HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, November 16, 2016

Legislative Chamber

Department of Health and Wellness
Department of Community Services
Homes for Special Care

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Public Accounts Committee

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Ms. Kim Langille
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Mr. Terry Spicer
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Ms. Dianne Chiasson
Audit Principal

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Ms. Carolyn Maxwell, Director, Liaison & Service Support
Mr. Perry Sankarsingh, Senior Exec. Director, Client Service & Contract Administration
Ms. Paula Langille, Acting Director, Finance Services

Department of Community Services

Ms. Lynn Hartwell, Deputy Minister
Ms. Dale MacLennan, Executive Director, Finance
Ms. Martha Gillis, Director, Licensing Services
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House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, NOVEMBER 16, 2016

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: I call this meeting of the Public Accounts Committee to order. Today we have the topic of homes for special care, and we have with us the Department of Health and Wellness and also the Department of Community Services. This was Chapter 1 in the June 2016 Report of the Auditor General. We'll begin with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Just a reminder to everyone, to make sure your phones are on silent during the meeting today.

We'll start with opening comments, with Dr. Vaughan.

DR. PETER VAUGHAN: Good morning again, Mr. Chairman, and thank you again for the introductions. We are very pleased to join you today to discuss the management of health and safety risks in our homes for special care in response to the Auditor General's June Report.

It may be helpful to outline our specific roles in delivering our services in our homes for special care. These facilities operate under the provisions of the Homes for Special Care Act. It is under that legislation that the Department of Health and Wellness licenses nursing homes and residential care facilities.

The Act and regulations also prescribe when facilities are to be inspected to ensure the requirements are being met. All homes for special care must be inspected at least once a year, and homes that provide nursing care must be inspected twice annually, at a minimum. Of course, more frequent inspections do occur in facilities where significant deficiencies have been found.

Our Investigations and Compliance Division is responsible for licensing nursing homes and residential care centres where nursing care is provided. Health and Wellness currently licenses 135 homes for special care, housing almost 7,800 people. Our team of Investigation and Compliance Officers visits every one of these facilities regularly to ensure that each of those residences is receiving the highest standard of care.

The Department of Community Services also licenses adult residential centres, other residential care facilities, regional rehabilitation centres, group homes, small options homes, and developmental residencies. While some of the residents of these facilities may have disabilities, they do not necessarily require nursing care. As a general rule, the facilities overseen by Health and Wellness are larger, some with up to 400 residents.

Because of our important shared responsibility under the Act, our two departments collaborate very closely to protect the health and safety of residents and of the workers who care for them. We do this in many ways - we work together to develop shared care plans to allow clients to stay in their homes longer; we collaborate on complex cases to ensure that clients with unique and challenging needs are well cared for; and we participate jointly with the Workers' Compensation Board and other partners in the work to build a new five-year strategy to protect the safety and security of those who work in our homes for special care. These are just a few of the examples of the ways in which our two departments work together, along with our partners, including the Nova Scotia Health Authority, to put the needs of patients and residents first.

Mr. Chairman, the Auditor General identified a number of areas where improvements were needed to ensure the health and safety risks were fully identified and addressed.

I am pleased to say, Mr. Chairman, that we have made and are making those changes. Work to complete two of the Auditor General's six recommendations is already complete. We have established a licensing and inspection quality review process that includes written guidelines on what needs to be reviewed and how often.

We have also finalized our long-term care program requirements, along with policies and procedures to ensure our inspection and compliance processes are effective.

Work to respond to two other recommendations will be complete within the next few months. By March we will have built a risk-based framework to ensure the more serious deficiencies and facilities are corrected on a timely basis.

We are also working towards better forecasting models, including improved population projections to better plan for future demand for long-term care services. We have also accepted the two remaining recommendations and are working to upgrade our information management systems and to implement performance-based contracts to improve accountability for our service providers.

Mr. Chairman, next year we will introduce a new, five-year continuing care strategy. I expect this will include a superior demand forecast modelling, a long-term care capital asset plan, and better alignment of the roles and responsibilities of the department with the Nova Scotia Health Authority and our independent service providers. Together, this work will form the foundation of a more sustainable, long-term care system for Nova Scotia.

Mr. Chairman, at this time I'd like to turn things over to my colleague, Deputy Minister Lynn Hartwell, for her comments on behalf of the Department of Community Services. Thank you very much.

MR. CHAIRMAN: Thank you, Dr. Vaughan.

Ms. Hartwell.

MS. LYNN HARTWELL: Thank you very much, Mr. Chairman. Good morning, it's my pleasure to be here before the Standing Committee on Public Accounts to talk about Chapter 1 of the June 2016 Report of the Auditor General on homes for special care. As you know, I delight in any opportunity to come and talk about the great work that is being done at the Department of Community Services.

The Department of Community Services has a mandate to offer support and programs to some of our province's most vulnerable population, including people with disabilities. Our Disability Support Program, which we call DSP, offers a range of residential support programs, so people who require support in their everyday activities and require support in where they live.

Our goal is to create a range of residential programs that support people at various stages of their life, of their development, all in a path for as much independence as is available for them. This can include small options homes, group homes, developmental residences, residential care facilities, adult residential centres, regional rehabilitation centres. Overall we have 335 such facilities, and just to give you a sense of the scale, 195 of those are small options homes.

These options were created over many years and have very disparate operating models, so part of our work has been building this into one seamless continuum of supports. In any setting our goal is to provide the best support possible to our clients. We are supported in this by strong service delivery partners who do strive to provide excellent service. To do that we need to have a strong and efficient system and it's often those backbone systems that the clients or their families don't necessarily see or deal with directly - our financial processes, our licensing, our quality assurance, for example. These are the things that provide the strong foundation for our programming.

We welcomed the Auditor General's Report and appreciated that he addressed this important topic because, as you know, we have a significant transformation agenda in our department, particularly in our disability program. We agree fully with the recommendations of the Auditor General and we've implemented some of them already, and progress is being made on the others.

For example, in September we issued a request for proposals to help develop a corporate agreement management process - another acronym, CAM - for our department. As you know, not just in this program, but in any other programs we rely on third party service providers and to date we have not had a strong agreement foundation to provide service-level agreements for clarity for both the operator and for the department. So CAM will deliver stronger processes, policies, tools, and will, in the long term, support transparent and evidence-based resource allocations. It's a piece of work that we're very proud of and excited to be moving forward on.

Many of the services delivered by our department, as you know, are provided by external service providers.

I've mentioned the residential, but I'd be remiss if we didn't talk about the day programs and the vocational supports that are provided by external service providers as well. We have learned that while it's important to pay attention to where people are living, it is just as important to pay attention to what people are doing during the day and how they're able to be included and part of their community.

The CAM process that I've mentioned - we are at the point in the process where we've reviewed the proponents and soon will be awarding the contract, if it hasn't already been awarded. I've seen the final documents and we're poised to move forward to build these systems. This will line up with the Auditor General's recommendation to establish long-term processes for monitoring and evaluating the long-term sustainability of funding for homes for special care. As I've said, that will also have impacts on other areas of the department.

Our transformation is about so much more than the processes, although the processes and systems in place are required. Along with our partners at the Department of Health and Wellness, we are committed to starting with a people-centred, people-directed

process. This is a big shift for our department, to be able to change our systems to line up with the expectations of Nova Scotians.

We are in the process of exploring improved assessment and planning tools to grow our ability to plan, predict, and model future needs and future costs, and most importantly, to be able to develop systems that allow the clients, their families, and their advocates to be at the heart of some of these decisions.

I mentioned the work with the Department of Health and Wellness, and my colleague, Deputy Vaughan, mentioned as well that we work very closely, and as part of our transformation, have formed a working group with the Department of Health and Wellness and the Nova Scotia Health Authority to determine how our systems work together at an individual and at a larger level and to make sure that we have the appropriate, needed systems and supports in place for people with disabilities and to align to the individual needs of the client.

Overall, we are committed to developing and improving our social service system. We want people to be as independent as possible and reach their full potential. I know that's a goal that is shared across government. We want better results for Nova Scotians, and I was pleased to see a recommendation in the Auditor General's Report that some of our transformation work is putting us on this path.

We are working hard to turn a big ship, and so while I'm very pleased that the Auditor General has highlighted our progress thus far, I'm also pleased that there has been a light shone on the work we have underway. I look forward to hearing your questions. Thank you.

MR. CHAIRMAN: Thank you, Ms. Hartwell. We'll move to Mr. Houston and the PC caucus for 20 minutes.

MR. TIM HOUSTON: Thank you for the opening comments. Deputy Hartwell, just before I start, in the Auditor General's Report, the Auditor General in his conclusions on Page 7 said, "In 2014-15, Community Services spent $244 million on 2,263 residents in 332 homes." In your opening comments you referenced 335 homes. I don't know if there's - did the Auditor General miss a couple?

MS. HARTWELL: In the intervening period we opened three new small options.

MR. HOUSTON: Over the last couple of years?

MS. HARTWELL: That's right.

MR. HOUSTON: Okay, thank you for that. Now, in this Chamber we've talked a lot about the budget cuts, 1 per cent budget cuts. I know we've talked about those in the

context of the Department of Health and Wellness quite a bit. I'm curious, did that 1 per cent budget cut extend to Community Services as well?

MS. HARTWELL: Yes, it did.

MR. HOUSTON: The Auditor General found, for Community Services, that there's no evaluation of long-term funding needs. The same finding applied to the Department of Health and Wellness - no evaluation of long-term funding needs. I'm curious as to how the government determined, let's just do a 1 per cent budget cut, without having any real sense of the long-term funding needs.

