House of Assembly
Nova Scotia

HALIFAX, TUESDAY, APRIL 11, 2023

SUBCOMMITTEE OF THE WHOLE ON SUPPLY

3:26 P.M.

CHAIR
Nolan Young

THE CHAIR: Order, please. The Subcommittee of the Whole on Supply will come to order. It is now 3:26 p.m. The subcommittee is meeting to continue the consideration of the Estimates for the Department of Labour, Skills and Immigration as outlined in Resolution E13.

We will continue with the NDP round of questioning, with one minute remaining. The honourable member for Halifax Chebucto.

GARY BURRILL: The list of things that I could express in one minute is very short. We don't have any more questions on our part, and we invite the minister to make a closing statement.

THE CHAIR: I invite the honourable Minister of Labour, Skills and Immigration to make some closing remarks.

HON. JILL BALSER: I just wanted to take the opportunity to thank the members for their questioning on Thursday. I appreciate the opportunity to be able to answer questions on behalf of the department - and really just to say thank you to the team, which has been here every step of the way. LSI doesn't usually get the opportunity to speak to Estimates, so I think everyone was really enthusiastic to be able to be here on Thursday and of course today. Just a really big thank you to the finance team and of course the leadership team in every branch. We are a special department, and we're a department that touches people. It takes special people to do that type of work. From the bottom of my heart, thank you to everyone in the department. Of course, I would be remiss if I didn't thank my mom and dad and my constituency assistant, Taylor, for holding things down together for me while I'm always here in Halifax - and of course to Cecily, too, as my special advisor. Thank you for everything that you do.

THE CHAIR: Shall the resolution stand?

Resolution E13 stands.

We'll take a brief recess while we get set up for our next round.

[3:28 p.m. The committee recessed.]

[3:35 p.m. The committee reconvened.]

THE CHAIR: Order, please. The subcommittee will now consider the Estimates for the Department of Seniors and Long-term Care, as outlined in Resolution E37.

Resolution E37: Resolved that a sum not exceeding $1,331,978,000 be granted to the Lieutenant Governor to defray expenses in respect of the Department of Seniors and Long-term Care, pursuant to the Estimate.

THE CHAIR: I now invite the Minister of Seniors and Long-term Care to make some opening remarks - up to an hour if they wish - and introduce their staff.

The honourable Minister of Seniors and Long-term Care.

HON. BARBARA ADAMS: It is my privilege and my pleasure to introduce the Estimates for the Department of Seniors and Long-term Care for the 2023-24 fiscal year.

Joining me today are Deputy Minister Paul LaFleche; Tracey Barbrick, the associate deputy minister; Jason Varner, the executive director of finance; Janet Lynn Huntington, the senior executive director of continuing care; Sophia Foley, the director of policy; and Paula Langille, the acting executive director of infrastructure.

I want to start by acknowledging and thanking the staff and volunteers who work in the continuing care sector. This has been an extraordinary year for continuing care as we take great strides to bring stability, equity, and accountability to our sector. I am so grateful to everyone who works to provide the ever-improving quality of care to our most vulnerable.

This is the second budget for our department, and this year's investments build and expand upon the foundation we established over the course of our first year. When we took office, this new Department of Seniors and Long-term Care was formed to focus on the unique needs of older Nova Scotians in all facets of their lives. We know that our province is aging, and the need for more services and supports will only grow.

For years, this sector has been chronically underfunded in several key areas: (1) infrastructure; (2) staffing levels, training, and safety; (3) flexibility for our home care clients; and (4) supports for our family caregivers. This resulted in a decline in all aspects of care. I saw the effects of this on the front lines in the continuing care sector over the course of my career working in this field.

I saw it in how it demoralized the workforce. Underpaid and underappreciated for years, people were turning away from the continuing care sector as a career, leading to increased workforce pressures across the sector and ultimately resulting in beds being closed due to staffing.

I saw it in how our facilities were in dire need of upgrades and renovations and an overall need for an increase in capacity. This lack of capacity has also put pressure on the entire health care system, as much-needed acute care beds and resources were required to be used for the purposes of people waiting for long-term care.

I saw how much more flexible supports directed to individuals could help remove barriers and allow people to stay in their homes and in their communities longer.

Our government has made health care our top priority, and this includes continuing care and supporting Nova Scotians through all stages of their lives. Our path is clearly laid out in the Action for Health plan. My mandate letter reflects the concrete steps we are taking to provide more access to health care services faster.

During our first year as a department, we focused on stabilizing our continuing care system to ensure that the support and care Nova Scotians and their loved ones need is ready for them where and when they need it. We accomplished this through a historic level of strategically targeted and sustainable investments, investments that are evidence-based, investments that are paying off, investments that are resulting in improvement in performance indicators in all areas of the continuing care spectrum.

Let me be clear: Our goal is not only to stabilize our continuing care system; we want to make working in this sector a career path of choice, and to position Nova Scotia as a leader in delivering the highest level of care in the country. We also want Nova Scotia to be a leader in age-friendly communities, where people can grow old with dignity and stay in their homes until a time of their choosing.

This year's budget builds on the foundation of last year's work. It invests further in the programs we know will help Nova Scotians age well in whatever setting they choose to do so, be it at home, in a community-based program, or in a facility. As a reflection of this, this department's budget will be increasing by approximately 11 per cent compared to last year's estimate. This year's budget, as mentioned, is expected to be over $1.33 billion.

I'd like to take you through some of our key priorities and how this year's budget strengthens the foundation we built in our first year while expanding further on that success.

In long-term care, we know that the wait-list is still too long for long-term care spaces. We know that the need is only growing with our aging population. As such, we greatly expanded the plan for long-term care infrastructure, bringing the approximate total of net new spaces to 1,200 and replacing 2,300 beds with single-living spaces. This plan will result in 3,500 more single-room beds in 34 long-term care facilities across the province.

Each of these spaces is designed with privacy and dignity in mind. Each has its own bathroom and provides an individual with a living space they can make their own. The new design and layout of these spaces will also help further enable staff to provide quality care and mitigate infection control issues. Family members will be able to visit a loved one in a home environment that will be more personal, where important social events and conversations can be done in a private setting. Given that our loved ones sometimes finish out their life in a long-term care facility, this additional privacy will bring much-needed comfort when the time for palliative care comes.

Three of these nursing homes will open over the course of this year. As such, you will see our budget this year includes $13.5 million to open 240 new and renovated spaces at Mahone Bay, Villa Acadienne, and Eskasoni long-term care facilities this fiscal year. These spaces will bring much-needed capacity to those communities and see the first long-term care facility in a Mi'kmaw community. This cultural partnership will further government's ongoing commitment to improve access to continuing care services for Mi'kmaw community members.

All of the work related to the expanded infrastructure plan announced earlier this year is on track to be completed by 2027. This includes 14 facilities expected to open in 2025: Taigh Solas in North Sydney; Mountain Lea Lodge in Bridgetown; The Birches in Musquodoboit Harbour; R.C. MacGillivray Guest Home in Sydney; Carefield Manor &

Dominion Community Guest Home in Sydney; Gables Lodge in Amherst; Highland Manor in Neils Harbour; seven new facilities in the Central Zone, including two facilities in Bedford, three facilities in Dartmouth, one facility in Sackville, and one facility in Tantallon; and 17 facilities expected to be open by 2027. They include Waterford Heights in New Waterford, Grand View Manor in Berwick, Shoreham Village in Chester Basin, Northwood in Fall River, Foyer Père Fiset in Cheticamp, Queens Manor and Hillsview Acres in Liverpool, Dykeland Lodge in Windsor, Harbour View Haven in Lunenburg, Wolfville Nursing Home, Melville Lodge in Halifax, Glen Haven in New Glasgow, Victoria Haven in Glace Bay, R.K. MacDonald Nursing Home in Antigonish, Valley View Villa in Stellarton, St. Anne Community and Nursing Care Centre in Arichat, Roseway Manor in Shelburne, and Maple Hill Manor in New Waterford.

