were battling wait-lists, and that's a function of being one organization. So we can move pretty nimbly and pretty quickly, and share our expertise across the province.

On the long-term-care side, an example I can give you is where we've had very complex and challenging situations with individuals with unique needs. We've been able to pull on expertise from across the province and across the Health Authority. So whether it's within Continuing Care, we're working with a family and an individual in Yarmouth, and we've been able to bring in expertise from our team in Cape Breton or Halifax, for example. We've also been able to do that with our seniors' mental health team through the senior director of Mental Health and Addictions and her team in the Health Authority.

MS. LOHNES-CROFT: Have the investments to home care helped in reducing the wait-list for long-term care?

MS. STEVENS: Yes, we're able to support more people at home longer - and people want to stay at home. So with the investments in home care and in other programs such as the caregiver benefit, the seniors wheelchair loan program, and a number of other complementary programs, those are the things that do help people stay at home longer and either avoid or delay placement into long-term care.

MS. LOHNES-CROFT: Dementia is a more challenging aspect of long-term care. How does dementia fit into the two-year time period into long-term care because you can't predict - I mean some people with dementia decline very quickly while others, like my mother, sort of level off for periods of time, then decline, level off - she has been in long-term care for more than two years, you're not going to kick her out.

MS. STEVENS: No, of course not.

MS. LOHNES-CROFT: Oh, I knew that answer. How does dementia work into all the long-term care?

MR. CHAIRMAN: Dr. Vaughan.

DR. VAUGHAN: I'll ask Carolyn Maxwell, who lives and breathes this every day, but we all experience dementia within our families and friends. That's unfortunately a reality that is confronting many more Nova Scotians as we get older, and we're going to see more of that.

We have a dementia strategy that is part of our addressing the needs within the long-term care sector as well, but not just that. We have specialized individuals who are available for the long-term care sector who deal with challenging behaviour and those individuals are experts and are available, on request, to provide assistance. I'll ask Carolyn to really sort of drill down on your question.

MS. MAXWELL: The Continuing Care Strategy that the deputy has spoken about is a real opportunity for us to link a variety of good work that has been done in the past and is going forward.

We're in year two of the dementia strategy. In year one, working with the Alzheimer's Society, we've increased the number of community partners to deliver education and information sessions; we increased information line coverage and that meant Monday to Friday that individuals who were having some challenges at home with their loved ones could call for support; we increased first-link primary care physicians linking with newly diagnosed Alzheimer's patients; and increased supports to under-represented populations such as the Acadian population.

We're in year two, so we're looking at an action plan, and we're in the midst of developing the terms of reference for our collaborative work with the NSHA and a variety of stakeholders on that, what is going to happen in year two and basically continuing on with that great work, continuing to enhance that work.

As far as how does it link with long-term care, obviously we'll be looking at how are our policies and practices across the board, whether it's in home care or long-term care, are we meeting the needs of those individuals and their families who are experiencing this disease?

MS. LOHNES-CROFT: Thank you. Dr. Vaughan, you mentioned in one of your replies that some facilities are hiring or spending money on staff or administration above the government requirements. Can you expand on that?

DR. VAUGHAN: I'll ask Carolyn to drill down on the details of that. I'll just say that we don't run those facilities - we provide the global budgets for those facilities and they live within those global budgets. If they choose to pay people more than would be a comparative within that sector, then that's their decision and they have to address that. I'll let Carolyn deal with the specifics.

MS. MAXWELL: Since 2015-16, the Department of Health and Wellness has been working with HANS and representatives from CGO and CCANS and the Continuing Care Council around budget mitigations and the planning on how we are going to meet those challenges together.

One of the things that we've looked at is having the opportunity to speak to each of the facilities. For example, if a facility was having any challenges, they would call our service support consultants, and we would look at their budgets with them and identify any possible areas where there could be cost savings. For example, we would look at administrative budgets, look at how much individuals were being paid, and if they were above what was actually intended to be in the budget.

MS. LOHNES-CROFT: So are there audits each year that you have access to?

MS. MAXWELL: We have financial statements that are audited that come into the department each year, but from the perspective of actually drilling down and supporting a

facility that has been experiencing some significant financial challenges, we use a financial template approach, and we look at it from a variety of different aspects, as well as draw on some of the wonderful expertise that exists within the long-term care sector to help each other identify areas for cost savings.

MS. LOHNES-CROFT: When a family or a worker at a facility has a concern, how does your department go about addressing an issue in long-term care? You're saying you don't have control over it, but you must have some way of making sure that there are certain guidelines?

DR. VAUGHAN: It's an important question. First of all, we have the Legislative authority so we do go in and inspect, as I said, twice a year. We adhere to the standards, and those standards drill right down into the food quality, which are overseen by dietitians. It's not just a cost that's a factor. So we ensure that all of those issues are maintained.

There are family and resident councils in each of the facilities that, more importantly than anyone else, are able to raise their concerns with the administrators at the front end. The department, if there are any complaints, we go in and look at those immediately. If we hear about anything, we go in. These are inspections that are unannounced, so we're very much concerned that they adhere to the standards.