Deputy Hartwell, can you maybe comment on your understanding of where the 1 per cent number came from? To me, it feels like it was picked out of the air. Would that be a fair assessment?

MS. HARTWELL: The 1 per cent cut, as I understand it, was a government-wide decision that was brought to us and asked if it was something we'd be able to implement. We certainly did our best to meet our target, and we did in Community Services.

The recommendation the Auditor General made about the need for better long-term planning is something that, again, our transformation is premised on that required us to have really good data on who we are serving now and really good data on who we would be serving in the future, and to understand the cost pressures that we have currently - and they're significant - but also our systems and how we can improve them to respond to the changing need.

While it would be wonderful to exist in a world where we would never have to consider cost, we are aware that the costs, particularly in our Disability Support Program, the costs have been increasing and that it was in our long-term interest to develop a funding view that was beyond two, three, or five years and really to - we've talked about a decade of change, and I think that's optimistic. So we'll continue on that path. I wasn't part of any conversation about where the 1 per cent came from, but it was certainly something that we were able to absorb and deal with and make decisions around.

MR. HOUSTON: Thank you for that. Obviously everyone is concerned with the fiscal envelope that the province has, but there are certain realities in caring for people. I don't think caring for people is necessarily a place to scrimp and I've always been focused on this 1 per cent because - and nothing in this report tells me that I should not have been focused on that.

There is a chart in the Auditor General's Report on Page 23. It's the Department of Community Services, Services for Persons with Disabilities Approved Estimate versus Actual Spending. It goes back to 2000. In pretty much every year since 2000 the actual spending has exceeded the budget, so that either tells me that the department is a very

terrible money manager, which I don't think is probably the case, or the budget has never really been enough to care for the people that are needed to be cared for.

So, in the face of that, we have a government that comes along and says cut your budgets even further. I am always curious about what the impact is on care when you do that. Ms. Hartwell, how would you say care has been impacted by the budget cuts?

MS. HARTWELL: I would say that care, particularly in the Disability Support Program, has not been affected - and I'll explain why I believe that to be true. When we started our transformation process, we identified early on that we believe that we could create some efficiencies by changing our operating model, how we actually worked - not the front-line services to clients nor supports to staff, but our operating model.

Several years ago we made some decisions around how we set up, so we reduced our management level in our regional offices, for example. That hasn't been without its bumps, but overall I would say that has been a significant improvement and that's one of the ways that we moved to achieve our 1 per cent.

MR. HOUSTON: But the 1 per cent - there are 335 homes as we sit here today, so that statement implies that none of that 1 per cent impacted those people on the front line because you were able to do it at some higher level - is that the case?

MS. HARTWELL: We did not pass on any of the 1 per cut to any service providers; it was absorbed within the department. At the same time, I would actually - if you look back at the budget documents, which we can certainly pull out - at the same time government made additional investments in our Disability Support Program and additional investments in our transformation project that actually, for us, netted out the 1 per cent because we had additional funds to invest in the long-term planning and the strategic planning that we've been wanting to do for the program.

MR. HOUSTON: So you didn't have a 1 per cent budget cut at the end of the day?

MS. HARTWELL: At the end of the day, government made other investments and we were near even. Dale MacLennan, who is our CFO, can let me know if it was close enough, but my recollection is that we were evened out because government made additional investments and, I would say, has subsequently made even more investments, particularly in our program area.

MR. HOUSTON: Maybe we can table that, the 1 per cent and then how it was kind of bumped up.

Dr. Vaughan, in the Department of Health and Wellness did you have a 1 per cent cut or did it kind of net out to zero for your department as well?

DR. VAUGHAN: I'd like a clarification of that question - are you asking if the entire departmental budget had a 1 per cent cut?

MR. HOUSTON: No, in the homes.

DR. VAUGHAN: In the continuing care?

MR. HOUSTON: Yes.

DR. VAUGHAN: Well as we've spoken about earlier, we had a 1 per cent reduction in the long-term care.

MR. HOUSTON: We have chatted about that before and I know there's a number of groups that believe the 1 per cent cut has impacted care. Nurses have said that - I have tons of quotes here to read from. The president of the Continuing Care Association of Nova Scotia wrote to the Premier expressing concerns about food in this particular case, I think.

Is it the department's position that the 1 per cent cut to the homes did not impact care in any way?

DR. VAUGHAN: Thank you for the question. As we've talked about before, the intention and the direction to the homes was to not impact patient care but to look for efficiencies within administration, as we've talked about - HR, insurance, group purchasing. There are many good examples that we've heard back about. We've spoken to over 80 per cent of those facilities and we've heard many examples where they've sought to mitigate that 1 per cent.

We appreciate that not all facilities - especially smaller facilities - have been able to meet that challenge of the 1 per cent reduction easily, but they have been able to do that. We're listening to what the sector is saying and we're working with them as best we can.

MR. HOUSTON: Thank you. In your opening comments you referred to the Act and the regulations around the homes. Does the Act or any of the regulations stipulate - let's call them legislated care requirements? You mentioned that the number of inspections is legislated. Is there anything in any of the Act or the associated regulations that stipulate the care that people get?

DR. VAUGHAN: There are standards within the Act, but not actual what we would call clinical guidelines. That's not detailed within the Act, but there are certainly care standards that are requirements to be in that.

MR. HOUSTON: In Ontario, I think before the Legislature, there's a Private Member's Bill called the Time to Care Act. I don't know if you've seen this or not but it would legislate four hours of care per day per resident. So that bill would be speaking to staffing levels, essentially, I guess - right? They're trying to bring their hours of care per

day per resident up to four hours. I don't know if that bill will pass, but they're trying to bring it from something up to four.

It made me wonder, what is the corresponding number in this province? How many hours of care per day per resident - is that a statistic we have? They are trying to bring theirs up to four, what would ours be at?

DR. VAUGHAN: I'll ask my colleague Carolyn Maxwell to address the specifics of that.

MS. CAROLYN MAXWELL: Thank you for that question. We have three different approaches to staffing but all of them are based on a 2.45 CCA level of care per day per resident, plus one hour of professional services or professional nursing care. We do have some homes that are a little higher, some of them that may have clients who have a higher level of dementia, but the minimum is 2.45 plus one hour of professional nursing services.

MR. HOUSTON: So 2.45 hours of CCA and an hour of nursing.

MS. MAXWELL: Right. Also appreciating that based on the level of care, someone may need less, someone may need more of that.

MR. HOUSTON: Okay, sure. So that's 3.45 hours a day. Now, can the homes do that? I do hear about layoffs in the homes because of the budget cuts and stuff like that. Are they able to do that?

MS. MAXWELL: I have met with the long-term care facilities actually this month, collectively. We've talked about the results of the phone calls that my team actually made to each of the facilities, the 102 that were impacted. What we've talked about is that they feel they are meeting the long-term care program requirements. For example, under the program requirements it would have the responsibility to assure that every individual resident has care plans that are specific to their care needs. We have provisions around oral care, risk mitigation, business continuity - all those things.

MR. HOUSTON: So the homes are in a tough spot. When the department calls and says you're supposed to be meeting 3.45 hours a day, are you meeting it, that is a pretty tough question to ask a home. But have you ever asked . . .

MS. MAXWELL: I would say that that was not the question. We're asking them how they're doing.

MR. HOUSTON: That's the homes, though, and the administration of the homes. What would the CCAs say about it? Have you talked to their association? We hear stories about how overworked they are and not being able to get to all the patients and stuff like

that. I wonder what the actual people providing the care would say about their ability to do so.

MS. MAXWELL: We have a variety of different mechanisms for staff to talk about care - not necessarily directly to myself, but it would be with their unions. That's a normal ebb and flow between the employee and employer. Also, we meet with the unions as well. The department does, with NSHA, and a variety of different working groups. We would hear directly from them if they felt there were any challenges.

MR. HOUSTON: Are you hearing from them?

MS. MAXWELL: What we're hearing is that the work around the WCB about staff, perhaps the injury rates - we're working with NSHA, the IWK, ourselves, LAE, and DCS to look at reasons and root cause perhaps for some staff injuries. For example, when we talk about root cause, there are educational requirements and different mechanisms. For example, the driver with WCB rates with the staff would be related to soft-tissue injuries and transferring . . .

MR. HOUSTON: So you're mostly hearing from them on workers' compensation?

MS. MAXWELL: Right. Those are some of the discussions that we've had.

MR. HOUSTON: The Nova Scotia Nurses' Union described the state of long-term care in the province as in a state of crisis; they describe their working conditions as deplorable - any response to that from the department?

MS. MAXWELL: What I would say is that we are meeting with NSNU, the IWK, the employers, and the unions, to talk about the Broken Homes report. We have dovetailed their concerns around violence in the workplace under the WCB plan. We continue to be at the table with respect to their other recommendations, which would be around the sharing of data, the collection of data, improved communications, nurse practitioners, and long-term care, for example.

MR. HOUSTON: Is it your belief - I guess, Dr. Vaughan or somebody - that the one hour a day of nursing care that's meant to be provided is not an issue for the nurses? They would feel that they're able to do that with the current staffing levels and the current budget? They're worried about other issues, but not that - am I hearing that correctly?

DR. VAUGHAN: It's important for everyone to understand that each care plan is customized to the individual needs of that individual patient or client. Those guidelines that my colleague was talking about are the minimum guidelines. But individual care plans are very much based on the individual's requirements.

MR. HOUSTON: Right, so some would be much more than an hour.

DR. VAUGHAN: Exactly.