These are exciting milestones in our ever-expanding long-term care infrastructure plan. While the delivery of continuing care is our primary focus, these builds also provide economic benefits to their communities and add additional job opportunities in these areas. We will be seeing the operational funding for these upcoming facilities included in future budgets as the remaining long-term care spaces open over the next three years.

We will also continue to explore any opportunities to convert beds into permanent long-term care spaces whenever we can. I'm pleased to say that over 200 beds that had initially been considered a temporary measure are now being converted to permanent long-term care spaces, further increasing our total going forward. We are leaving no stone unturned while we carefully monitor the demographics and needs of communities across our province. This allows our department to make sound strategic decisions based on data and analysis to ensure our services and supports match our projected needs well into the future.

The province is also doing the necessary work to extend the life of many of our current spaces as well. We are investing $25 million more in capital funding for long-term care facilities for equipment, upgrades, and necessary repairs. These repairs help pre-emptively address issues that would normally shorten the life span of a given facility. For example, some issues - like the need to eventually replace a roof - may not have a direct impact on operations on a day-to-day basis, but left unchecked, this could lead to a more serious structural issue down the road.

We also need to ensure that these facilities can provide the top care in the country. We are Canadian leaders in implementing the average of 4.1 hours of care per resident per day in our facilities, along with the Yukon. For over 12 years, unions, staff, and families have called on previous governments to increase the staffing level of care in long-term care. Those calls went unanswered. In fact, the previous government called on a long-term care expert panel to make a new staffing level recommendation to government, but the truth was that researchers were unable to find sufficient patient data to make a staffing recommendation. However, our government knew that the current level of acuity of care in

long-term care had risen dramatically, and that we could not wait 5 or 10 years to collect sufficient data to make a determination.

[3:45 p.m.]

Our government knew that urgent action was needed - 4.1 hours of care, which was mandated in my letter from the Premier on Day 1, means that the average number of hours of direct care by a continuing care assistant in Nova Scotia will increase and has increased from 2.1 to 3.1 hours of care per client per day. That is a 50 per cent increase in CCA hours per resident per day in Nova Scotia, the leader in the country.

Given that approximately 56 per cent of the total workforce in continuing care is by a highly valued and trained continuing care assistant, that is a historic increase in the level of care for CCAs by a government, our government in Nova Scotia. This means better care. This means safer care. This means greater confidence of family that their loved ones are being treated with dignity. This means the highest level of care offered in a long-term care facility anywhere in Canada. I am very proud that our government is leading the way in building sector pride and making continuing care an area of first choice for many of our allied health care professionals to work.

The majority of our facilities are indicating they are staffed up and ready to deliver 4.1 hours of care. In fact, several of our facilities have 4.1 hours of care in action on the floor today. We are working every day with the rest of our partners to support them to be in a position to be ready as well. As of last month, 69 nursing homes were assessed as ready to implement 4.1 hours of care. That means they have their existing staff positions full. They are ready and recruiting for the additional staff supported by the 4.1 hours of care funding.

In all of my time in my career in this sector, this number of staff in a facility seemed out of reach. It is my honour and privilege to see this level of care roll out across the province and position Nova Scotia as a leader in providing the highest standards in the country.

This year’s budget invests an additional $10.7 million towards these efforts, with a focus on ensuring that all of our facilities meet this leading standard of care. We believe in providing an average of 4.1 hours of care per resident per day because we believe in the quality of care for our residents and for our staff. We are building a world-class system, and ensuring a standard amount of care for residents in the province means that no matter where you live, whether it is in Seaview Manor in Glace Bay or Tideview Terrace in Digby, you can expect quality care from health care professionals, including our hard-working CCAs, nursing staff, and allied health professionals like physiotherapists and recreation staff. All are equally important.

Overall, this year’s budget will see over $100 million in additional funding invested in our long-term care system. I’m sure that over the course of our time here at Estimates,

we will have an opportunity to detail even more of these investments and outline how they are helping Nova Scotians access more continuing care services faster.

Now I want to take some time to talk about home care. It is critical to have long-term care available for those who need it, but we know that most Nova Scotians want to remain at home, and most can with enough support. Continuing to invest in home and community care programs is making it easier for Nova Scotians to maintain their independence at home. This happens primarily through our community nursing program - delivered by the VON and Nova Scotia Health, which provide nursing services at home and in our community clinics - and through the province's growing home support programs that provide personal care, home support, and direct funding programs to help people live at home with supports. The department's community program also brings home oxygen, hospital bed loans, wheelchair loans, and more into people's homes so they can continue to live well at home.

Building on our suite of home care services, the province is investing almost $26 million more into direct funding to provide more flexible supports for families that choose to hire their own staff to support their loved ones at home. Work is under way to streamline these programs so that they are even easier to access for our home care clients and their families. Our investments are working. We are providing more care faster to seniors at home.

The department reaches now almost 40,000 individuals through home care supports. Visits from home care agencies have increased, and the wait-list for home support has been dramatically reduced over the past year. We know more work needs to be done, and we continue to make the right investments to meet Nova Scotians with the care they need where they need it, with innovative programs and partnerships.

For example, the new CAPABLE pilot will be bringing teams of professionals into homes to support older Nova Scotians to set and achieve their personal goals, helping them regain or retain independence. CAPABLE stands for the Community Aging in Place Advancing Better Living for Elders. CAPABLE will be a brand-new program in Nova Scotia and the first in Canada. This will partner a nurse, an occupational therapist, and a handyman to help older people live more independently. They will do this by developing a plan with the individual that may include small safety upgrades like grab bars and step repairs, as well as occupational therapy and nursing home health supports. Three teams will be trained and supported to help about 300 clients over the next year achieve their independence goals.

Home support meal programs are growing across the province, delivering tens of thousands of meals per year to home support clients who have difficulty preparing their own meals. Our department is piloting adult day programs for people with higher-care needs, providing social activities for clients, respite for family caregivers, and efficient delivery of home support services.

Our new Home Lift Program helps individuals and their caregivers deliver safe care to people in their homes by providing access to mechanical lifts. These devices are used to lift, transfer, and position or reposition someone who is unable do to so independently. Home lifts are also an important tool to help reduce injury and strains for our home care workers and others who are caring for people with limited mobility. Workplace safety and other investments are key to addressing the workforce challenges that have been growing for years.

I want to take a few minutes to talk about our important and vital workforce. Like other areas of continuing care, staff had been chronically underinvested in for years, which led to a workforce that was both understaffed and overworked. Over time, the sector gained a negative reputation for high stress and low pay, leading many to choose other careers or to leave the sector altogether. I saw this happening in real time during my career in the sector. We knew that we were reaching a breaking point and that COVID-19 and the pandemic pushed the sector past the point of breaking. We knew that a new approach was required.

Since the formation of this department, we have taken swift action to address many of these long-standing issues. I am pleased to say that these investments are paying off.

As many know, long-term care has the distinction of having the highest rate of reported workplace injury of all employment sectors. High injury rates, low pay, and high stress were leading to burnout across the board, directly impacting the level of service that could be delivered. Last year, we were seeing hundreds of beds shut down due to workforce pressures. Through strategic near-, medium-, and long-term investments, we have been able to work with our facilities to open all beds that were closed due to staffing pressures. I'm going to read that again. We have been able to work with facilities to open all of the beds that were closed due to staffing pressures, while also recruiting the workforce of tomorrow that we know we will need.