MS. LOHNES-CROFT: Do you see the minutes from the Family Council and the Resident Council meetings?

DR. VAUGHAN: Yes we do - we get that information.

MS. LOHNES-CROFT: I attend Family Council so I know minutes are taken. One other thing that I must say about the Family Council, the staff remove themselves - at least the one I attend - for a period of time, so that families are able to openly converse without feeling they're being watched by the staff. They can be anonymous in their reporting of a concern, which I really appreciate.

Is there a bill of rights? There is a patient's bill of rights in hospitals. Is there a bill of rights for residents of long-term care?

DR. VAUGHAN: I'll start and then I'll ask Carolyn, who will drill down into the details of that. We don't have a bill of rights specifically. We have many of - I say all of the elements of a bill of rights in the legislation that you would see in other bills of rights, in many of the elements in other jurisdictions. I'm only aware of B.C. and Ontario - some in Ontario are more specific than what we would have, but all of the elements of a bill of rights that would be contemplated already exist in legislation. Carolyn, you may be able to give some specifics.

MS. MAXWELL: Under the long-term care program requirements, many of the aspects that were presented, such as quality food, reunification of families, couples, being well-clothed - all of those kinds of things would be what we would be looking for under the long-term care program requirements, when our investigation compliance staff actually did onsite visits. We would be looking for many of those elements.

A bill of rights would give us more clout and more authority, utilizing our Homes for Special Care Act, as well as our long-term care program requirements when we do our licensing visits.

MS. LOHNES-CROFT: How easy is it to access the regulations that you govern? Is it on a website? Are families or residents given a copy of the regulations when they register?

MS. MAXWELL: All of our policies and long-term care requirements are on our website.

MS. LOHNES-CROFT: Dr. Vaughan, you're retiring soon. Do you see long-term care heading in a positive direction? Do you think that what you've so far established for the continuing care strategy is going in the right direction?

DR. VAUGHAN: We're headed in the right direction. There's more work to do, for sure, to modernize the sector, everything from the issues that we're talking about here today to capital asset planning to a more needs-based approach to funding. But I think the most important thing is the quality of the service that we are going to be facing.

We talked about some of those issues already. I think that's an important issue for us. We have the standards. We have the legislation that we have. Not all long-term care facilities in Nova Scotia are accredited by Accreditation Canada. We would like to see that become a conversation going forward. That covers many more of the clinical areas that are currently within a legislative standard and are required in other jurisdictions. We see the modernization to be really about raising the bar around quality of care. That means that institutions would think about accreditation. There are some organizations in the province that do a great job and are recognized for their accreditation status. Some of them, it's not even on the radar. We would like to see that as a measure of achievement for the sector as part of a continuing care strategy.

MS. LOHNES-CROFT: What is required for accreditation?

DR. VAUGHAN: Accreditation Canada is an independent organization that goes into every facility. There are a number of elements on the Accreditation Canada website. Specifically dealing with the long-term care sector, it relates to everything from medication reconciliation to some of the areas that we've already talked about in terms of safety and some of the other elements that are already being dealt with. We see it as an opportunity

for the sector to talk about achieving a national standard over and above what we already achieve.

MS. LOHNES-CROFT: I was involved in school accreditation. That took a two-year period. I don't know how long it takes in a hospital. I think the facility my mother is in is accredited. How much professional time comes out of that? You have a composition of your team which would be staff, board members, administration, and community members. Who do you draw out to be part of that accreditation team?

DR. VAUGHAN: All of those people are involved. Part of the benefit of accreditation is, first of all, focusing on the process to continuously improve what we are doing in the delivery of care. It's important to engage the residents and the families and the nursing staff and all of the staff, in fact, administrators. All of these folks have a role to play in ensuring that what we are doing every day meets the national standard.

MS. LOHNES-CROFT: Is there a recertification process? Once you're accredited, do you have to maintain a certain standard, and then there's follow-up?

DR. VAUGHAN: Yes, there's a whole process around accreditation. When people are learning to become accredited, there is a process that takes place. There is sort of a training wheels process, if you will, where they go through a mock kind of process to try it out, to learn. Again, this is a quality improvement process, so they're able to then see what they need to do to improve what processes are in place, what support they need to put in place to allow them to achieve accreditation.

When they go through accreditation, when surveyors from other jurisdictions come and are boots on the ground, so to speak, to actually walk in every facility and talk to residents and talk to staff and check out all of the kinds of quality measures that are a part of that, once they achieve that accreditation, then they are accredited for a number of years, depending on the level of accreditation, but say generally about three years. They're required to report continuously through that three-year cycle things like infection control that they must continue to report on to Accreditation Canada. Again, it's a third-party independent process.

MS. LOHNES-CROFT: I have no more. I'll wait for the next round.

MR. CHAIRMAN: Mr. Farrell.

MR. TERRY FARRELL: I think we're discussing a lot of these issues from a high-level perspective without a basic understanding being stated in the room today, about how the system works from the ground, from entrance into the system to entrance into long-term care. I'm wondering if Ms. Knox and Ms. Stevens could maybe just give us a fundamental description of how a client comes into contact with continuing care, and how they might work through that system and end up in long-term care.