MR. HOUSTON: Maybe we'll come back to that. I do want to talk about the inspection process.

We have two departments with two strategies basically trying to fill one need for Nova Scotians with varying degrees of care, but that's basically what we have here. The Auditor General found that the Department of Community Services was doing a pretty good job on inspections and kind of made the Department of Health and Wellness look a little Mickey Mouse on their inspection process, manual papers and stuff like that. It struck me, and I did hear in both sets of opening comments that there are some changes being made there and there's some discussion back and forth between the departments on different aspects of care delivery.

Isn't there some synergy? Could you have one inspection team? Do we need two separate sets of inspection teams, one operating historically pretty well and one needing a bit of work? What are your thoughts on that, Dr. Vaughan?

DR. VAUGHAN: I think it's important to understand, as I tried to outline in my opening remarks, that we have kind of different roles there. While we work together, especially on some of the complex cases where there is significant overlap, our role is primarily in terms of the health needs, and those needing the health needs require our facilities. DCS has spoken about their role.

So there are kind of distinct activities there that require different, if I could say, "competencies" in the inspection process that may not necessarily overlap, although we certainly agree with the Auditor General in terms of streamlining. We have streamlined the licensing process; we totally agree around the automation component of things and we are working towards that very quickly. I think there's a lot that can be done within that sphere.

If you are talking about one inspector for both functions, we would probably be looking at that in our continuing care strategy going forward, so it's not something that we would dismiss lightly at all. But to the Auditor General's point, we are making significant change.

MR. HOUSTON: I take your point on that. In terms of the length of the stay for people living in the various types of homes, does the Department of Health and Wellness have a - what's the average length of stay in a home - is that a statistic you would have? And I guess Community Services as well, even recognizing that there is different - how long do people live in one of the homes?

DR. VAUGHAN: The average length of stay - again, these are averages - three years for our facilities, the national average is two years. We've spoken before, if we were to reduce our length of stay to the national average we would eliminate the wait-lists.

MR. HOUSTON: Okay, and Community Services - average length of stay?

MR. CHAIRMAN: Ms. Hartwell.

MS. HARTWELL: The population that we support, it's for the length of their life so we have some clients who have been in the same place for 50, 60 years and we have others who come into a licensed facility for a short period of time, receive some additional support, and then return to their family or return to live-in communities. So it really does vary significantly across our spectrum.

MR. HOUSTON: And it's not really a relevant statistic is it, in that context? What about the wait-lists, what type of wait-lists does the department have for people waiting to get into a home?

MS. HARTWELL: We currently have a wait-list of just over 1,200. Of those 1,200, about 400 of those people are currently not in our program, they are waiting for a place in our program, and then the remaining roughly 800 people are in our program but the supports they are receiving may not be the supports they are looking for at this point in time.

We constantly have some movement as places become available. For example, since this year we've been able to move 187 people through. The way our system works is usually you move one person from one facility into another, that creates an opening and then there's a bit of a . . .

MR. CHAIRMAN: Order. The time has expired, I'm sorry.

We'll move to the NDP caucus and David Wilson.

HON. DAVID WILSON: I'll continue on with Deputy Hartwell around the wait-lists for homes in Nova Scotia.

She said there's roughly 1,200 but I know there are different needs for people on that wait-list. I believe you indicated there are three new homes that opened since the audit was done - 335 - how many homes have opened over the last five years, let's say - do you know those numbers? If you don't have that, you could provide it later.

Is there a plan to address the wait-lists on future homes and potentially expanding what's available for Nova Scotians in the communities?

MS. HARTWELL: First I'll correct the number that I gave, my staff just passed me - the number is even better than I thought, it's 230 placements since the beginning of the year, so it has been updated. That's great.

The wait-list is a changing thing. My expectation, though, is that the wait-list is a little bit of an artificial barometer of what is needed in effect because there are people who are looking for a different setting and when that choice comes up they may choose not to take it. They want to have the option, which you completely understand. Then there are other people who are supporting a family member at home and don't put the name on the wait-list because they kind of want to make it work, or others proactively put the name on the wait-list just in case something happens four or five years out.

It's important when we track it on a monthly basis. What we're really doing is we're asking our care coordinators around the province to refresh their assessments of all clients, including those on the wait-list, so that we constantly have a current sense of where people are and what their current needs are and what possible plans we could have for them.

In the last year, we have looked at the placements in our highest level of care, in our adult residential centres and our regional rehabilitation centres. Of the roughly 600 or so people who are in that, we've done a significant reassessment on well over half of them. So for the first time in a long time, we're poised to be able to look at a system and say, okay, here is where the need is and here is where we can actually start to move people, if they choose, with considerable support.

I don't say "move" lightly, because this is where people live. This is their home. I've visited facilities around the province, and when you go in - this is where people live. It's their room. They've decorated it. So we're not just trying to - our approach cannot be, let's move people to where it's the best fit for them and the best cost, or make the system most efficient. That's absolutely important, but what's most important is that we are talking to the client, seeing what they need, where they want to be, and what supports they need to be independent.

It is a time-consuming process to have that individualized level of planning, but to that extent it constantly keeps our wait-list a little bit more realistic for us if we know who is out there and where they are in their life and maybe we can try to prevent some of the crises that people can get into.

MR. DAVID WILSON: Are you looking at potentially expanding the number of facilities that you have - the number of homes - if that's warranted?

MS. HARTWELL: Absolutely. What we have said in our disability road map - which people will be familiar with - is that the province is going to move away from facility-based care over the long term. We can only move at the pace that we can do so safely and respectfully with the people who are involved.

In some cases, that will only be able to happen when we have robust community-based support. Right now, where people live is where they get all of their supports. If we say, you're not going to live in a congregate setting, or we're going to make an option for you to live independently in an apartment, you still need those supports. So we need to

have the community-based supports set up so that they can get to them, and that may involve creation of more small options down the road.

I would say that the assessment has been really enlightening. The recent reassessments have been enlightening because we have identified people who are currently living in 24-hour, seven-day-a-week facilities with some support and with a whole lot of courage on their behalf.

We have started moving people into apartments. We've started moving people into living with roommates. I obviously can't give the details, but I can tell you about the person I think of - there is a woman in her 80s who has lived 50 years of her life in the same facility, and she's moving into a seniors' complex. She is going to live independently. She has a friend and the friend is going to be visiting her, but I can tell you, that kind of change - it sounds simplistic and a little hokey, but getting to that level of change for the individuals in our program is really profound.

It may be that we need more independent apartments where people have support. We certainly hear from a lot of families. They want additional supports for them to be able to keep their family member with them. We've recently introduced a new program called Flex Independent, which is - we have a Flex program where family members have a family member living with them and they receive some support to have that person live at home, largely in the form of respite.

Flex Independent is a step over from that, where we support a family to have a loved one living in an independent apartment or with a roommate or over a garage, and the support is provided to that individual, but the family is still providing a role. We piloted it and within eight days every spot we had for the pilot was taken, so we know that we're on the right path. We're going in the right direction.

MR. DAVID WILSON: I appreciate that and I think we all have some personal experiences knowing people who have benefited from moving out and trying to live on their own, especially with the people that you serve. Many of them live at home with aging parents.

You mentioned one thing about the wait-list. If clients or residents are called and they're not ready to take a spot, do you remove them from the wait-list?

MS. HARTWELL: No.

MR. DAVID WILSON: So it's not the same policy that the Department of Health and Wellness has for long-term care. There was a recent change with the Department of Health and Wellness, that if you get called for long-term care placement, if you're on that wait-list and you refuse it you are just taken off that. It's interesting that the policies aren't the same, and I think the government needs to revisit that, and I think the Department of

Health and Wellness needs to revisit it because it is a huge impact when you make a decision to either go into a care facility or a home or a long-term care facility.

The 1 per cent cut that my colleague asked you about, you had indicated that the homes were not cut 1 per cent - you mitigated that within the department, correct?

MS. HARTWELL: Yes. If I may though, to clarify. I'm not sure we're talking about the same 1 per cent. Our 1 per cent cut was received in 2014-2015. So, we have not received a 1per cent cut since then.

MR. DAVID WILSON: Okay. So, it wasn't the two-year 1 per cent?

MS. HARTWELL: No.

MR. DAVID WILSON: Okay. That's good. Thank you.

I'll go to Department of Health and Wellness and Dr. Vaughan. The 1 per cent I know, and I've asked this many times, I feel like an investigator. I don't know how many times I've asked the question about what the cuts were and what the total amounts were - and I'm getting close to getting all the information, but we're just not there yet. I know I've asked you, and I've asked the minister.

During the House, the minister tabled continuing care budget mitigation by fiscal and type, and it definitely is different, a different calculation, a different table than what was provided to our caucus when we asked for it. But even going through this chart that was given to us, it indicates the 1 per cent for 2016-17, but the 2015-16 mitigations just talked about small equipment. So, I just want to see if I'm correct.

The table that I have now, I would assume you would have to add the 1per cent for 2015-16 - and, hopefully, you've seen what the minister tabled in the House, but it doesn't to me reflect the true cuts. So, is that correct? So, what was provided to me was more information, but not all the information I believe - I don't see the 1per cent cut for the 2015-16 year.

DR. VAUGHAN: So, Mr. Chairman, through you, if the question is, and I'm struggling to understand what you're actually asking here, if your question is was there a 1 per cent cut in 2015-16 . . .

MR. DAVID WILSON: Well, I mean really the question is, the simple question is, how much were long-term care facilities cut over the last two years? Every time I ask the question I get a different answer - I'm given 1 per cent for the total budget, and then this doesn't represent a 1 per cent in 2015-16, it just represents small equipment that was cut. So, all I'm asking for is, do we have a clear picture of, over the last two years, the list of the 136 long-term care facilities in the province - what were their budgets cut by over the last two years?