We gave our continuing care assistants a much-needed 23 per cent pay raise to bring them more in line with their peers and to better reflect the critical role they play in our system. We also introduced free tuition and books for individuals wanting to join the continuing care assistant workforce. It is my great pleasure to report that we recently handed out our 1,000th free CCA bursary, hitting the halfway point of our goal of 2,000 free bursaries over two years. As these new CCAs continue to join the workforce, we are seeing more positive results in many areas.

Along with the newly re-opened long-term care spaces that had been closed due to staffing, the Workers' Compensation Board recently released their latest data, and it shows positive results in both the home care and the long-term care sectors. This reverses a trend that saw workplaces struggling with absences due to injury for years. As a physiotherapist, I know first-hand that one single injury can derail or destroy the health and future well-being of a staff person.

Our department believes workplace health and safety continues to need to be prioritized in our sector through the hard work of the thousands of employees and employers in continuing care, along with our safety partners, like the Workers' Compensation Board, Aware NS, and the Health Care Human Resources Sector Council. Building on last year's investments, we are providing our workforce with the support and tools they need to deliver safe care, both in their facilities as well as in the homes of our loved ones.

[4:00 p.m.]

Sometimes investments that may seem small on paper compared to our overall budget can make a huge difference to the person delivering care on the front lines. This includes $750,000 for home care safety equipment, such as bath chairs, grab bars, mops and buckets, transfer sheets; $500,000 more to the Red Cross for the bed loan program to address wait-lists for hospital beds; $360,000 to support home care administration with temporary clerical staff to support technology upgrades; $1 million to support improvement and integration of our home care agencies, emergency preparedness plans to ensure agencies have tools and resources needed to respond in the event of emergencies.

We saw the importance of supporting this contingency plan during Hurricane Fiona. Home care agencies need to be equipped with the tools to respond to their clients no matter what the circumstances. Despite power outages, fuel shortages, and other barriers that kept most of us hunkered down inside our homes, they were out providing care to Nova Scotians who needed it.

We are continuing to invest in the employee and family assistance program to provide the sector with access to these services to support employees' psychological health and safety. This budget continues to provide over $500,000 for safety training initiatives through Aware NS. That will offer our employees access to education and training to build on their knowledge to keep themselves and others safe in the workplace.

The province is also recruiting nationally and internationally, including the recent successful trip to Kenya that saw some exciting results. Our Kenya trip was innovative in its approach. It focused on using the economic mobilities pathway pilots immigration stream. With 65 conditional offers made on the trip and many of those currently being matched with employers or with confirmed job offers, we are excited to explore more opportunities like this. To that end, we are working closely with our partners at the Health Association of Nova Scotia; Labour, Skills and Immigration; and the Office of Healthcare Professionals Recruitment to organize more recruiting trips of this nature overseas in the coming year.

We have also listened to the staff in our facilities and agencies who have been working day in and day out to provide essential care to Nova Scotians on our front lines. We have extended the funding of long-term care assistants in the long-term care sector to

assist with duties in facilities outside direct personal care, and we will continue to support our home care aides. This helps free up other support staff to focus on residents and clients with personal care needs. This is an additional investment of $8.1 million. This removes a significant burden on the time of our continuing care staff. We will continue to look for more ways to help them focus even more directly on our loved ones in their care.

Extra funding was provided for management and prevention of infectious diseases. This includes $4.6 million for infection control designate nurses. We're also continuing funding of our wound care pilot, which represents $2 million in this year's budget. We're also providing an additional $670,000 for more wound care supplies and related products.

Another key part of making continuing care a career path of choice is removing barriers for individuals wanting to advance their careers within the sector. The department is introducing a new pilot pathway for CCAs working in continuing care to study and become licensed practical nurses. This is a first-of-its-kind program in Nova Scotia. This program will cover the full cost of tuition and books and offer extra supports such as tutoring to help position them for success. This a $600,000 investment for this year's budget. We want all of our employees to know that there are long-term care career options and supports available for them if they would like to grow, learn, and progress into new roles within our sector.

In the Fall, we engaged with employees and employers to confirm that there was interest in these types of pathways, and we heard an overwhelming yes. This is a pilot project, and we will be sharing more information on it soon. I am personally very excited for this program to start and cannot wait for the first students to participate.

The province also recently recognized the essential role of those working on the front lines of health care and continuing care with an historic retention and recruitment incentive. This will put money directly in the pockets of health and continuing care workers, who have been working tirelessly throughout the pandemic.

Investments in administration and business operations may not be as visible as some of the other initiatives, but they are just as critical. Supporting our long-term care facilities also means helping the administrators and management to run smooth operations to create safe and welcoming environments for staff, residents, and family. Administrators told us they needed help. They needed support with day-to-day office responsibilities like human resources, finance management, reporting, and data management. We listened. We provided $4.5 million in clinical administrative support for all of our long-term care facilities. This investment ensures that our leaders and administrators can focus on the priorities that matter most, which are providing quality and safe care in a loving and nurturing environment for our seniors.

The department also recently issued an RFP that will provide board governance training for non-profit long-term care and home care agencies. This initiative will support

and equip the non-profit boards of up to 65 continuing care organizations with the tools and practices they need to enhance their governance capacity, which will support their overall effectiveness, their responsiveness, and their strategic approach to management and the delivery of programs and services. This work is critical to building accountability at every level of the system.

I'd like to conclude on this area by touching on a very important aspect of our work, which is the preventive steps we can support to allow more people to age well in our communities before they need the more direct supports offered by our home care and long-term care programs.

Now I want to talk about aging well in Nova Scotia. Older Nova Scotians often face unique barriers, including ageism, burnout, and barriers to aging in place, like social isolation. Meeting their diverse needs requires collaboration to produce innovative and flexible approaches across government, non-government, and our community organizations. We know that small course corrections and the removal of specific barriers earlier in life can allow people to live in their homes much longer. We know that access to and participation in social interactions and physical activity play a pivotal role in someone's eventual frailty level and ability to take care of themselves.

We are addressing some of this through programs like our Age-Friendly Communities grants. Recently, I had the pleasure of announcing this year's recipients. The Age-Friendly Communities Grant Program annually provides grants of up to $25,000 for community-wide efforts to create age-friendly environments and promote healthy aging. Thirty-seven groups across Nova Scotia recently received grants through this program to help create age-friendly environments and promote healthy aging through fun activities, programs to promote digital literacy, and other innovative initiatives tailored to our communities across the province.

For example, one of the grant recipients is the Upper Hammonds Plains Community Development Association, which, in partnership with the Black Wellness Co-operative, offers activities like group fitness classes, craft painting, and cooking to local seniors. The goals are to reinforce healthy habits, embrace healthy lifestyles, and create opportunities for social interaction.

Another program in Lunenburg is called Growing Friends. Led by St. Stephen's Parish, the program will see around 30 seniors tend community gardens and provide them with free, plant-based meals. They also host elementary school class visits so the younger generation can connect with seniors in their community while also learning about healthy food. Other programs will cover important areas like improving digital and computer skills, learning new hobbies and skills, being more physically and socially active, and providing additional non-medical support to seniors at home.

We're also building on a successful program like the Centre for Rural Aging and Health, known as CORAH, a partnership with NSCC that provides a seniors' hub for activities, information, and education, helping seniors connect to their communities. CORAH is expanding to two additional sites this year. We will be sharing more details on that expansion as the plans are finalized.

Another factor that can greatly impact someone's ability to age at home is their cognitive function. We know many of the activities we've listed above help in this area. We are investing further through partners like the Alzheimer Society of Nova Scotia. This year's budget doubles government's investment in dementia supports and allows the Alzheimer Society of Nova Scotia to expand current programs in Nova Scotia to address the growing support needs. It provides funding for $1.1 million to the Alzheimer Society of Nova Scotia to support earlier dementia diagnosis and intervention, more dementia care, and support for our physicians and nurse practitioners, and the dementia-friendly community support that trains workforces to support those living with dementia and their caregivers in the places they live, work, and play.