MS. KNOX: Thank you for that. I would just like to say before I ask Susan Stevens to really go through the process, as I'm sitting here listening to us have this conversation, we're really talking about our population in terms of, how do we support them and understand their needs as we age? So continuing care, home care, and long-term care make a program of support but as we go forward with having access in local communities for teams to help people be healthy and stay healthy, we want to look at all the assets that are in our community that support people to age well in their place, so that has to be our vision as we go forward.

That being said, this is a very important service and we want it to be the very best when people need the service to have access. I'll ask Susan Stevens to talk to how people access . . .

MR. CHAIRMAN: Order, I do apologize, but the time has expired for that round. We'll move back to the PC caucus and Mr. Houston for 14 minutes.

MR. HOUSTON: I'm thinking about the impact of the cuts on the quality of life of the people we're concerned about here today. As an MLA, I hear various stories of different situations that have happened to family members or that are occurring. Ms. Maxwell mentioned a service support hotline that the facilities can call if they are worried about their budget.

I'm just wondering, Dr. Vaughan, has there been any situation where a home has contacted you through the service support or otherwise, that said look, we just can't do this without impacting quality of life? Has there been any situation where they've done that to the point where the department has said, you're right, and has reversed some of the cut?

DR. VAUGHAN: Thank you for the question. I'm not aware of that occurring. As I said initially, we've been reaching out to over 83 per cent of the facilities, asking how's it going, are you having any challenges? This is proactively going out. We have not heard anyone coming to us saying they have not met the requirements of the legislation to maintain the quality that is defined.

MR. HOUSTON: Meeting the requirements and understanding the ramifications of the meeting of the requirements are two separate things. I guess what I'm asking is, nobody has come to you and said, we can make your cut, but here's what we have to do without, and it's not good for our patients. Nobody has reached out to you and said that?

DR. VAUGHAN: We get conversations all the time, long before the budgetary challenges that we face. We get conversations from facilities about various items that they have - boilers, or roofs, or whatever - and we deal with those right away. We did not have anyone coming to us and saying they cannot fulfill the requirements in legislation.

MR. HOUSTON: So they are fulfilling the requirements, but they're doing it with remorse, I would say, and they're doing it with sadness, probably. If I try to look at the cuts, and give myself some perspective - there was a nursing home in Truro that had a $270,000 cut, maybe somebody sitting in the department thinks, it's 1 per cent, it's only a couple of hundred grand, it's no big deal. But they have to do things to make that, so they either have to lay off some of the staff in the kitchen, or change the meals or something like that.

To try to understand that $270,000 and give it some perspective, I looked at just the travel expenses of the Department of Health and Wellness - they are $500,000. There are other departments that have travel expenses that are kind of shocking numbers. I think the Department of Agriculture - I don't know if I have it on hand here - well into the hundreds of thousands, I believe it was almost $800,000 in travel expenses.

I'm just trying to reconcile those things in my mind when you have that type of money being expended by government, and then over here in our nursing homes, we're saying, this is the legislation so you have to make that cut and do whatever you have to do and maybe don't tell us about it. I can't get my head around that.

Before I leave the cuts and the impacts on food and stuff, I guess the department's okay with that and the department is convinced that there is no impact, zero impact on the quality of life of these seniors.

DR. VAUGHAN: Thank you for the question. We take very seriously any suggestion that there's impact on quality of services delivered to the seniors in nursing homes in Nova Scotia. We expect the nursing homes to live up to the obligations of the legislation, and we inspect them as I said. The department has made significant reductions; we've moved out 130 personnel from the department. We've all been a part of bringing the province to fiscal balance. That's the challenge that we all face.

I can't speak to other departments, I don't know anything about that, but what I do know is within our purview of control we have all made significant cuts at the Health Authority level, at the department level, and we're asking the sector to also partner with us to look at how they can achieve efficiencies by working together. In the administration areas, there are other ways to achieve those cost savings. If they're having trouble in achieving that, we are very happy to talk to them - we are talking to them, working with them. But to suggest that the way forward is the way we've always done things in the past is not a solution to modernize long-term care.

MR. HOUSTON: I guess the flip side of that is a lot of people would find it depressing to think that the state of the care now is kind of the best it's going to be, that it's never going to get better. That's the feeling that I have as I sit here today. So on the budget cuts, and meeting that legislation and making that happen, does the department have any

sense as to how many of the homes had to cut their food budgets to meet the cuts? Do you know where they're making their cuts?

DR. VAUGHAN: I'll ask Paula Langille to specifically answer that.

MS. PAULA LANGILLE: Thank you for that question. I think we need to clarify, as Deputy Vaughan has mentioned, that these are private businesses. We provide a global budget; they are the ones who allocate their costs associated with their expenses, so we do not set their food budget. That is something that the facility would facilitate. We have looked at their food, and I'm speaking in the broad sense of raw foods so these are their actual costs for the raw food items. We're not talking about staffing or preparation costs or anything like that; we're talking raw food costs. We did look at financial statements from 2015-16, and the food costs range anywhere from $6 to $10 a day. So there is a wide range across the sector of what actual facilities are spending on the raw food costs.