DR. VAUGHAN: So, through you, again, Mr. Chairman, there was a reduction of $8.2 million over the two fiscal years, but there were also investments in certain areas in terms of human resources and other areas. We need to remember that there are 134 facilities across the province, only 103 were impacted by the 1 per cent. And we'll come back to this I'm sure, the different question around the go-forward and some of the questions around the need to modernize because we're dealing with living history here and how homes are funded, which is complex to say the least.

MR. DAVID WILSON: Well, I mean, that's the confusion. Every time I ask the minister, he says there are different streams. So all I was asking for is an up-to-date chart of the total cuts made to the long-term care facilities over the last two years. So, what I'll do is I'll provide you, after the meeting, what was most recently provided to me, and I just want to know if it's accurate, what the funding cuts were.

DR. VAUGHAN: The information through you, Mr. Chairman, the information we provided last time is accurate.

MR. DAVID WILSON: Okay. Thank you for that, until I find some more information. Anyway, it's frustrating. We looked at the Auditor General's Report, and I know that there were a number of recommendations that came out of that that you know there were some deficiencies, and how do facilities address the deficiencies.

So, my first question, do you feel that those deficiencies - and I believe you indicated in your opening statement that there's a plan to try to mitigate those deficiencies and hopefully we'll see those corrected quicker into the future - do you feel at all that the budget cuts that the facilities have received over the last couple of years have aided in those facilities not being able to address the deficiencies over the last couple of years?

DR. VAUGHAN: We've seen a significant number of facilities that have worked together to achieve efficiencies that had not ever been achieved before. We've had many people tell us that group purchasing has been helpful and they've seen real dollar savings. That is particularly true for some of the larger facilities.

As I said before, we've had facilities that are looking at their human resource components and efficiencies around that, and insurance - we've talked about some of the other areas. So there are real efficiencies that some homes have been able to achieve, but the basis of all this is that they are not all treated the same historically. That's the basis of our need to modernize. We're dealing with very different parameters for some organizations versus others, and that's a challenge for them. We appreciate that, we are listening to them, and we're very much interested in what we can do working together with our partner, the Health Authority, to improve those services.

MR. DAVID WILSON: We've seen from the Department of Community Services that when the government came to them and said we need a 1 per cent cut, they made a decision at the point not to pass that cut on to homes for special care in the province.

The Department of Health and Wellness didn't take a similar approach - why would you not look at where we could find savings? We've heard the government time and time again talk about the savings in the amalgamation of the district health authorities - why couldn't you find that 1 per cent saving in there and not pass on the cuts to long-term care facilities across the province?

DR. VAUGHAN: Thank you for the question; that's a great question. We have been holding firm on the health costs for the past two years, going to three years now, no increases in health care costs, which is unique in the past 15 years, yet we still have increases in demand, we still have increases in drug costs in the area of 6 per cent, increasing annually. We have been able to hold the line by containing costs within our own efficiencies within both the Health Authority and within the department - significant savings in both those areas.

When we were asked to look at a specific 1 per cent reduction for long-term care, it was focused on what they might be able to do to see how they could work together in a varied environment to achieve savings in those areas.

MR. DAVID WILSON: So when you said you were asked to look at long-term care, that was a separate initiative compared to 1 per cent reduction of the budget itself that government came forward with for a number of the departments?

DR. VAUGHAN: As you know from past experience, that through government there is a program review. Often external parties come in to look at where areas of savings might be achieved, and through that process we were requested to make those changes.

MR. DAVID WILSON: It's my understanding that there are nine investigation and compliance officers responsible for completing the inspections for long-term care, and we know there are 130-some - I think I said 136, there might be a little less - 134 homes for a capacity of about 7,700 residents. In Community Services there are eight licensed officers responsible for inspections for 335 homes with 2,200 residents. To me there's an imbalance here. Do you think that the Department of Health and Wellness is understaffed to meet the requirements of the inspections?

I know you mentioned in your opening comments - and I know there has been some criticism about the difference between the reporting and stuff from Community Services and inspections and the ability to address it and the Department of Health and Wellness. To me those numbers reflect that potentially you are understaffed with compliance officers and, if that's the case, has there been a request to government, to Finance and Treasury Board, to rectify that so you could ensure that those inspections are done, and deficiencies are addressed as quickly as possible?

DR. VAUGHAN: Sometimes in the past the answer to every question was to add people to the problem, and that is not the solution that we have found in either the

consolidation of the Health Authority or the redesign and the restructuring of the Department of Health and Wellness.

We believe that there are opportunities to have increased efficiencies using technology, using smarter approaches to the inspection process. That, I think, is where the focus needs to be - on the efficiency of the inspection process, and not merely just simply adding more bodies to the equation.

MR. DAVID WILSON: I understand that philosophy when you're dealing with a lot of other things within government, but we're talking about the most vulnerable people in our province, ensuring that the care they receive is appropriate, ensuring that the facilities that take care of them are doing it in a way that is proper and follows the rules, and we know across the country we've seen in more recent months and years the challenges that staff face with violence - not only from residents to staff, but residents to residents.

So I don't think that statement of just adding more people is the answer. I would think the answer is to ensure that inspections are done properly. So it's your opinion that you don't need any more inspectors or compliance officers - the number is good - even though we see quite a difference in the number of facilities that are inspected by compliance officers from the Department of Community Services?

So I just want to be clear that your answer was that you feel, no, we don't need any more compliance officers or inspectors to inspect our long-term care facilities?

DR. VAUGHAN: I think it's important for all of us to understand that it's not just about adding bodies to the equation. We can train people, we can use technology, and we can make it easier and smarter for them to do their job using the better technologies today.

We inspect every facility annually and our nursing home facilities are inspected twice a year. We have had no concerns raised around the need for more people to do that work; in fact, we are working more efficiently and working better and still doing those jobs that are required to meet the Act.

What we need to look at going forward - and we are - is helping our employees be better trained, but also giving them the tools to be able to do their jobs. I think that's the focus, not more people.

MR. DAVID WILSON: The Auditor General, I think, would disagree. He indicated, in his report, the overall conclusion that the Department of Health and Wellness, "does not have an efficient, consistent, and timely inspection process." That concerns me when the Auditor General who takes a look at the issues within Health and Wellness has an opinion like that. That's a strong statement.

I believe I'm out of time, aren't I?

MR. CHAIRMAN: You are - you have better eyes than I do. (Laughter) We'll move to the Liberal caucus and Mr. Farrell.

MR. TERRY FARRELL: I guess I want to preface this with some complimentary remarks about the Auditor General and the work that they do because I think it's extremely important. I'm continually impressed by the practical nature that they bring to their recommendations and the insight that they're able to gain into each of the departments, and the issues and the problems that are facing the departments. I think for that reason we have a high level of compliance within departments in terms of the Auditor General's recommendations.

But I think that one of the tasks that the Auditor General has is to look at current operations in departments, and I'm not sure that it always takes into account the direction that a department might be going, or the trajectory that they might be on, and why they're in the current situation that they're in and what they've been doing independently or irrespective of the report in terms of developing, growing, and improving the processes within the department.

I'm thinking, particularly, with respect to the Department of Health and Wellness and the homes for special care under the jurisdiction there that we have. A little bit of historical context might be helpful to understand how we got where we are and why some of the things that the Auditor General brought to light are in existence - why those circumstances exist. If I could turn it over to Dr. Vaughan to maybe explain to us a little bit about that and how we got where we are.

DR. VAUGHAN: I won't take the probably three hours it would take to outline the complete history of the long-term care process in Nova Scotia. Let me say that we live in an ad hoc environment of various agreements between homes over long periods of time, everything from very small to large. We have contracts that are built in what would be called a traditional environment going back over decades, and those tend to be some of the larger facilities; there are very new and modern facilities which have very different contractual arrangements.

We have some complex situations that are very much ad hoc. The complexity of the environment is one of the challenges, but also one of the opportunities of the continuing care modernization strategy which we're working on to try and address and streamline any of these challenges. It's very much an ad hoc environment that has not kept up with the modern world in many cases - some obviously have; others haven't. The information that is required sometimes is paper-based, and that's often a challenge.

We appreciate the Auditor General's Reports very much. Some might think we don't, but we actually do. We're interested in constantly improving what we're doing. We are making progress - maybe not as fast as I would like, but we're certainly making progress in those areas. The Auditor General said we need to streamline some of our licensing processes and we've done that, across all that complex environment that we've

just talked about. We agree completely around the automation of that process, and we are doing that.

We very much value the Auditor General's focus on these areas. They are things that we want to do. It helps highlight for us the need to do it sooner. We won't get to all of the elements of complexity until we start to modernize the long-term care process itself. I'll leave it there.

MR. FARRELL: In that same vein, I guess the last time that you folks were here from Health and Wellness, we got on the issue of whether there are ways you can look at the savings that have been gained over the last few months through the processes that you've been going through. Can you apply those line by line to the budget of each facility? Can you say that one facility should spend a certain amount on food or one facility should spend a certain percentage of their budget on any other item?

Ms. Langille, I believe, was in the process of discussing that at that time, and we ran out of time.

So I was hoping that in terms of the complexities of these different contracts that you have with each, whether they're individual contracts with individual homes or certain types of contracts with several different types of facilities, could you maybe expand on that and explain for us the complexities of why we can't apply a certain percentage of spending to any one item and how each of those contracts sizes up?