This past year has been challenging for everyone and particularly hard on seniors. In addition to the $500 Seniors Care Grant that we introduced in our first year, in 2022, we added two more grants worth $250 each to help with home heating and Hurricane Fiona cleanup needs this year. This funding helps support approximately 40,000 people in need. This year's budget sees over $29 million in continued investment in the Seniors Care Grant. Last year, the criteria for applications were significantly expanded to allow more services to be covered and provide more flexibility for people who needed support. That support will continue in this budget.

Also related to the safety of our seniors, we contribute funding to 15 community senior safety programs across the province, providing a valuable resource that provides support directly in communities.

I'd also like to highlight the important ongoing work at our department in divisions like the Adult Protection Investigation and Compliance and Eligibility Review units. The employees on these teams work directly with individuals, often at times when they are at their most vulnerable, to ensure that they are able to live in safe and healthy environments and to help them access the supports available to them. While these historic investments are required to address our current and future long-term care needs, the delivery of this care can only be accomplished through a properly supported and engaged workforce.

In conclusion, the work of the Department of Seniors and Long-term Care covers all aspects of a person's journey through the later stages of their lives. While the primary focus may often be on long-term care and our facilities, it is important to not lose sight of the many other factors that impact a person's ability to age well in our communities. This year's budget reflects that holistic approach while making historic investments in our workforce, home care, and long-term care.

This approach is made possible through valuable and ongoing collaboration, engagement, and the hard work of our partners, such as the Seniors' Advisory Council, the Workers' Compensation Board, Health Association Nova Scotia, AWARE-NS, Caregivers Nova Scotia, the Alzheimer Society of Nova Scotia, our home oxygen and equipment loan providers, the Nova Scotia Health Authority, and our long-term care facilities and home care agencies. It also crosses over with our partners across government and the health care sector. For example, while not included in our department's budget, Nova Scotia is investing $4.7 million to provide high-dose flu vaccines for all seniors aged 65 and over for free.

[4:15 p.m.]

It is through our combined efforts that we are reversing many of the negative trends we had been seeing in the continuing care sector to ensure that we are ready to meet our current and future needs.

I would like to finish by saying a special thank you to my diligent, caring, committed, and hard-working staff at the Department of Seniors and Long-term Care. The amazing work of all my department staff and those who work with them, which I have just outlined, is only possible through the dedication and commitment that they display each and every day.

With that, I'll be happy to answer questions.

THE CHAIR: Thank you, Minister, for your opening remarks.

I think everyone knows by now, according to practices developed in this Legislature, each caucus will take one hour. We'll start with the Official Opposition, the Liberal Party.

The honourable member for Bedford Basin.

HON. KELLY REGAN: Thank you to the minister for updating us on all of the important changes that have taken place over the past year or 18 months, depending on the particular change. I have a lot of little questions, and I apologize if you gave the answer during your speech, because sometimes I might miss something.

Right now, how many seniors do we have in hospitals waiting for a bed in long-term care?

BARBARA ADAMS: Approximately 250 at the present time.

KELLY REGAN: How many seniors are on the overall wait-list? If I could get the breakdown per zone.

BARBARA ADAMS: Approximately 1,650. I don't have the breakdown by zone with me right now.

KELLY REGAN: If we could get the breakdown per zone, that would be great.

You may have answered this question in your speech. How many of the 34 promised long-term care homes will open this fiscal year? I think I heard three.

BARBARA ADAMS: Yes, during the speech - there are three that will be opening this year: Mahone Bay, Villa Acadienne, and Kiknu in Eskasoni.

KELLY REGAN: That was Mahone Bay, Villa Acadienne . . . (Interruption) Thank you. Sorry, I'm trying to take notes.

How many CCA vacancies are there in long-term care homes across the province?

BARBARA ADAMS: As the member would know, in the past, there was no mandatory reporting of staffing in long-term care facilities. In fact, we didn't have CCA registries, so we didn't even know how many we had. We certainly know exactly how many we have now and approximately 56 per cent of our workforce are CCAs. In the past, there was voluntary reporting of how many staff you had. We have now made that mandatory reporting. Once we have that data collected, we will certainly be able to provide you with that information.

KELLY REGAN: We don't know how many vacancies there are in long-term care homes across the province right now?

BARBARA ADAMS: We know exactly how many of our facilities are operating at the 4.1 hours of care, how many are fully staffed at that level. Right now, 40 per cent of our facilities are already achieving the 4.1 hours of care, so they have zero vacancies. Forty per cent are recruiting at that level, so they are staffed at the 3.1 hours or whatever staffing level they were at, and there are approximately 20 per cent that are not ready, whether that is for CCAs, LPNs, or RNs. When we have mandatory reporting, we will have those statistics.

KELLY REGAN: I'm sorry if I'm misunderstanding something here. You said that we do have mandatory reporting now?

BARBARA ADAMS: That wasn't in place before. We have implemented that recently. When that data is all collected, we will be able to report on that in the future. It's really important that we know exactly how many staff we have in our facilities because one of the things that we experienced in the past was that each facility did not have an equitable number of people, whether it was physiotherapists per 100 beds. It was very difficult when you were dealing staffing shortages if you didn't know exactly how many staff were in

each facility. This is one of the things that is a priority for our government, and certainly the CCA registry has given us that ability. Of course, one of the requirements is that we have no beds in our province closed due to staffing shortages at all, so we have sufficient CCAs in every facility to remain fully opened at this time.

KELLY REGAN: I'm obviously missing something here. The minister has said that we have mandatory reporting. Do we have mandatory reporting at this minute?

BARBARA ADAMS: As the member would know, all CCAs are required by law to register with the CCA registry. In the past, the survey that went out was a voluntary registry. It's an annual survey that goes out. When the next one goes out, it will be a mandatory survey.

KELLY REGAN: It's done by a survey. How often is the survey sent out?

BARBARA ADAMS: As I just said, it's annual reporting.

KELLY REGAN: It's a snapshot in time, it's not a monthly one where we have any idea of who is where or anything like this. This is actually a snapshot in time and happens once a year. Does that mean we don't know how many RN vacancies there are, how many LPN, how many nurse practitioner or physiotherapist? Do we have any of that information available right now or does that wait for a similar kind of thing?

BARBARA ADAMS: Just to reiterate something that was said before, it is an annual survey that goes out, but my staff are in constant contact with all of the facilities on a regular basis. We know that we have 40 per cent of our facilities already achieving 4.1 hours of care, so they are fully staffed at the 4.1 hours of care. We have 40 per cent that are at their level of care and are recruiting to reach the 4.1 hours of care, so they are fully staffed. There are approximately 20 per cent that are not quite ready yet to achieve the 4.1 hours of care. Our staff are working with all of the facilities on a regular basis to ensure that. The mandatory reporting will also give us that.

The other thing that we have is fixed envelopes of care, so we know that the money given to these facilities for employees is to be used for the employees. That is something that our government brought in. We are continually working with any facility that is in need of staffing. We will have more information in the future because the staffing reporting will become mandatory.

KELLY REGAN: Thank you for walking me through that, because I was not understanding why I couldn't get the numbers right.

Last year during the Estimates the minister said there were 6 of the 13 nurse practitioners hired or about to be onboarded in long-term care homes. Could the minister please update us on that number?

BARBARA ADAMS: Of course, as the member knows, we need nurse practitioners in all areas of care. As of December 31st, 79 per cent of those FTEs have been hired, and they're in place right now. We are recruiting internationally as well as locally to fill the remaining 21 per cent.

KELLY REGAN: Thank you for that number. In terms of VON and home care health care workers, what's the staffing situation like there? Are there challenges in there? Can you speak to the actual numbers about that? I know this may be not something you're able to speak to specific numbers, but could the minister share that with us?