So, just to sum up, the Department of Health and Wellness does not set the raw food budget cost for our long-term care facilities. That is at the administrators' discretion.

MR. HOUSTON: If I did, I didn't mean to imply that the department set that. What I'm wondering if the department accepts that by making a budget cut, they have forced the administrators to find somewhere to cut, and food is a variable cost; it's a place where cuts can be made. So I'm asking, does the department understand the ramifications of the cut to the point that it knows, okay, 50 per cent of administrators found this cut in their food budget, 20 per cent of the administrators found this cut in their food budget? Do you have a sense as to how they meet the cut?

DR. VAUGHAN: Each facility, as we keep saying, is independently run. We are encouraging those facilities to work together. There are opportunities to consolidate the administration. Some of those facilities have done that. If they are choosing to find those savings in areas that are impacting patient care, we take that very seriously.

MR. HOUSTON: Do you know though? I guess the question I'm asking is: Do you know?

DR. VAUGHAN: We know through the processes of the Patient and Family Councils if we're seeing anything in those reports, if there are any complaints about those systems. Remember we have gone in when we have heard any sort of suggestion way before things show up in the media. We've gone into facilities to look at food. Those food elements are all reviewed and have to meet requirements of licensed dieticians. So it's not just the costs that we look at.

MR. HOUSTON: Let me ask you the question in another way. In your analysis of financial statements of the homes, which percentage on average of their budget goes to food - it's in the single digits, right? Do you know how much it is?

DR. VAUGHAN: We don't have that aggregate number because each facility is an independent agency that has their own audited financial statements.

MR. HOUSTON: Right, but if somebody called in to the service support hotline and said, I'm having trouble making the budget cuts, you'd say, well how much did you spend on food? Normally a nursing home would spend 3 per cent and I see you spent 4 per cent, so there you go. So you must have an expectation of - what is the department's expectation of how much of their overall budget should go to food?

DR. VAUGHAN: Again, they are independent agencies.

MR. HOUSTON: If you don't have a benchmark to compare it to, I don't understand how you could even have a service support hotline. You must have a benchmark as to an expectation of how much of the budget should go on food, should you not?

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

MS. MAXWELL: When we receive phone calls from long-term care facilities - whether it's about food or any financial challenges, we sit down and talk with the facilities. We go through their budget and we look at areas where they could possibly have improvements. We don't specifically . . .

MR. HOUSTON: But how do you know that? How do you know where they could possibly have an improvement if you have no benchmark?

MS. MAXWELL: We compare similar-sized facilities with similar-sized facilities. So to Paula's point, they receive a global budget and the administrator is responsible for the safety and care that's provided within the facility. Based on the long-term care program requirements they receive a global budget and they're required to meet the required outcomes.

MR. HOUSTON: Okay, we'll try this again. I think we referred to $6 to $10 a day was the number that I heard for food. That's the department's expectation that a home would spend $6 to $10 a day per resident.

MS. MAXWELL: That is the amount that the industry is setting amongst themselves as independent operators.

MR. HOUSTON: So if a home comes to you and says we're spending $15 a day on food, you'd probably say too much, you could save some money there. Is that fair?

MS. MAXWELL: No, that wouldn't be our decision. We would be looking to the facility to say, where can you possibly reduce your budget?

MR. HOUSTON: You would point them to . . .

MS. MAXWELL: We speak with every facility when they come in if they have financial issues; we sit down and do a financial review and we look at both their administrative budget and their operational budget. For example, when we asked 102 that were impacted by the 1 per cent - through our conversations this past year and this year with our long-term care providers - we've talked to them about areas where they have made improvements and areas where they see that if they had some additional reinvestment that they might be able to do something differently.

MR. HOUSTON: I just want to follow up on that though. If $6 to $10 is the accepted norm and somebody came to you and said they're spending $3 a day on food, what would you say?

MS. MAXWELL: What I would say is that we have inspection compliance officers who would have to go in and look at the food, look at the quality of the food and ensure that it was up to the standards that would have been set by the Canadian Food Guide, and the menus would be set by the dieticians.

MR. HOUSTON: So $6 to $10 is the best we're going to do on an estimate of where the food should be. Do you have a similar estimate on what the profit margin should be of an operator?

DR. VAUGHAN: We don't have an expectation of profit margins. Many of these organizations are not-for-profits, so there is no expectation that we have of them to make a profit.

MR. HOUSTON: The Nova Scotia Nurses' Union said that the state of long-term care in the province is in a crisis. Nurses called the conditions in many of these places "deplorable", and 64 per cent of nurses who work in long-term care facilities have seriously considered quitting their jobs in the past year. That's a pretty staggering number - I don't know what we would do if they did quit.

We'll finish with Ms. Knox. To what do you attribute the nurses being so distressed and upset with their word conditions at long-term care facilities? Are they just wrong?