DR. VAUGHAN: I'll start, and then I will hand it over to my colleague Paula Langille to drill down into that. These 134 facilities, 103 of which were impacted by the 1 per cent reduction, are all independent - independently run, independently managed. Many have their own boards. They have their own structures. We do not run those facilities. In the past, they may have had line-by-line items in the budget that we controlled, but we don't do that anymore. We give them a global budget, and the 1 per cent reduction was applied to that. They then manage within the criteria in order to meet the licensing standards, and they have certain commitments that they have to achieve within those standards.

Those are the broad strokes. I'll ask Ms. Langille to drill down.

MS. PAULA LANGILLE: To further clarify on our last appearance, as Ms. Maxwell articulated earlier, there are many different models that we have in long-term care. We have some that are traditional models, our legacy ones that have been around since we took them over in the 1990s. These ones, as the deputy mentioned, are global budgets. Unfortunately, there is no standardization. There is much variation of how the funding is allocated to those facilities.

As the deputy mentioned in his opening remarks, we would like to work towards moving to a standardized and efficient funding model. We're not there yet. When we

moved to the new bills that we did for replacement facilities and new census bills, we were trying to determine a standardized staffing model for those facilities. We also indicated the health care envelopes where we wanted to make sure that the funding stays in place so that the care for those clients is not compromised. If they don't spend the funding there, then it comes back to the department.

There's a lot of variety, but as the deputy mentioned at our last appearance, there is no magic bullet or magic number across the country that says this is what you need, this is how much money you need to feed the residents, and this is how much money you need to staff the residence. There isn't a magic number. We're all working towards trying to determine what that is.

Also, as Ms. Maxwell says, we have care plans that are specialized for each of the clients. We need to work with our partners, and NSHA as well, with a collaborative approach as to what that funding model should look like. We are taking steps towards that, and the Continuing Care Strategy will hopefully address that, but we're in the working process right now, moving to that shift.

MR. FARRELL: I want to go back to Dr. Vaughan about how that process is working - is there more you can tell us about the steps being taken to move towards a more standardized form of contract, if you will, or funding, and to bring all the different homes and the different models into line so there is a more uniform treatment of them and a more uniform form of funding?

DR. VAUGHAN: We are working with our partners, as has been said, and in conversation with the facilities and the sector to achieve performance-based agreements. This is a critical element in everything we are doing across the health sector, so it's no different in the long-term care sector. This is to achieve accountability for resources that are spent. We spend over $800 million in this province in long-term care and home care combined, so we need to have clarity and transparency in that transaction. But also, what are we looking to achieve in those areas? We are working with our partners, as I said, to look at performance-based agreements, which will add clarity for everyone in this regard.

MR. FARRELL: With respect to, I guess I'll call it the reporting issues that were pointed out by the Auditor General, and the efficiencies that exist in Community Services as a result of using the AMANDA system, can you tell us where you are in moving towards a better system there and a more uniform type of information control and reporting?

DR. VAUGHAN: We are very excited about moving to the AMANDA system. We are in the process, through our Internal Services Department in government, to implement that system. We're looking to have that up and running within early 2017. The first quarter is our goal, March 2017. We're working with Internal Services to take that up.

MR. FARRELL: Is there anything in this chapter of the Auditor General's Report that you take exception with or that you are not moving towards effecting in the department?

DR. VAUGHAN: As I said in my opening remarks, we've already achieved some, and we're working to achieve all of them. We don't disagree with any of the recommendations: in fact, we agree with them all, to put a better spin on that. It is actually what we want to do, so we're very pleased with the report. The drive to take up AMANDA, we very much appreciate that recommendation. It helps us to focus our initiatives across government and to actually achieve that.

MR. FARRELL: If I could move to Deputy Hartwell, please, and get back to my initial preamble. I'm sure you were listening intently.

In the context of the Department of Community Services, and particularly the context of support and services for persons with disabilities, it seems like there are probably a number of historical factors that are really at play in there. There's a rapid evolution that's happening there and it would affect things within the department, including spending and including the way that services are provided - could you give us some context to that please, deputy?

MR. CHAIRMAN: Ms. Hartwell.

MS. HARTWELL: I like very much the phrase that Deputy Vaughan used, that "it's an ad hoc environment and we have ad hoc relationships." That is entirely the context for this sector as well. Over time, the organizations that provide the support, they may have been run by municipalities, they are almost, almost all entirely run by non-profit boards, we have very different operating procedures and processes in each of them, and so part of our conversation about transforming this system was about how we can, where it makes sense, move to standardize processes and support, and that we can understand some of the special populations that they may be supporting so we're not losing the individuality as well.

So I did, in the opening remarks, mention our corporate agreement management system which will be able to not only provide us with really strong data about what's happening in their facilities, but also will allow us to do that long-range planning that we need to do.

The other piece that was picked up by the Auditor General was really about the need for understanding the population we have and anticipating the population that is to come. So we have a lot of anecdotal information from service providers on who they're serving now and what their pressure points are and where they are seeing gaps. So part of our work is really pulling that together into one cogent piece.

I will take the opportunity to say that we are working quite closely with the Department of Health and Wellness and really benefiting from their expertise in the delivery of medical interventions, and bringing our expertise in supporting people who maybe have complex behavioural issues to have - while we will be having two systems for Nova Scotia - to have a system that is aligned across and so that people can understand where they can go for support, but also how we work together and take advantage of one another's strengths. So, it does feel to me that our collaborative, we really have an all-time high in terms of our collaboration, which is great.

MR. FARRELL: I guess when we talk about how that gives rise to a need for funding and the way that services for persons with disabilities are funded, one of my colleagues in a previous question referred to the chart on Page 23 and that there is somewhat of a trend there for the spending in that area of the department to exceed estimates, and I think the context of that question was that that chart is some kind of a report card and that it doesn't indicate a very high grade on the part of the department. But I'm sure that there must be factors that go into the provision of support for persons with disabilities. I mean, the other thing that we see from the chart is that the spending in that area is rising consistently on a yearly basis, and I think that there must be reasons for that.

I'd ask you to make comments on both of those issues - not just the yearly increase in spending, but also the fact that the spending often exceeds the estimates.

MS. HARTWELL: Yes, that chart on Page 23 is our chart, and it's one that we use to describe the spending trend that exists that really is indicative of the growing complexity of needs of the people that we're serving. I would say one of the largest drivers of cost is that we are supporting folks who have quite complex needs and we're supporting them over their lifespan - so not for three years or five years, it can be for decades, their entire lives.

I would say an increase in the incident of autism has had an impact, and I would say we are slowly, with the support of colleagues, slowly making gains there to understand the complexity of the needs that people may have.

The other thing, I would again compare it to the experience in the Department of Health and Wellness, is that absent having a strong, robust, community-based support system when we have had people in crisis or when we have had, you know, a situation that needed to be dealt with, we create quite cost-prohibitive one-off situations. We have a number of those around the province, and the cost is concerning. It's not a sustainable model to have $300,000, $400,000, $500,000 individual placements for one person. That's not a model we can sustain.

But more important than that, I don't think it's the greatest outcome for the clients, who essentially are in a one-off situation, absent the supports they might get in a facility because we don't have a model that is designed to provide them with supports yet. That's

exactly what the transformation is all about and exactly what the Auditor General picked up on in terms of our long-term planning.

There is an opportunity to manage this curve. It can't be by simply creating one-offs and having three-on-one staffing all the time when there's a crisis. That's actually not helpful for the client and it can't sustain it, but how do we provide those supports in a different way? So far we've had really robust and, I would say, rigorous conversations with families and clients, service providers, who are largely aligned to where we want to go. It is how we get there and how we do so in a way that, as I said earlier, we can do safely and respectfully.

There is an opportunity to work with people most affected, to design how we do that. We have some great examples: There's a strong outreach team from the Kings Regional Rehabilitation Centre, which is our largest residential facility, but they've also identified that there's a strong outreach need. If that model can be improved on and built on, we know that we're going to have to have stronger transitions from school into adulthood. So last year we provided additional funding to adult service centres to help design how we can work with youth who are moving into adulthood and have significant disabilities.

It really is designing a system other than the one we have and keeping the one we have afloat and keeping it going. That to me is the complexity, the historical complexity that can be frustrating; you can see where we want to go, but we need to get there in a way that is not tearing down everything we have, not once.

MR. FARRELL: I have a tendency to look at issues like this from a legal perspective and how the law has brought us to where we are. I think that a lot of what we're dealing with now comes from the - it goes back to the Charter of Rights and Freedoms, where people were granted very particular individual liberties and clear rights of self-determination. The responsibility to ensure those things happen has come back on government, and we're evolving how we deal with that and how that goes ahead.

MR. CHAIRMAN: Order. I think you are finishing on a good point there, and time has just expired, so we'll move back to the PC caucus and Mr. Houston.

MR. HOUSTON: Earlier I talked about the chart on Page 23 of the AG's Report. I talked about that chart in the context of how we see that historically, in the Department of Community Services in this case, actual spend is exceeding their budget. That's a fact. Then I asked it in the context of now we have a 1 per cent cut in the face of no evaluation of long-term funding. You have a history of spending more than anticipated and you have no expectation of what future needs are, no evaluation of it, yet somebody comes along and says, but I think you should do a 1 per cent cut. That's the environment that these homes are operating in, and that's got to be a tough environment.

We're trying to get to the bottom of where the 1 per cent comes from. I do have this chart here that was tabled by my colleague today, and I actually think we're getting somewhere as to where it came from. I do want to speak to this tabled document a little bit and just kind of get an understanding from Dr. Vaughan as to how this came about. The tabled document lists - I think I counted quickly - 103 homes, which was consistent with Dr. Vaughan's comments that 103 out of 134 received cuts. First off, why 103 and not 134? Maybe we can clear that up first.