BARBARA ADAMS: Happy to talk about that. How much time do I get?

We all know what the challenges were in home care, and certainly COVID-19 just laid bare what happens when you are short staffed in a sector where family are waiting for a continuing care home care worker to show up, and they cancel, whether it's evenings, weekends, or holidays. We know the number of home care visits for the previous five years before we became government went downhill and COVID did not help that at all.

Previously, governments had provided approximately 3 million or so home care visits. Last year, 2021-22, there were 4.5 million home care visits, or authorized hours, which is an extraordinary increase over the last couple of years, well above what was offered pre-COVID. It's the highest in the province's history. Those visits were provided by home care staff because the staffing in our home care agencies was supported because of the 23 per cent pay raise for CCAs, because of the free tuition. Many of those free-tuition programs, I think it's 70 per cent - don't quote me - of those taking the CCA course did the work and learn, which is an extraordinary change. That meant that people were able to go to school, and then when they doing their on-the-job training were actually able to get paid. Staffing in home care, although it's not perfect, is certainly far better than it was in the past.

One of the other things is - in addition to authorising 4.5 million hours of care - in the past, the number of clients seen was around 30,000 to 31,000. That stabilized for a few years. In the last year, 2021-22, the number of total home care clients increased to 38,575. That's a dramatic increase in the number of people needing home care and a huge increase in the number of people receiving home care.

On top of that, our VON care, which was under 1 million visits, was 1.1 million visits on top of the regular home support visits. At the same time as the number of people needing care went way up, the home care wait-list - when we took over in September 2021 - was just shy of 1,500 people on the wait-list for home care. It is now 800 people on the wait-list for home care. It has almost been cut in half, despite the fact that the number of people needing the care and the volume of care being provided has risen so significantly.

[4:30 p.m.]

One of the things we've seen is, because the injury rate in both home care and long-term care has been declining for the first time in my knowledge, we've seen more staff be able to return to the sector. Certainly, the 23 per cent pay raise for CCAs brought an awful lot of people back to both the home care and the long-term care sectors. What we are seeing is - although there are still gaps in home care and there are still instances where someone will say they cancelled on an evening, weekend, or holiday, or they were supposed to get two visits a day and they only got one - the number of visits has risen to 5.6 million hours in visits for the past fiscal year.

KELLY REGAN: Thank you very much for all of that information. Do we have any sense of - again, it may be difficult for you to provide because of the nature of the registry - how many CCAs are off on long- or short-term disability at this time?

BARBARA ADAMS: I don't have the exact number, but our estimation is approximately 400 staff are off due to injury, which is 400 too many.

What I can say is - and as a physiotherapist, I am extremely happy - that the injury rate in long-term care has been reduced by 15 per cent, and the injury rate in home care has been reduced by 8 per cent. That is a dramatic drop in injury. One injury is far too many, but there are so many workplace safety initiatives that have been put in place in the last year and a half. I just want to remind us of the significance of them because it's hard to understand how one little program can make a difference.

The Home Lift Program, which is $650,000 provided through the Red Cross, puts a lift straight in the home of someone. In the past, when you reached that point of needing a lift, there wasn't enough home care that you could put in place, because people just could not get in and out of bed, so either the family member was getting injured or the staff were getting injured. That's just one initiative that was put in place to reduce in the injury rate.

Then, of course, we have $420,000 for the Employee and Family Assistance Program to help support the psychological health and safety of all of our staff. Of course, there are safety training initiatives of $550,000 through AWARE-NS, which offers employees access to education and training to build their knowledge, to keep themselves and others safe in the workplace. I want to say, as an example, when I worked for six months during the pandemic up at Ocean View continuing care centre, I did more unsafe lifts than you can shake a stick at because I couldn't find somebody to come and help me. I shouldn't have done that, but you did what had to be done. So, making sure that the staff are fully staffed is the number one safety measure that you can put in place.

The other thing that we did is we brought in $1.1 million for the Stay-at-Work/ Return-to-Work program. That supports direct access for our staff to health care resources

to promote their recovery and to reduce the amount of time that injured or ill staff have to remain off from the workplace.

I just want to say again, caring for people in long-term care and home care is very physically demanding work. There have been far too many injuries. It is the highest injury rate in the continuing care sector - sorry, continuing care is the highest injury sector of all. That includes construction workers, and you can imagine how difficult theirs is.

For us, all of these investments in creating a safe work environment and supporting people to return to work safely from injury have been a key focus of our staff. We know that these safety initiatives are working because the number of staff who are off work because of injury has continued to decline.

KELLY REGAN: Prior to meeting me - I came on the scene well afterwards - my husband was engaged to someone else who was a nurse. I was not involved when they broke up, I just want to be clear. (Laughter)

She was working in a long-term care home, and I remember him telling me that he would pick her up and her arms would be covered in bruises. I have known about that for years.

I think it's in your mandate letter to hire 1,400 new CCAs. Is that correct? Do we know how many new CCAs have been hired, and also how many have left the system during the same time?

BARBARA ADAMS: There are a number of different routes that people come into the sector, and they're all working for - each individual nursing home is owned or managed by an independent owner, or non-profit or municipality. Each of them keeps their own roster of CCAs and how many are coming and going. In the past, where the reporting of CCAs was not mandatory, we didn't have an exact number. We have finally, after one year, a total number of the CCAs that are here. That is annually updated, so as that is annually updated, we will have the exact number of CCAs in the province. Because in the past, previous governments didn't count how many CCAs there were, we're going to have to go on a forward basis in terms of how many we're going to have. I will say that HANS itself has recruited 350 alone - the Health Association of Nova Scotia.

Moving forward, we will have exact reporting when the mandatory reporting of staffing comes forward. Then, on a go-forward basis, we will be able to provide that reporting in terms of the exact numbers of staff we have in all different professions across the sector, moving forward.

One of the other things that I just want to mention is that we have done a number of things to increase the number of CCAs in the province. As I mentioned, the newest is the CCA to LPN program. We know that is going to make it even more attractive for people to

want to come to Nova Scotia, when they see that they come in as a CCA and advance to the LPN sector, how we have over 1,000 students who are about to graduate in the next few months. We're excited to see them added into the workforce as well, plus all of the other students who are now registered for the next student year. Providing free tuition for an additional 1,000 students will help us to reach that mandate of hiring the 1,400 CCA students. Of course, as I mentioned, the work-and-learn program, which offers the two days a week in on-the-job training as well as three days a week in the classroom, has been a huge success in our sector.

Then, of course, we have expanded the human resources innovation fund and program professional development opportunities that will help employers to bring more employees into the workforce. With the mandatory continuing care assistant registry, which went live February 2022, we had a certain number of CCAs that were registered then. That was 8,298 CCAs registered in 2022. This year's registry was just shy of 9,000. I have the exact number floating on one of these pages. That's approximately 700 more than we had the first year. We have over 700 people going through their recognition of prior learning process as we speak right now.

KELLY REGAN: The registry went live in February 2022, and it was mandatory then?

BARBARA ADAMS: I love all this conversation about the CCAs and the registry. The CCA registry is mandatory. That was started. They knew that everyone had to sign up, and that process was ongoing. That's an annual registry. The renewal process is happening right now. It's like, I have to register with the College of Physiotherapy. I do it on an annual basis in December. Come January, the college will be able to tell you exactly how many people are there. There is a distinction, though, between the mandatory reporting of staffing in long-term care. That is a different process altogether. We will have both sets of data.

Also, the member had asked about the long-term care wait-list by zones. I have those numbers, if you'd like to them. The total was 1,679 - this is wait-listed from community. There are 346 from the Western Zone, 251 from the Northern Zone, 394 from the Eastern Zone, and 688 from the Central Zone.