MS. KNOX: I read the report. You're referring to the Broken Homes Report. I take it at face value of the perceptions and lived experiences. What we need to do is work with those folks to create the kinds of environments that are acceptable to them and to the residents . . .

MR. CHAIRMAN: Order. Sorry, the time has expired. We'll move to the NDP caucus and Mr. Wilson.

MR. DAVID WILSON: I'll be sharing my time with colleague. I just quickly need to ask a question about something that recently happened. I think many were appalled by a letter that went out to Nova Scotians waiting for mental health services in the northern part of the province. I think the Premier even apologized in the House. Did a similar letter go out to those on long-term care wait-lists asking them, you've been on the wait-list for a year or two years, can we take you off the list?

MS. KNOX: Thank you for raising that. As you know, we have apologized for that letter. I would also say the individual who sent that letter is feeling very, very badly about the whole issue. It was an attempt on the part of the service provider to interact, and ask the clients, what services do you need? No, we have not sent any similar letter.

MR. DAVID WILSON: I know I was specific about long-term care. Are you aware of any similar letters, maybe not as cold as that one was, to people waiting for other health services - surgery, any kind of wait-list? Has there been an attempt to address wait-lists by sending a letter out asking if they want to be taken off that list?

MS. KNOX: Our whole approach of assessing people who are on wait-lists is to meet with them and talk about what their needs are using a triage system. To my knowledge, we have not sent letters to people. We do need to talk to people who are on wait-lists and have them reassessed from time to time. So that is one of our processes.

MR. DAVID WILSON: I'll pass my time off to my colleague.

MR. CHAIRMAN: We will move to Ms. Peterson-Rafuse.

HON. DENISE PETERSON-RAFUSE: First, I want to talk a little bit about the reality of the situation in our long-term care facilities. I also want to make a point, which I'll go into in a few minutes, about the fact that you can't do one without the other. That's the problem. It seems that the government is trying to boast and tout that they're putting all this money into home care. However, for anybody who is in home care, there is going to be a point - unless they pass away - when they need long-term care.

How many long-term care beds has this government created since they've been in power, since 2013?

DR. VAUGHAN: Nineteen beds.

MS. PETERSON-RAFUSE: So 19 beds. Are those replacement beds or new beds?

DR. VAUGHAN: Seven were replacement, 12 are new.

MS. PETERSON-RAFUSE: That's very sad in comparison. When we had the privilege to be in government, 1,000 beds were created. That's part of your crisis, not

having a strategy where you're balancing your home care - during the transition of building more resources for home care, you can't ignore long-term care. That's what has happened.

The other thing is you mention that these cuts are not having an effect on long-term care. I've had staff come to me and talk about the fact that one staff person quit their job because it took her 40 minutes just to get a senior a glass of water, because of the reduction in staff. I had another person come to me who has worked 40 years at the same home, and put in for one day off in August for November, and had been refused, because of the lack of staff. I've been contacted by staff that there are only two working in a locked Alzheimer's ward. I would suggest to you that there is really a crisis there, and there's a need to get on the floor of those long-term care facilities, and see what is actually taking place.

I have a question with the fact that in 2013, there was a very strong, loud promise from the Liberal Government to fulfill any capital projects that the NDP had announced. One in my constituency is Shoreham Village senior citizen home and I'll give you a little picture of that home. It's a home where the rooms were built for one person, and very quickly, the need was so strong, that they put two people in a room. I want you to also envision that this is a very tiny room - maybe if you took four or five of these desks and go back, that's what you would get for a room for a senior who has lived all their life and given to the community.

My questions is, why was Chester told during the election, very strongly - one of them in the Party said it's not all bread and roses from the NDP because we were looking at replacing the 69 beds there. We were even criticized that we weren't adding extras. Can you tell me why the people of Shoreham Village were betrayed?

DR. VAUGHAN: Thank you for the question. We've gone out, and know Shoreham Village well, and know the administrators there, and the people who work there, and some of the residents, in fact. My sister died at Shoreham Village, so I know it very well. We have talked to all the facilities on that list, and looked at what we can do, what their needs are, what their short, medium, and long-term needs are. We look at listening to Nova Scotians, as I said earlier, who have told us over and over again that they want to stay in their homes as long as possible.

When we look at the data, when we look at the number of the length of time Nova Scotians spent, on average three years, compared to the national average of two, as Ms. Knox said earlier, we would not need replacement beds. We would have over 1,000 beds - 1,400 beds - that would be available just by improving the number of people who were able to be treated in their homes longer. That is part of the strategy. To simply just put up more facilities without looking at the long-term implications will create a problem down the road for Nova Scotia and that is not only a fiscal problem but a quality-of-care problem.

The technology is allowing us to allow for more Nova Scotians with more chronic conditions that once used to be treated, or be admitted to long-term care facilities, to now be able to stay at home. There are a lot of opportunities to develop home remote monitoring to improve the quality of care where people are in their homes; other jurisdictions are doing that. That has good evidence of maintaining the quality of care, the cognitive function of individuals, and the improvement of their lives.

We have been looking at replacement beds, and we have been working with each and every one of those facilities, and we've assisted many of them in short-term requirements as we look towards the longer term.