DR. VAUGHAN: We've been trying to articulate the complexity of this environment historically, and I appreciate the challenges of why the 103. They are very much contractual agreements. Some have contractual agreements, that built in profit sector within this number - the other homes, shall we say. So it very much depends on the contractual arrangements and . . .

MR. HOUSTON: Does that say you couldn't - the ones that aren't on this list, they couldn't? The contract said you can't cut our budget. Okay, so these are the ones where the department felt there was some room, contractually, to cut the budget. Obviously we can see there are some cuts to the small equipment budget. This is a print-off of an Excel spreadsheet, so I'm assuming this is a bunch of formulas that just say take this number and times it by some percentage and then you kind of worked from that. Small equipment budget cuts, was that an across-the-board percentage?

DR. VAUGHAN: We looked at the expenditures historically in this area over the past couple of years and we were not seeing the expenditures within that area. Up to 50 per cent was being retained, so that's where the cut came from.

MR. HOUSTON: So that was a spend-it-or-lose-it type of cut. What about the profit line - what does that mean? The column is titled "profit line," but I'm not sure what that means - is that the profit that the home had?

DR. VAUGHAN: Historically, as I said, there are some homes that had a profit line built into it.

MR. HOUSTON: So that's gone now.

DR. VAUGHAN: That was a portion of it, not the entire thing.

MR. HOUSTON: I guess what I would ask, and I don't know if it would be possible, this is a print-off of an Excel spreadsheet, would it be possible to get the Excel spreadsheet in a usable format so we could actually understand what's happening - is that something that could be provided to the committee?

DR. VAUGHAN: We can give you the Excel spreadsheet.

MR. HOUSTON: Thank you. Maybe the clerk will take note of that.

In the initial discussions we had today about the cuts - I don't want to mischaracterize what you said, Dr. Vaughan, but I think you said that there were some homes that had difficulty meeting the cuts. I do want to focus on that because if a home could easily make it, maybe they did find administration savings and stuff, but the ones that are having difficulty meeting the cuts that are laid out and presented to them in this, I'm worried about those because they're trying to care for vulnerable Nova Scotians, and if they're having trouble making the numbers work - they've got to make them work, right? I think you said some homes were, but I wonder if you can quantify that. There are 103 homes on here - would you say that 20 of them said to you we just can't do it?

DR. VAUGHAN: To be clear, again, the idea here is to encourage the facilities to work together to try and achieve efficiencies; that's the modus operandi behind this.

MR. HOUSTON: "Incentivize" I think was the term from last time.

DR. VAUGHAN: Some people like to see challenges as opportunities. I think Benjamin Franklin said "necessity is the mother of invention." If you need to make change, that's when you make change. That's what we were looking for, and we have seen a lot of that. I think there are three homes that we've been working with to try and look at what we can do with them. But that's the answer to your question - three out of 103.

MR. HOUSTON: So three are really struggling. Some number more than three have kind of maybe done it, but are probably not feeling great about themselves about what they had to do it, I guess, might be fair, based on some of the media reports and stuff like that - cutting food or cutting staff, a diaper a day, or all these types of things. They're very serious things that we hear about and, I think, sometimes get desensitized to when we hear them.

I would say if three are saying I don't know how to do this, then there is some subset that is saying we did it, but we're not feeling great about how we had to do it. I'm sure there are a big number of homes that would probably be in that bucket - would you say that's fair to say from your discussions and understanding?

Some probably did it easily - I suggest that's probably on the one, two, or three side as well; there are three that are just sticking their hand up in the air and saying we just can't do this; and then there's a group in the middle that are saying this is how we had to do this and we don't feel great about it. Would you quantify that group, or what would you say to that group?

DR. VAUGHAN: It's difficult for me to quantify that other than the numbers that I've given you. The key here is a small number where we're having conversations because they're having difficulties. Nobody likes a 1 per cent reduction at all. We appreciate that; we appreciate the challenge. We appreciate the work many of those facilities have gone into to work together to achieve efficiencies. That's what we're looking for. That's what change is.

Change is difficult. Unless we make that change we're not going to see any different results. So, yes, there are those who don't want to reduce and, yes, there are those who would like to see us back away from that. We haven't backed away from it. We've worked with them to see how we can help them work together to achieve those efficiencies. I must say, the vast majority of them have risen to the task. They might not like it, but they've risen to the task. They understand what we're trying to do, and they are working better together to do that.

MR. HOUSTON: But it does feel like it's in a vacuum. We have no assessment of what the long-term funding needs are and we don't really understand where we're going, yet we have instructed people to find the shortest way there. We don't know where we're going, but take the shortest way you can to get there. That's a hard thing, right? To ask people to do that without properly understanding what's at stake, it's a difficult thing to do.

We're not going to solve that one today. That one's been done. But I hope as a province, we don't find ourselves in a position where a government sticks a finger in the air and says make this happen somehow; however you do it, don't tell us about it, but do it. That's what it feels like happened here. Maybe I'll look at the Excel spreadsheet and try to see if we can understand the rationale behind it. I think the bigger picture is, where are we going with our long-term funding needs? Nobody seems to know that today, and that's a shame.

In terms of where we are with the inspections and deficiencies and follow-ups and stuff like that, in the Department of Health and Wellness area, the AG did report that in some instances the follow-up inspections on deficiencies could take up to five months. I don't know, that seems like a long time, but I'm sure there's an order of magnitude of the type of deficiency. Can you give me any comfort? Obviously, they must be categorized as urgent, less urgent, or whatever. If something was determined as a really serious deficiency, can you give me some assurance that that's at least followed up quicker than five months?

DR. VAUGHAN: Sure. I'll ask my colleague Perry Sankarsingh to drill down into that.

MR. CHAIRMAN: Mr. Sankarsingh.

MR. PERRY SANKARSINGH: First, I recognize the efforts of our team of investigation and compliance officers at the Department of Health and Wellness. There are some good numbers today around the work that they do, and I want to recognize that.

When an audit is performed, there are typically findings, and the findings are varied in nature in terms of severity. So the timelines that we give in terms of addressing those issues also vary in relation to the severity. Things that pose an imminent threat to patient safety, which is always our overarching concern, are addressed right away. The primary mechanism that we have to deal with that is the short-term licensing process, which is essentially saying we'll continue to license you as a home, but you have to get this cleared

up within a certain amount of time. For issues of a lower magnitude, of lower importance, where the risk to client safety is minimal or can be mitigated over time, we do take a longer track with it, working with the facility. In some cases, that can take weeks or months; however, I think the important point here is that we address issues based on the severity of risk and that the time lines match that.

MR. HOUSTON: Maybe if there's a chart or something you can provide that says severity and action time required, that might be useful for the committee.

MR. SANKARSINGH: We are working to prepare that. One of the findings from the audit was that the department doesn't have a clear delineation of that risk striation. That's something that we are working to produce as part of the audit requirements.

MR. HOUSTON: I do want to finish up with Deputy Hartwell on the CAM, Corporate Agreement Management, system and the discussion over improving the contractual agreements between the homes and the department down at the service level, and I think you said it just provides clarity of operation for the department and for the home.

But it's always been a curiosity of mine that the actual person is not involved in that. We're talking about an agreement between the department and the home. Meanwhile, those homes are housing over 2,000 Nova Scotians, and they're not really part of the agreement in that sense.

I'm sure there are things in the files and stuff but I wonder, would you say that a resident in one of those homes would have the right to have a full understanding or full clarity of what they are entitled to and what the agreement is? Should there not be something that they sign or their family signs that says here are what our expectations are and here is what you, as a resident, have a right to expect from us as well - do you think that's an agreement that should be in place?

MS. HARTWELL: Thank you very much for that question. When we talk about service level agreements, we are talking about our relationship between us and the service provider. Between us and the client we have what currently we call a care plan, which is a plan developed in consultation with the client and with their family or their advocate. It is a collaborative document that sets out what care will be provided to them. We are moving, though, to building on that and we have some great examples of best practice in the province that are already doing it to really thinking of it as a client's life plan, again because we have people who need . . .

MR. HOUSTON: Just in the interest of time, that plan wouldn't stipulate like a notice period before they are evicted and those types of situations, so I think it should be a more fulsome agreement that they know what to expect from the home.

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

MS. LENORE ZANN: Thank you very much and again good morning, it's great to have you in here. I'm actually very pleased to be able to ask a few questions about these issues because in Truro-Bible Hill-Millbrook-Salmon River we do have a number of long-term care facilities in particular, and that is going to be the main focus of my questions today.

Although Dr. Vaughan has said - and I wrote it down - that it's not just about adding bodies to the equation, I have to say that if we don't put more money into our long-term care facilities and looking after our seniors, it is going to be about adding bodies to the equation, literally, because a lot of these seniors are suffering right now. I'm hearing from staff and I'm hearing from family members who are definitely being affected by these cuts.

Please correct me if I'm wrong, but you said that $8.2 million cut over two fiscal years from 103 facilities, out of 134 long-term care facilities. For instance, the staff that have come to me from some of the places in my constituency, in one case in particular they lost two full-time staff members, nurses, and they also lost two part-time kitchen staff, so that's three, and they said the problem is they no longer have any time. They were already run off their feet; they put a lot of time and effort into their jobs, but what they're finding now is that they don't have any time to talk to seniors.