I do want to say for the record that when our government took over, we weren't sure how many beds we had or how many CCAs we had. The staffing reporting was voluntary. It's very difficult to plan under those circumstances, so we've worked really hard with all of our employers to make sure that we have a very good understanding of the staffing levels in both home care and long-term care. Certainly, moving forward, as the years go on and we have the data, we will have a more robust ability to identify staffing levels across the sector.

KELLY REGAN: Just so I understand, in terms of the renewal process, the notifications go out when, and when do they need to be back for the CCAs who are working in the system?

[4:45 p.m.]

BARBARA ADAMS: The end of April is the renewal time for CCAs.

KELLY REGAN: When the minister said we're just about to have 1,000 to graduate, that was CCAs, am I right?

BARBARA ADAMS: Yes, that's just for CCAs. That doesn't include those who are going through the PLAR program or those who may be brought in from other provinces or countries around the world.

KELLY REGAN: I did mean to say congratulations on the work-and-learn program because, as former Minister of Labour and Advanced Education, I'm a big fan of co-op programs, and also a student. I did a co-op program at university too. I just think that people who come out of their training who have some hands-on training are just way more equipped to handle what the job throws at them along the way. My humble suggestion is that in any place where the minister can - and also you get some people working - any place where they can do that, that would be a good thing to do.

At Health Committee - I think it was fairly recently - the nurses' union suggested that RNs might be able to expand their scope in the long-term care sector so that seniors could get medication for non-complex ailments such as UTIs on-site rather than going to an emergency room. Is the department looking at expanded scope for RNs in long-term care? A UTI in a senior - I was astonished at some of the effects that it could have. If we could get those treated quicker and not have to cart somebody over to the emergency, I would think it would be a good thing, but the minister might think otherwise. I'm just wondering if you're looking at that.

BARBARA ADAMS: As somebody with a mother who seems to have a urinary tract infection every six to eight weeks, I know that it's a challenge, and it creates confusion and all sorts of other things that can seriously impact someone. The faster we can treat anything, we want to do that.

Certainly, all of the health professionals who are working in home care and continuing care, as well as in acute care, know that there are certain things that come up over and over and over again. We are always working with people to ensure that we are maximizing scope of practice. Of course, we certainly have advanced care paramedics who come into long-term care facilities. We have the clinical nurse practitioners, who are able to prescribe as well. We are revamping all of the physician forms to make sure that we are not inappropriately tying up a physician's time to fill out forms that they don't need to be

filling out. We are looking at prescribing capacities right from frailty level 1 through to frailty level 9 and trying to figure out the best ways to do that.

Falls and urinary tract infections are probably the two most frequent things that you see that can take you to an emergency department. We're looking at all opportunities to reduce the transfer rate and to speed up the ability to track someone who might have a predisposition to a urinary tract infection.

KELLY REGAN: We know that we have refugees from Kenya coming into the system to work as CCAs. Do we know how many have come in, how many are working in long-term care homes now?

BARBARA ADAMS: My staff are just collecting some information for me, but there were, as I mentioned in my speech, 65 conditional offers. As you can imagine, there's a bit of a time to process all of those, and there are an awful lot of things that have to be in place to have someone move from another country to Canada. There were 65 conditional offers that were made, and they're working through that process right now. If I'm given any more information, I will come back to you on that one.

KELLY REGAN: Perhaps when the minister comes back with additional information, we can find out if any of those 65 offers have been accepted and the people are actually here working now.

Not long ago, I had a message from a friend who was working with a company, and they were trying to bring over - I'm not sure if it's nurses or CCAs, not from Kenya but from Lesotho, in southern Africa. They couldn't get an answer from the government. It may have been simply that it was a different kind of training or whatever.

I'm just wondering - when Nova Scotians, when MLAs, when any of us hear about these kinds of opportunities and people who would like to immigrate here, who would you like us to send them to? I'm assuming it's the Office of Healthcare Professionals Recruitment or whatever, but I would like to actually have a number and a name that I can refer people to, because we need as many - whether it's a doctor, whether it's a CCA, wherever they're coming from, I want to make sure that I'm sending them to the right people. I would suggest this might be a good thing to send out to all the MLA offices, that if you're hearing this, we want them, and this is who you talk to. Otherwise, we're just kind of like, Well, let's see, I'll just call somebody and see if they know something. I don't know if they were CCAs or nurses, but they ended up going to P.E.I. That's where they ended up.

BARBARA ADAMS: We never want to hear about anybody who would rather come here going to another province. We certainly don't want that. I do have one of my staff here, Sarah Melanson, who is responsible for all of that. She's certainly happy to take any phone calls. On a different level, we very early on got funding for six CCA recruiters.

That's in additional staff to just recruit CCAs from around the world. What I can say is that the Health Association of Nova Scotia manages that part of the system. If anybody is looking for a number - I'm having Tracey look up the HANS phone number right now. (Interruption) Yes, so you know.

The Health Association of Nova Scotia has been an extraordinary partner for us, so that's where all those inquiries would go. Certainly, if it's another allied health professional, like a physician, then they would go to the physician recruitment team.

Just to wrap up - this is a great team, I have to say - of those conditional offers, 26 of them have been accepted, which is a great start.

KELLY REGAN: That's great news. So 26 have been accepted. Are they actually here practising yet?

BARBARA ADAMS: They have all been matched, and they have had employers who have accepted their applications and have found a position for them. Now the employers are going to work through the process of bringing them here and getting them settled and wrapping the supports around them.

KELLY REGAN: The employers bring them here. Do they pay to do that? How does it work? I'm just curious as all get-out. If someone's immigrating from another country, does that person who is immigrating bear the cost? Do we bear the cost? Is it the employer? How does it work?

BARBARA ADAMS: In this particular case, we do have a sponsorship program, and the employers pay to bring them here and help support them when they get here.

KELLY REGAN: I'm just wondering if we're recruiting more CCAs from other refugee - I hate to say camps - refugee situations, I guess.

BARBARA ADAMS: I appreciate the delicacy of how you describe it because it's an extraordinarily sad situation.

We're planning out the next trips coming. Certainly the intent and desire would be to return to the refugee camps, if you will, in order to bring more health care professionals and others who want to come to Nova Scotia. There are certainly plans in the works for those future trips.

KELLY REGAN: For the long-term care homes that are bringing them in, do they find housing for them? Is that part of the supports that they wrap around the new recruits?

BARBARA ADAMS: There's an extraordinary support system that each of the facilities is trying to put in place for everyone who's brought in. Oftentimes, someone

who's coming has relatives or friends who are already here, so those are supports. There's Grand View Manor - the owners of that facility purchased a home for some of the immigrants to live in. We certainly recognize that that is a major challenge for people to be able to come and find housing that they need. There are plans moving forward to try to help the employers to support their employees.

KELLY REGAN: That gives me a little more sense of what's going on in that particular situation.

On the matter of 4.1 hours of care, the minister said 40 per cent are doing the 4.1 hours, 40 per cent are doing 3.1 hours, and then we have 20 per cent that are not up to even that 3.1 hours. Do we have any sense of how many of the 3.1 hours folks are going to move to 4.1 hours during the next year?

[5:00 p.m.]

BARBARA ADAMS: I just want to clarify that not all of the ones not at 4.1 hours are at 3.1 hours. Every facility had a different level of hourly rates. There were some that were already at 4.1 hours. So 40 per cent are already achieving the 4.1 hours of care. There are 40 per cent that have all their beds open. They're fully staffed and ready to bring on the additional staff that would bring them up to 4.1 hours of care. It doesn't mean that they're necessarily at 3.1 hours right this minute. They could be at 3.2 hours or 3.6 hours. Every one of them is different.

Then there are 20 per cent that aren't fully staffed yet, so they're not able to go up to the 4.1 hours of care.