MS. PETERSON-RAFUSE: I agree with the fact that seniors wanting to stay in their own home longer is certainly what they want, but there is a point in people's lives that what they want is not reality, and they have to have a home. So as I said, we cannot ignore the long-term homes when we talk about investments and staying home.

My question with respect to home care is, if you talk to many seniors, there are little issues that are small in our eyes, but huge for them to be able to stay in their homes longer, such as snow clearing, wood cutting, piling of wood. So if the province wants to encourage people to stay in their homes longer, this is something that's almost virtually impossible to run by volunteers. Why did the government cut the pilot project on the South Shore that was actually fulfilling that need? There was a growing need for that.

DR. VAUGHAN: I'll ask Susan Stevens.

MS. STEVENS: Thank you for the question. The Nova Scotia Health Authority receives funding from the Department of Health and Wellness for - we call them instrumental activities of daily living. These are the activities you refer to - the things outside of the normal health care range of supports and services we think about that do enable people to stay at home longer.

We use that money in different ways, in different parts of the province, to respond to the needs of seniors and people with disabilities, in those areas. In some cases, wood piling, wood cutting, snow removal, transportation to doctor appointments and to the pharmacy to pick up medications - those are the needs that aren't being met for low income seniors, and we are using money to support those types of activities through a variety of partners - most often not-for-profit organizations in communities.

On the South Shore, we had to make reductions in that program because the need was greater than the funding that we had.

MS. PETERSON-RAFUSE: Thank you, and that's part of what I'm pointing out - where the need was greater, the money should be invested in that. That was a pilot project that certainly showed that there is a need. I find that there is talk out of one side of the

mouth and one on the other side because you're talking about the importance of home care, and people living in their homes longer. I'm not seeing changes that would support that.

For example, through Housing Nova Scotia, the income cut-off level for seniors to get home repair is very low. There are many seniors that, even on a fixed income - it is so low that they don't qualify. So the government will say, we have a program and there isn't a great uptake on it, but the reason there's not a great uptake is because of the restrictions that are put on the program.

My other question with respect to home care - I want to take as an example, if you had two seniors and one senior has, let's say, dementia, how much home care service would they get in terms of hours in a day?

MS. STEVENS: The amount of home care an individual or family would receive is based on an assessment by one of our care coordinators and we look at - what the needs are in that situation, and match that up with the supports and services that we can provide.

There are maximum amounts that are set by the Department of Health and Wellness home care policy that we are required to follow. For home support, those are the services delivered by a continuing care assistant - things like personal care, assistance with meals, feeding and so on. If that's the need that a person has, we can authorize up to 150 hours per month, so roughly five hours per day.

If there is also a need for nursing care, then it's a maximum of 100 hours of home support and up to 60 nursing visits per month.

MS. PETERSON-RAFUSE: The problem is that the care level that a lot of these individuals or families need are way higher than what those five hours would encompass. So you have a big gap there when you're saying . . .

MR. CHAIRMAN: Order, the time has expired. We'll move to the Liberal caucus and Mr. Farrell.

MR. FARRELL: I'll go back to the question I started to ask last time. I think you were somewhere at the midpoint or maybe getting towards the end of the answer to my question when you were addressing the last question from the last member of the Opposition.

Just a thumbnail, if you will, or an explanation of what's going to happen to me when my time comes and I have to come in contact with long-term care or the Continuing Care system and, eventually, the long-term care system?

MS. STEVENS: Thank you very much, I appreciate the opportunity to talk about how people access our services. I take every advantage of that every time I have that opportunity.

We have a 1-800 phone number that people can call anywhere in the province that will connect them to one of our local offices. We will take some basic information about them and their situation and, with their consent - or if it's a family member who is speaking on behalf of somebody else with dementia, for example - we will then open a case and we will refer it to one of our care coordinators. Our care coordinators are licensed health professionals: nurses, social workers, occupational therapists, physiotherapists, and dietitians. They will make arrangements with the individual and the family, in most cases, to come out and do an assessment in the home.

Again, it's a comprehensive assessment, it is really looking at the individuals' health conditions but, more broadly than that, their living environment, the supports that families are able to provide. As Janet indicated earlier, supporting somebody to live their best possible life in the community is not only about health care and support services but there's a whole range of assets in communities that can be brought to bear to assist that person and that family.

We try and make sure that we refer to those other supports and services that people might need outside of us. We have a range of programs that we start off with in terms of supporting people at home first. That could be home support, that could be nursing care at home. It could be the Caregiver Benefit Program which provides $400 a month to a caregiver. It could be the use of a hospital-like bed, an electric bed that we can access through the Red Cross that assists that individual to sleep more comfortably and helps their family caregiver and any paid caregivers going into that home as well. It could be through the Seniors Community Wheelchair Loan Program as well.

So we have a variety of supports and services we can bring to bear in those situations. Our focus is always, how do we support you at home first? What do you and your family have that you can offer that you are doing and then what can we do and what other supports and services are available in the health care system or, more broadly, in the community?