We all know that seniors need special attention and doctors have told me that one of the biggest issues facing seniors today is around mental health issues such as depression and loneliness. Some people have families who come and visit them, and many don't. So the nurses and the staff are telling me that now they have no extra time to sit and hold somebody's hand and spend that little bit of extra time. That's one thing that's being affected.

The other thing is that they also tell me the food budgets are being affected. I'd like to know, do you have any idea at all about how many facilities are having their food budgets affected by these cuts?

DR. VAUGHAN: First of all, my comments earlier around adding human resources were related to compliance, the question was really to compliance, so not to be misconstrued in context of this conversation. Let's be clear that we don't manage those facilities; we don't run those facilities as I said. We provide them with a global budget and we inspect nursing homes twice a year at minimum, plus we go in right away for any issues that arise, as has recently been detailed in one case not too long ago. We don't tell them how much to spend on any particular item within their budgets; that's within their purview.

MS. ZANN: Do you have a list, though, of the facilities since you are supposed to inspect them - do you have a list of facilities where the food budget has in fact been cut?

DR. VAUGHAN: I'm not aware of any list.

MS. ZANN: So when they go in there and inspect, do they report back about what's happening with the food allotted for people, because we're hearing some people are being expected to live on $5.40 a day. I don't see how anybody can survive, let alone thrive, on $5.40 or $5.12 a day.

DR. VAUGHAN: Yes, in fact we have specific criteria, not just in terms of the food itself, but the nutritional value. Remember that dietitians are the ones who develop the menus. So the inspectors actually go in and talk to residents, and they actually sample the food as well – it's not just a paper exercise. People have the confidence that it's dietitians who are building these meals as well.

MS. ZANN: I can imagine. But I can also imagine that $5.12 a day and $5.40 a day does not actually feed an adult appropriately and properly or nutritiously. So when you go in there, I'd like to see the details about exactly what people are receiving in these homes and how many of them are having their food budgets cut back. As I said, I already have proof in my own riding that each one of the seniors' homes was cut, and people are coming to me saying that it's affecting people on the ground.

The other problem is, I know you mentioned that there's less of a waiting list now but it's the time that people are on those waiting lists - two or three years people are waiting to get into these homes - and the other issue is a lot of people, when they finally are accepted into a home, it's far away from where they live.

For instance, I just went into a local store the other day doing my business, and a woman who worked there said, listen, can I talk to you in private for a second, I've been meaning to call your office, and I'm like, yes, come on. We went in a corner and she said, I just had to put my husband in a long-term home. He's not a senior, but he's got early-onset Alzheimer's. She said and, oh my God, it is way far away and I can't get to it now. I go every day, and I have to drive there before my work in the morning and I make sure I take food with me because he seems to be always hungry. She said, isn't there any way that they can have more spaces and build more of these homes to look after the people?

We have an aging population - I know I don't have to tell you - where 1,000 Nova Scotians per month are turning 65. This problem is not going to get better; it's not going to get less. We need places that will look after our loved ones, the loved ones who cannot be looked after by their loved ones at home.

So, if you had your druthers, would you like to see some more money invested in these homes and building some new long-term-care facilities in Nova Scotia to deal with the aging baby boomers?

DR. VAUGHAN: We are working with many of the homes to look at what their immediate needs are and what their long-term needs are. While we know very much that

Nova Scotians have told us over and over again that they want to stay in their homes as long as possible - and by the way that is what people want and it's probably the right thing for many reasons, not just in terms of the health care but also in terms of their socialization and, to your point, around familiarization of where they are in their communities - so we are listening to Nova Scotians when they tell us that.

Will there be a time when we will look at additional resources? I think we've seen that there's a conversation that we've been having with some of those homes around what we can do to help with repairs, what we can do to help with replacement, or whether or not we need to have additional development of those facilities. We're in those conversations with them right now, so it's not black and white - it's all of the above.

MS. ZANN: So you've been told to save 1 per cent in the budget, so you've put these cuts down and you're saving 1 per cent, basically to balance the budget for this particular government, I would suggest. Yet meanwhile, as I said, 1,000 Nova Scotians are turning 65 every month. A lot of people, yes, would like to live in their homes, but they can't, or they can't look after their loved one, like the lady who spoke to me privately, the other day, in the corner of where she works.

She said, I've been looking after my husband and I just can't do it anymore. She said, I've lost weight; I've lost sleep; I just can't do it. I don't want to have to put him in a home, but we both agreed it's the right thing to do. Now, because there aren't enough spaces, the only place we could put him is far, far away. Again, I would say that I think it's urgent that the government actually start to invest in long-term care facilities as well as helping people stay in their homes.

Other things - therapists, is there money to have therapists there? Mental health therapists, physical therapists, art therapists, art therapy, music therapy - all of these different things make the quality of life better for seniors. Again, one of the biggest problems facing seniors today is loneliness and depression - how much do you set aside in your budgets for things like that? Even dentists coming to the seniors' homes - do you have a set amount that you advise them to be using for these kinds of things, or do you just give them the money and then it's up to them whatever they do with it?

DR. VAUGHAN: I think it's important to reiterate that we don't manage the facilities. Many of the items that you mention are important for seniors who are living in facilities. We all have experience with that. None of us, no family doesn't have someone or know someone, part of your family, so I think we all appreciate what those facilities do every day, the work the staff is doing every day to deliver the best care that they can to those clients. We don't tell them what to do to manage their facilities. I know that many of them work together to try and accomplish, in an efficient kind of way, the kind of enhancements that you've referred to that do improve the quality of life of our seniors and are important. We do not tell them what to do in that regard.

In terms of dental care, that is privately funded, so that's not something that we are involved in, directly.

MS. ZANN: I suggest actually it would be something you should look into in the future, because dental care is part of the overall health care. I think that dental care should be something that should be included for seniors, since most of them can't really afford it.

Are there ratios of staff to residents that are followed in long-term care facilities? What are the staff ratios for different types of staff, for instance nurses, CCAs, et cetera?

DR. VAUGHAN: There are no specific ratios. I'm not aware of any ratios anywhere in Canada that determine the right mix. We do use models of care, as I said, with our different kinds of agreements with different homes. Some of them have a different mix of staffing, very much based on that ad hocery of the past that we're looking to improve.

MS. ZANN: When facilities are being licensed or checked for compliance, do staff from the department look at criteria related to the quality of life of the residents as opposed to the quality of care?

DR. VAUGHAN: I'll ask my colleague Perry Sankarsingh to drill down on that one.

MR. CHAIRMAN: Mr. Sankarsingh.

MR. SANKARSINGH: The basis of our audit and investigation work is defined in the program requirements policy that the Department of Health and Wellness maintains. It outlines what we look for when we enter a long-term care facility, not just in terms of the physical facility, but also in terms of the client rights.

There is a substantial list of things we look for in terms of how the resident is implicated as part of the facility. Are they consulted? Are they engaged? Is the facility planning for their psychosocial needs? What are the avenues by which the home engages the client in daily life and provides for the social and the higher-order needs that you referred to earlier? So that is definitely part of what we look for and evaluate when we visit.

MR. CHAIRMAN: Order. Time has expired.

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

MS. SUZANNE LOHNES-CROFT: I'm finding this very interesting. You have a remarkable task ahead of you with the road plan.

One of the things I find comes to my attention in my constituency office is that some of the care plans for people, especially in their homes, fall under both departments. I

find it a little daunting and confusing as to who looks after what. I'm amazed at how collaboratively you work together.

Can you give me some information on how I, as an MLA, can serve my constituents with questions concerning who does what, and how you work that out amongst yourselves?

MR. CHAIRMAN: Ms. Hartwell.

MS. HARTWELL: I'll start, and then perhaps someone from Health and Wellness will want to join in, in the spirit of collaboration.

I would say the successful collaboration is on at least two levels. On the ground, our care coordinators work very closely with staff from the Health Authority and, when appropriate, with folks from Continuing Care. The primary contact for me whenever I get an inquiry is the individual care coordinator. They are the ones who have forged the relationship and are aware of the clients' network - not just the government-funded network, but their family network and their community network. That's always my go-to place.

At a systems level - and there are probably layers within that - we have developed complex case tables where people are meeting to go over if there's a particular family or a person who is in crisis or has complex needs that are not easily fit within each department. We have a table where senior staff are able to go and problem-solve and then talk about resource allocation.

It happens on a relatively frequent basis that we have clients who are involved with both departments. It's not unusual for those clients to have an involvement with the Department of Education and Early Childhood Development or the Department of Justice as well. But I would say our two departments really form the nucleus, if there's a complex case, we are going to have a conversation and work it through.

We've already mentioned, but I'll just add to it - we've formally established a working group to look at how our systems align together to make sure that our systems and our complex bureaucracies aren't getting in the way of the really great collaboration that takes place on the front line between our staff.

MR. CHAIRMAN: Dr. Vaughan.

DR. VAUGHAN: Thank you, Mr. Chairman. I'll start, and then I'll hand it over to my colleague Carolyn Maxwell. We work across many government departments, not just Community Services. There's a lot that we're doing with Community Services, and we'll talk about that in a minute, but we're also working with Labour and Advanced Education, in terms of the training of providers within the sector and the skills in the mix and how we use the skills of providers within the long-term care sector to really enhance the scope - and actually, we get better care out of that.

We've introduced nurse practitioners in some of our homes in your area. In particular, in Bridgewater and Mahone Bay and three other areas in the province, we already have nurse practitioners. We're looking to expand nurse practitioners. Again, this is about really improving the care, and the quality of life as a result of that, for our clients in those facilities. I'll ask my colleague Carolyn Maxwell to also talk about the other areas.