Specifically, when we announced the 4.1 hours of care, the number of staff addition needed to achieve that was 550 additional long-term care staff. Approximately 400 have been hired. We're short 150 staff in order to bring everybody up to the 4.1 hours of care.

KELLY REGAN: The 40 per cent that are at least at 3.1 hours, which is what I understood - yes, okay. We just know that if we hire another 150 CCAs, then we're going to get everybody up to 4.1 hours or the ones that are at 3.1 hours and higher to 4.1 hours?

BARBARA ADAMS: The additional staffing to get everybody up to 4.1 hours of care was estimated to be 550 staff members. We're at 400 right now. Of course, staff are always coming and going. I forget, I think it's 10 per cent to 20 per cent of staff change where they're working in a given year. I don't know if that number is stable. That's what it was like when I was there. There may be people coming and going, but of those facilities that are recruiting right now and the ones that are trying to get up to the 4.1 hours of care, it's approximately 150 staff that they are looking to recruit and retain.

KELLY REGAN: We have 1,000 graduates who are supposed to graduate. I'm assuming that we're pretty sure we're going to make the 4.1 hours at the end, once these folks graduate, which I'm assuming is in May.

BARBARA ADAMS: The exciting part is that several of these programs end at different dates. It's not like when I graduated. Everybody graduated in June across the country, and if you were going to be somebody, you had to get them on July 1st. The way the programs are organized across the province, there are people graduating at various times. We need those increased staff to graduate because we are going to open up more beds. We are also going to see the number of seniors grow. We're going to be expanding the amount of home care that we provide. There will be a position - there will be a job for everyone who graduates in the province of Nova Scotia. We certainly need that.

As we increase the number of beds total, that's 1,200. We also expect some of our CCAs are going to want to go through the program to become LPNs and possibly other health care professionals, so we are building the workforce for the future.

Whenever you have a wait-list like we do in home care, even though it's half what it was before, we don't like people having to wait to get services in any area of continuing care. So those staff who are going to graduate over the next three to four months, we'll certainly be able to find them all jobs.

KELLY REGAN: I'm just going to switch up a little bit here in the final minutes of my hour and then pass over to my honourable colleague.

The other day in the House, you made a very interesting point, I thought, about seniors who are living on old age pension and CPP not being able to qualify for the rent supplement under the new rules. Has the minister been hearing anything about seniors not being able to afford rent? Is she concerned about that particular cut-off? Is that going to leave a lot of seniors out of luck if they're not spending 50 per cent of their income on their rent?

BARBARA ADAMS: Of course, as the member would know, the Minister of Municipal Affairs and Housing would be someone, I believe, who was asked about all this. Of course, any time a senior is struggling is always a concern for me. It is one of the reasons why we immediately brought out the Seniors Care Grant the first year and then we expanded it this year to $1,000. There are almost 40,000 seniors who were able to get that grant plus the Heating Assistance Rebate Program.

One of the things that people really don't talk about is if you're a senior struggling, you're not going to be paying for your home care. You might not be paying for any costs in long-term care. Those are the things that my department is responsible for. Certainly, there is a sliding scale when you are needing home care services. There are significant portions of seniors in this province who are not paying anything for their home care, who are not

paying anything for their long-term care, and now, of course, there are seniors who will get the high-dose flu vaccine and will not have to pay for that either.

Those are all things within my department.

KELLY REGAN: All of that is good news, but if they don't have anywhere to live, that's a really significant problem for seniors. I was just wondering what the minister would say to seniors who are unable to afford their rent now, what she would say to them, given that it's not just long-term care that the minister is responsible but also she is responsible for seniors. I just don't know what to tell people in my riding when they find out that the rent supplements have been jacked up. Don't get me wrong. There are people who are absolutely spending 50 per cent of their income on housing - or more - particularly people who are vulnerable, who are on income assistance, who are disabled. Some of those people are seniors, and some of the people who are spending 48 per cent of their income on housing are seniors. They're not going to get these new rent supplements. If somebody becomes a senior, they retire, and they're on this, they're not going to be eligible, and I don't know what's going to happen to them.

THE CHAIR: The honourable Minister of Seniors and Long-term Care, with five minutes. Afterwards, we can take a quick recess, if you like.

BARBARA ADAMS: Thank you. I have a senior's bladder. I appreciate that.

One of the things that people don't even think about is we had under 8,000 long-term care homes for people in the province. We're going to build an additional 1,200 homes for seniors. Many people who are going to qualify for those long-term care home beds are not going to be paying any premium to stay there because of their income level. That is within my purview as the Minister of Seniors and Long-term Care.

There is the seniors housing program, which is under the Minister of Municipal Affairs and Housing. Also, the federal government has increased CPP, Old Age Security, and GIS for seniors in the Province of Nova Scotia. Of course, we work very closely with all of the other departments in our government. One of the things that I want to say is that there is enormous work being done in our department to ensure that our most vulnerable seniors get as much of the care from the community care sector as they can.

We also have the Seniors' Advisory Council of Nova Scotia, which is a government advisory council. They have a subcommittee, and they are working on providing recommendations to government and to provide us with advice on this.

One of the things that my staff have heard me say over and over again is the experience of family members looking after loved ones is something that is extremely important to me, not just the care of the senior themselves. I know that there are circumstances where an adult child has taken a loved one into their home because that was

what was needed. We appreciate when parents and seniors are living together. They support each other in a lot of different ways.

I know that there are challenges. I know that the Minister of Municipal Affairs and Housing, who is responsible for housing in the Province of Nova Scotia, has spoken about this. I can't repeat all of the investments that he has talked about because I don't have his list along with my list of investments - but there are a lot of direct benefits to support seniors in the Province of Nova Scotia. There are the expanded home first benefits. There are benefits for those who have dementia. There is the Seniors Care Grant.

Certainly our department is working on making the access to the programs that we have for continuing care even easier to access. That work is continually ongoing. One of the things that is also really important is that the family members know that they have the ability to reach out to our continuing care staff to get the supports that they need from the caseworkers. I know that my staff work very closely with all of the care coordinators in the province to ensure that people who want to remain in their homes are understanding all of the programs that they need to access.

Other things like the home renovation through Municipal Affairs and Housing to make it even easier to make the renovations that they have - things like the CAPABLE program - are also there to address people who want to remain in their home longer. Access to the equipment from the Health Equipment Loan Program. All of these things which seem like little things - if you have a hospital bed and you have toilet safety rails, and you have a Hoyer Lift, and you get the education that you need to keep a loved one home - can make all of the difference in the world. We're extremely happy that the CAPABLE program, which ironically came from a member of the Liberal Party - it was a recommendation from one of their members to look at providing this kind of support to people in their homes - means that we are trying to enable people to stay in the home that they already own or wherever they're living right now. There's an awful lot of effort there to make sure that people can remain in their home for as long as possible.

One of the other things is the Caregiver Benefit, which people don't often hear about. It is to recognize the support that caregivers give to a loved one that means they can remain home longer than they would have otherwise . . .

THE CHAIR: Order, please. The time has elapsed for the Liberal caucus. We will take a five-minute recess and then we will start with the NDP.

[5:15 p.m. The Committee recessed.]

[5:21 p.m. The committee reconvened.]

THE CHAIR: Order, please. It is now time for the NDP caucus, which will have an hour.

The honourable member for Halifax Chebucto.

GARY BURRILL: I'll begin, I guess, where my colleague from the Liberal Party left off. I thought it was right, in the opening statement, that the minister had to speak about the broad range - I think the word that was used was "holistic" - of concerns that have to do with - I think the phrase that was used was "aging well in Nova Scotia." There is this broad range of elements that are within the department's legitimate purview.