For a number of people there does come a point when home care is not enough and it's no longer safe or appropriate to be cared for at home, so then we explore long-term care. We currently have two levels of long-term care that are available. The first level is called residential care facility and that is a lighter level of care than you find in nursing homes. Typically somebody who does well and requires the level care in a RCF - a residential care facility - is somebody who can no longer manage the day-to-day activities at home. They can't do the grocery shopping, they struggle with looking after the house or the apartment, transportation may be an issue, but they can still do a number of things for

themselves. They might need some assistance with their personal care but they need the supportive living environment, so then we explore a residential care facility.

For other people they need the level of care provided in a nursing home and we would then explore placement to a nursing home for those individuals.

MR. FARRELL: So there has been an increased emphasis on keeping people in their home longer; there have been resources directed towards that. I guess if I'm allowed to express my personal opinion here, I think that's something people want, people want to stay home, they don't want to be removed from their homes and go into care.

How have the increased resources that have been directed towards that end resulted in expanded services that are there to make sure that good care takes place to allow that to happen?

MS. STEVENS: Twenty years ago when I was a care coordinator, we had a very limited range of options to offer people. We had home support, and nursing, and long-term care. Starting back in 2005, we started to see the introduction of new and different programs for people, because what people want and what people need is a range of options. Everybody's situation is different, and what works for you may not work for another family or another individual. So, we have seen, with more investment an introduction of new and different programs.

In 2005, it was the Self-Managed Care program. That program serves people who have significant physical disabilities and impairments. We provide funding to them so that they can hire their own attendants to do their personal care, and provide supports and services to them, and it's a very successful program. It's just another option.

In 2009, it was the Caregiver Benefit Program, which provides $400 a month to unpaid caregivers for people with very significant needs with whom they have a caregiving relationship. That program started small and for a number of years, we had under 1,000 people in that program. With more investment, we have over 2,000 people receiving that benefit now.

Of course, there are other programs that have been added: the Supportive Care Program, which provides funding to people who are caring for individuals at home with dementia; the Seniors Community Wheelchair Loan Program; the Bed Loan Program, which was expanded. As I mentioned earlier, the Health Authority started receiving money for other supports and services that might be required in different communities, so there has been a host of other supports and services we can now offer because of that investment, which are helping more people stay at home longer.

MR. FARRELL: Now, you're starting to go into the levels of service that are available - the amounts of nursing care and home support and that sort of thing. What do

those break down to? What would the maximum amount of service that a person could receive, say, on a daily basis, just prior to entering into long-term care if they were receiving a maximum amount of service?

MS. STEVENS: For home support, it would be about five hours a day. That would be the maximum amount but depending on their situation, they may also be receiving other supports and services from us, so it might be 150 hours a month, or five hours a day, for home support. Their caregiver could also be receiving the Caregiver Benefit. They might also have a wheelchair through the Seniors Community Wheelchair Loan Program. They may also have a bed through the Bed Load Program. They could also be receiving some supports and services through our Instrumental Activities of Daily Living Program, so they could also have home oxygen. There could be a whole range of programs.

MR. FARRELL: Nursing care?

MS. STEVENS: They may have nursing as well. Absolutely, we could have nursing visits in there.

MR. FARRELL: I guess I was appalled, but probably not shocked, at the implication that was raised at the beginning of the questioning by the member of the Opposition, who tried to tie in the initiative to keep people in their homes longer, with the deaths of people on the waiting list.

I know the attempt there was to colour the government with that statement, but I also think that it doesn't give credit to the professionals who are there providing the service, providing the care on a day-to-day basis. I'd like to give you this opportunity to reassure people that this is the kind of program that people want, and this is a program to keep people in their homes safely and happily, until the time comes when that's just no longer possible for very valid reasons.

MS. STEVENS: Thank you very much for that question, and the opportunity. Absolutely, our goal is to meet the needs that people have. Most people want to stay at home as long as possible, and they work with us to make that happen. When that's no longer possible, when people reach the point where the care that's required is beyond what the health care system can support and what their families can support - because caregivers are critical, absolutely critical to supporting individuals at home - then we look at other options, and we explore long-term care.

MR. FARRELL: I think the implication was that people weren't just dying while on the waiting list but were dying because they were on the waiting list. I'm satisfied that those people are receiving a very high level of care, and that the stated goals and results of the program are successful and that that's simply just not happening.

MS. STEVENS: If I could, there are two things to that. Many people want to die at home, and our supports and services enable that. We work with them. When that is their choice and they want to die at home, we provide the supports and services for that to happen.

A person who is on the wait-list for long-term care, if at any point in time there is any change in their situation, they know to call us and we respond. We can get people to beds immediately. It means we can't wait for their preferred choice. I might say I want to live in nursing home A, but if my situation changes dramatically - my caregiver becomes ill and is no longer able to assist me - we can get a person to a bed very, very quickly. We have to look for the most appropriate bed as close to home as possible, but we can get people into beds when they need them.

MR. FARRELL: But I'm also hearing that you don't have to wait for them to call with those concerns. There are trained professionals in their household virtually every day who will be able to bring those concerns to the attention of the appropriate authority as well.