MS. MAXWELL: We've had some wonderful opportunities in many past years just to work together between the Department of Health and Wellness and DCS on clients who actually do fit within our program requirements, not duplicating each other's services but basically augmenting each other's services to maintain people at home as long as possible. If individuals are actually in a DCS facility, we provide acute care nursing services to DCS clients that may need IVs, as an example.

As the deputy has indicated, we are also currently on a working group, it is a steering committee that's looking at the realignment of the health system. Particularly of note is the work on the responsive behaviours of clients who have complex cases. These individuals may actually be within our facilities, or they may be individuals who do not fit with either program but are Nova Scotians, and we are trying to find a place for them to call home or working to have them receive services in the community.

The other opportunity here is looking forward into our future with the Continuing Care Strategy. One of the areas that we had a meeting on actually this week is looking at youth in long-term care, whether they're in the Department of Community Services or the Department of Health and Wellness, looking at the type of programming that we could potentially do together or separately. That's going to be supported by some of the great research that should be coming out of Dalhousie University with Independence Now, which is in a youth advocacy group that's currently within the Department of Health and Wellness.

I would say that that probably sums it up, except we are also doing a lot of work with DCS about the WCB rates that are rising for staff working in long-term care. We trust that a lot of the cross-jurisdictional work and the results of the root cause analysis will help us to work with the unions, the employers, and across government to look at that issue and how we can reduce our WCB rates and create a better environment not only for the residents but also the staff.

MS. LOHNES-CROFT: Ms. Hartwell, I know the long-term care qualifications for staff, but what are the qualifications for staff in your homes for special care or your group home settings?

MS. HARTWELL: We have a variety. We have some CCA positions, and we have some others that I would say are closer to the health professions. We also have a lot of folks who have psychology backgrounds. We have a significant training piece that's going forward right now. Like in the Department of Health and Wellness, our service providers

are not run directly by us, but we have put in place both standards for staff and also training standards on a go-forward basis which we're happy to share.

MS. LOHNES-CROFT: Can you give me an idea of the ratios? Some of your facilities have nursing staff, and then they have other workers - I don't know what they're called in the system.

MS. HARTWELL: We would have a predominance of personal care workers and continuing care assistants. We would also have recreation staff. Again, the facilities are so different that in a larger facility, we do have some limited nursing staff, occupational therapy, dietitian, et cetera, all across the spectrum. It's important to remember that 80 per cent of our clients are served in community-based settings. They're either living on their own with support from a family member, another family, or they're in a small options where they have staff whose training really is as personal care workers. They may have a focus on youth, or they may have a focus on geriatrics. People who are the caring individuals come into the homes but are usually part of a larger organization that does the hiring and the training on behalf of the department.

MS. LOHNES-CROFT: My concern with staffing is as you transition to the road map, that's already an area that we know is going to cost to make it effective, and whether it can be sustainable is questionable. How are you going to work with that transition and your staff ratios and covering all that? It's a huge obligation.

MS. HARTWELL: It is a big shift. Historically, our entire programming for the last X number of decades has really been based on a custodial care model. We've heard loud and clear from clients and their advocates and, frankly, best practice around the country and the world that that model is not appropriate and that we have to have a client-centred model that starts from the presumption that we need to support people to live as independently as possible.

So our entire orientation is one that we are shifting. We have very skilled staff who have worked within that model and I would say have done everything they can to make that model vibrant and responsive to individual clients. So despite the system they've worked in, the expertise and the caring of staff have made it work, and we believe there will probably be a time, as we move away from facility-based care, that we are going to need to support staff to provide care in a different setting, whether that's a home-based setting or a smaller options setting, or on an outreach basis. But, make no mistake, we're going to need the staff who have that caring skills set. Our need for staff isn't going to diminish, but they're going to have to work differently.

We have started work with the facilities themselves, the employers, who have been part of a lot of conversations about transitioning and we are starting to have some conversations - we had some initial and we're picking up, hoping to have some conversations with the unions, where we have unionized staff, to talk about how to support those employees in transition.

It's important, though, for everyone to keep in mind that it's not a switch that's going to be flipped. The system was built over 100 years and it's not going to be dismantled within a few years. There will be lots of opportunity for us to work collaboratively with the employees, with their unions, with their employers and, most important I think, with the clients themselves, to talk about how we're going to provide care in this new way.

You are absolutely right to point to the sustainability as a factor because right now we have a system that has a good number of people who are over-served. They are in a place where they are getting too much supervision and structure - they don't actually need it but there has never been an alternative for them. We have other people who are being underserved or we know that their emerging needs are - they have aging parents and the example we can all think of is, everyone can probably think of people who are in their 80s who have a child in their 60s and as those parents age, you start to wonder what the future is for that child who is an adult and needs to have a life plan of their own.

We know that we have to create the supports outside a facility-based system and the only way to do it is to bring the staff that are currently in that system on that journey with us. It won't be easy but over time, and we have the example of what has happened in other jurisdictions, what has worked really well and what has not worked so well, so we have the opportunity to really take advantage of the skill we have and just have it go to a slightly different arena.

MS. LOHNES-CROFT: And what about those who don't really fit the mould?

MS. HARTWELL: We'll have those, as Ms. Maxwell indicated, we have identified that we have people who, because of either extreme behaviours or different diagnoses or because of aging issues, no longer fit with where they currently live or have exhausted caregivers, there's a whole range of things and people who don't easily fit.

It's our job and part of our transformation work is to reorient our system so it's less about saying who fits into this program and who doesn't, and more about here's a person and what systems and supports do we need to wrap around them. I can't guarantee, or I can't say there will be a world where everyone will have their own individualized programming in their community at exactly when they want it, as they need it, but we're moving towards that and that certainly is the desire, that the client and their needs are at the centre going forward.

I would suggest that that is actually our only hope of being able to bend and monitor the cost curve, to identify where we have over-service and have that be replaced by the appropriate service for all folks.

MR. CHAIRMAN: Time is just about to expire.

MS. LOHNES-CROFT: I was going to ask you something about dementia, the dementia strategy, where it fits in - is there a place in homes for special care or is it all long-term care?

MR. CHAIRMAN: Just a 30-second answer, if you can. Sorry, Dr. Vaughan.

DR. VAUGHAN: The dementia strategy is really working across the entire province and is not focused on any one particular sector, but on needs of individuals no matter where they live.

MR. CHAIRMAN: Time for questions has expired. We just have 60 seconds to each department for closing comments. Perhaps we'll begin with Ms. Hartwell this time, and then we'll follow up with Dr. Vaughan.

MS. HARTWELL: I'll be very quick. I would like to first thank the staff who accompanied me here, who didn't have to say anything, and also the staff who prepared the support materials for us to attend. It's our hope when we come that we're always able to provide you with the information that you're looking for. Certainly, if you have any questions arising from this, I would be more than happy to provide that.

I would also like to thank the Auditor General's staff for the audit and the constructive insight that they provided and a window into the complex worlds that we are trying to navigate.

My final offering is that the Department of Community Services is on a wonderful transformation voyage. I appreciate your support and would be more than happy, at any time, to answer any questions or provide any information that you might need.

MR. CHAIRMAN: Dr. Vaughan.

DR. VAUGHAN: Thank you very much, again, for the opportunity to come here today to talk to you about the province's long-term care homes and the efforts we're making to protect the most vulnerable amongst us in the province.

We've talked about, and you know about, the second-oldest population and the worst health outcomes and why we need to change. We've talked about this before. We've talked about how much money we spend. Most importantly, according to the Conference Board of Canada, our health outcomes rank seventh out of ten provinces. The Conference Board of Canada gives us a D score, which I believe is a clarion call for us to do things differently – and do things differently is what we are doing. This means not simply doing the same things in the same way we've always done them before. This is about change, and we must change the way we are doing things if we're expecting different results.

The Homes for Special Care Act, the Protection of Persons in Care Act, and their regulations are there to protect the health and safety of the residents of our long-term care

homes, but we are always reviewing our laws and policy to make sure that we meet the needs of Nova Scotians.

Earlier this year, we updated the long-term care program requirements. These protect the rights of every citizen and every resident to be treated with courtesy and respect, to eat high-quality nutritious food, and to keep and display personal possessions.

Mr. Chairman, we are working to build on the success of the previous 10-year strategy to look forward to a new and modernized long-term care strategy coming soon.

MR. CHAIRMAN: We have just two minutes left. I believe there is a motion. Mr. Rankin, would you like to put forward a motion?

MR. RANKIN: The committee has adopted the practice of formally endorsing the recommendations issued by the Auditor General. So I will make the motion: I move that the Public Accounts Committee formally accept and endorse the accepted recommendations contained in the Joint Audit of the Atlantic Lottery Corporation where the Province of Nova Scotia is a shareholder of the corporation, and ask that the province commit to and take responsibility for full and timely implementation of those recommendations it has agreed with and accepted.

MR. CHAIRMAN: Would all those in favour of the motion please say Aye.

I see unanimous consent there. The clerk will take note of that.

We just have one minute left. I apologize for rushing, but we do have to finish at 11:00 a.m. sharp.

We have one piece of correspondence from the Department of Communities, Culture and Heritage that was received on October 19th, based on the October 19th meeting we had.

Our next meeting is November 30th. It's an in camera meeting with the Auditor General to discuss the Fall 2016 Report of the Auditor General.

Is there any further business to come before the committee?

Hearing none, I thank everybody for being here today with us.

Thank you for answering our questions. We will return on November 30th.

This meeting is adjourned.

[The committee adjourned at 10:59 a.m.]