MS. STEVENS: Yes, it's a combination. Those people with very high care needs where we are providing care five hours a day, we have professional people in there absolutely caring for them. They're our eyes and ears. We have care coordinators in regular contact with them as well. And family members are involved, and they contact us with any concerns.

MR. FARRELL: I know I only have a little bit of time left. I want to switch over to the Department of Health and Wellness team just for a moment, around the funding models with respect to the various long-term care facilities in the province. How many different kinds of management structures, if you will, are there among the long-term care facilities in the province?

MR. CHAIRMAN: Ms. Langille.

MS. LANGILLE: Currently, we have for-profit operators, we have non-profit operators, and we also have some municipally owned facilities as well.

MR. FARRELL: Do those varied models lend themselves to strict budgeting guidelines around percentages for each line item on their budget? Or does that vary between models and, in fact, between different facilities or particular municipalities or particular not-for-profits?

MS. LANGILLE: You are correct. They vary by organization structure and by all the different facilities because they're all private entities, and they run their businesses differently. There doesn't seem to be a rule of thumb for what the percentage is for each line item.

MR. FARRELL: From what I've heard this morning, the goal of all of this is to try to standardize that somewhat and to try to make all of them work better and make better use of the resources that they have.

MS. LANGILLE: That is correct. As we mentioned earlier, there is much variation across the sector as to the funding, so we're trying to move everyone towards a standardized approach.

MR. CHAIRMAN: Order, time has expired. That concludes our questioning.

We are a bit short on time this morning. I want to give an opportunity for the Health Authority and the Department of Health and Wellness to provide some closing comments but would ask you, if you can, to keep it very brief. Dr. Vaughan.

DR. VAUGHAN: I think we'll just have the closing comments and save you some time if that's okay with you.

MR. CHAIRMAN: Well, thank you very much. We appreciate that.

DR. VAUGHAN: I want to thank you and the committee very much for the opportunity to be here today and to address some of the very important issues of concern to all of us on the subject of long-term care. In 2006, the government released a 10-year strategy for continuing care. Since then, annual spending on long-term care has grown by over 70 per cent. This year, we will spend over $565 million, over 66 per cent of the continuing care budget. The fact is, the Nova Scotia budget for continuing care is now over $820 million, making Nova Scotia one of the best funded systems in the country. Our ratio of long-term care beds to population is also one of the highest in Canada. But as we've heard today, we need to do things differently if we are to have a viable continuing care model to support our aging population.

Minister Glavine has challenged us to do more to ensure that Nova Scotians are receiving the quality of care they deserve and getting the best value for their tax dollars. That's why within the next few months we will launch a full public consultation that will form a new Continuing Care Strategy, a strategy that will support a model of care to sustain us over the next decade and beyond.

In conclusion, on behalf of Minister Glavine and everyone at the Department of Health and Wellness and the Nova Scotia Health Authority, I want to express our appreciation to the thousands of men and women who work selflessly to care for our aging population. These are the physicians, the nurses, the nurse practitioners, the personal care workers, the dietitians, the administrators, the social workers, the physiotherapists and the countless other clinicians and volunteers who support our loved ones every single day. They deserve the best support we can give them. Thank you very much.

MR. CHAIRMAN: Thank you, Dr. Vaughan. We do have just a little bit of committee business here. We had three pieces of correspondence: from the Department of Health and Wellness from the October 5th meeting; the Department of Health and Wellness and the Health Authority from the September 28th meeting; and from the October 12th meeting an information request from the Auditor General. Are there any questions about any of that correspondence?

Seeing none, our next meeting is on November 9th (Interruption) Mr. Rankin.

MR. IAIN RANKIN: Not on that topic, but I had to put a motion forward for the next meeting, just to make a minor change, if I could.

MR. CHAIRMAN: Please proceed.

MR. RANKIN: If I could just elaborate - the next meeting we have scheduled, the sustainable transportation program, so that encapsulated five different programs, so we inadvertently had three of them listed that actually end up with a totally different department, Municipal Affairs, and then the Blue Route was listed as well and that's with Transportation and Infrastructure Renewal.

So, without over-complicating it, we were just going to try to limit it to two departments, so Connect 2 would be with Energy. We already have Energy scheduled and we were just asked to make the addition of bringing in Transportation and Infrastructure Renewal so we could discuss the Blue Route, because if it's only Connect 2, then we might not have a fully productive meeting without more added to it. We're just saying that, adding Transportation and Infrastructure Renewal with the Blue Route.

MR. CHAIRMAN: All those in favour of Mr. Rankin's motion.

Seeing unanimous consent, our clerk has made note of that and we'll make the adjustments. Thank you.

That meeting is on November 9th, from 9:00 a.m. to 11:00 a.m. It is on sustainable transportation programs. We will be having a briefing at 8:30 a.m. on November 9th with the Auditor General and that's on homes for special care, which comes out of the June 2016 Report of the Auditor General. That's all next week.

With that, is there any further business to come before the committee?

Seeing none, we are adjourned.

[The committee adjourned at 11:00 a.m.]