When we speak about aging well in Nova Scotia, department or no department, I really don't think we can evade, at the moment, the question of housing - in particular, this growing serious issue in the life of seniors in the province of the homelessness of seniors. It is quite startling that 15 per cent of people living on the street in the HRM are seniors. When they asked that question in that point-in-time survey of people who are homeless, when they identified those for whom this is the first experience of homelessness in their life, they asked of that group of their age, they find that a quarter of them - actually a little more than a quarter - are over the age of 60. I want to ask a couple of questions related to how housing pressure and homelessness related to it among seniors are affecting the lives of seniors in the province and to ask what the minister thinks about it.

I'll go back first to the issue that my Liberal colleague was raising about the recent changes in the rent supplement program. People speak about 30 per cent and 50 per cent. What does this mean? It means that till January, if your rent was more than 30 per cent of your income, you qualified. Your application would be received and processed, and it was a pretty good chance you would get a rent supplement. With the change of the last couple of months to 50 per cent, unless your rent is 50 per cent of your income or more, you no longer are eligible for the help that comes from the government's rent supplement program. I do think it's incumbent on the government to recognize when we say, Who is in this 30 per cent to 50 per cent category?, a considerable part of that category is people with OAS and some modest CPP income. This is a pretty significant group of people in Nova Scotia with old age pension and some but not a great deal of CPP.

I want to ask the minister if she is not, as the Minister of Seniors and Long-term Care, concerned that this is a change that is going to have a negative impact on seniors homelessness in the province.

BARBARA ADAMS: As the member knows, I am the Minister of Seniors and Long-term Care. My staff have a budget of $1.33 billion to deal with the issues that we are responsible for, which is adult protection, which is home care, and which is continuing care. I have my staff behind me here who are more than ready and able to answer the questions as they relate to my department. I understand that the member is passionate about this issue, as others are. I also know that the member has asked the Minister of Municipal Affairs and Housing and the Premier these very questions. I will encourage the member to continue to raise those questions with the correct department. My staff are here to answer questions on what our department is responsible for.

GARY BURRILL: I just want to be clear about that. Is the minister saying that she does not regard my question as a legitimate question for the Minister of Seniors and Long-term Care?

BARBARA ADAMS: No, that is not at all how I would characterize my answer. As the member knows, we have an entire Department of Municipal Affairs and Housing which is responsible for this. I am very privileged that the deputy minister of my department is also the deputy minister of Municipal Affairs and Housing, so I am acutely aware of the challenges that seniors are facing in the province of Nova Scotia. We have a number of subsidy programs in the province. There are a number of grants. There are a number of programs that we offer in continuing care that support people financially to remain in their homes longer.

Just to remind the member, some of those programs are the Seniors Care Grant, which almost 40,000 seniors in this province benefited from. It's the first of its kind in our province. It was $500 the first year. It was $1,000 this year. We also have the Caregivers Benefit, which is up to $400 a month to help those who are trying to look after a loved one in their home. That is within my department's purview. We have an extended care benefits program. The combination of those programs have provided - I forget the number - over 5.6 million hours of home care to people in this province. It has also allowed families to hire someone to come into their home who is of their choosing, which is a newer program for the province of Nova Scotia. We also have several hundred thousand dollars' worth of age-friendly grants to bring programming and services to seniors in the province of Nova Scotia.

Some of the other things that we have done to support seniors in this province is the Alzheimer's Society and doubling the budget to provide the programs and services to help seniors remain in their homes, to help families know how to address the needs of someone with dementia. It is a disorder that very few people know intuitively how to handle, and the Alzheimer's Society of Nova Scotia is the first stop, first step, for physicians and anyone who is facing a diagnosis of dementia.

We also have another number of programs around the province like Chebucto Links, like Community Links, like the wheelchair and home equipment loan programs that are going on in the province. The number of things that we have done is so varied that I have both sides passing me information. The expanded Home First program is $25 million. The Self-Managed Care Program is shy of $10 million. The Supportive Care Program is $8.9 million. Independent living is $472,000.

One of the things that I have said before, from 40 years of working in health care and going into people's homes and seeing the struggles that seniors and their family members are facing - housing is one of them, certainly - but the health care and the home care that people are looking for has been there historically.

[5:30 p.m.]

When I graduated from physiotherapy school in 1984, we knew the senior tsunami was coming. It always sort of shocks me how many people are taken by surprise when it comes to this. Years ago - I think it was, give or take, 14 years ago - the member for Argyle published that government of the day's strategic plan for continuing care. That was the last strategic plan for continuing care in Nova Scotia until our government came up with the Action for Health strategic plan.

It makes me sad when I think about that, because if you don't know where you're going and how you're going to get there, there's no way to evaluate the success. The Action for Health plan is specifically designed to answer the challenges that seniors are facing in the province. As I said, housing is certainly one of them, and we're acutely aware of that.

That is why we're going to go from having double rooms and in my facility at Ocean View Manor when I was there during the pandemic, we had four-bed rooms that had to be shut down. They were used for recreation and other things. The building of 1,200 additional single-bed rooms is a huge investment in the province of Nova Scotia in order to provide housing for those who are most vulnerable, those whose family has made that heartbreaking decision - I cannot look after you at home anymore - for whatever reason they make that decision. Building 1,200 additional single rooms to bring it to 3,500 new single rooms in this province is responding to the housing crisis in Nova Scotia.

There are also other food programs that we are putting in place in the province. There was mention in the Legislature during Question Period of a Meals on Wheels program where instead of the CCA going into the home to cook you a meal, we had a meals delivery program so the CCA who came to the home could do health care in the home while the meal was delivered. These are all designed to take pressures off families, to support them to be able to stay at home longer.

Certainly, those financial incentives, like the $1,000 a month for those with dementia - all of those initiatives, when you combine them all, take the financial pressure off loved ones in terms of where they're able to live. Of course, we have the Personal Alert Assistance Program, whereby if you don't have an income to sustain it, you get a free personal alert, which is a fall button which you wear on your wrist. It triggers an alarm to a family member or a neighbour if you happen to fall. There are an awful lot of supports that we're putting in place for seniors in order to take the pressure off them financially, which then helps with the housing situation.

Another thing that the Seniors' Advisory Council was calling for - all of those organizations - was the coverage of the high-dose flu vaccine. That's another financial support for people who are still living at home. I forget the dollar amount - $4.7 million of additional funding to provide supports for people like that.

Then we talk about the CAPABLE program. I'm so excited about it. People are all familiar with the INSPIRED program, and that's for COPD. It's a home-based program that takes the pressure off people to have to travel to go get the care that they might have otherwise had to travel to get. The CAPABLE program is going to bring an RN straight into the home of a person who has mobility challenges. That RN is going to assess the needs of that person who is challenged as well as the needs of the family members. They're going to educate them on things like medication, like meals, like keeping them moving. It's also going to send an occupational therapist in for six visits as well that are going to help train the family members on how you keep someone mobile as opposed to how you compensate by doing things for someone.

Then, of course, the newest thing is bringing the home renovator in to pay for home renovation needs that the family members would not have otherwise been able to afford on their own. That helps to deal with the housing issue. My own mother is a perfect example of this. When an elderly person gets to the point where they can't get up out of a chair, the family member's first instinct is, well, got to put them in a nursing home. You can go to Lawtons or Harding Medical or any one of the assistive devices facilities, and you can get these blocks that go under someone's chair and it will raise the chair up to the point where now that elderly person is able to get out of the chair. Or we will put toilet safety rails on someone's toilet so they can now transfer independently - or modifications to the bathtub so that someone will be able to get out of the bathtub with the support of one possibly elderly caregiver.

All of these extraordinary changes that we are bringing about address the housing challenges that people are facing. What we know in our hearts, and we hear it all the time, is everyone wants to stay at home for as long as possible. When we talk about the housing stresses for seniors, it isn't just affordability, it's accessibility. As a physiotherapist for 40 years, I have been teaching family members how to lift someone on and off the toilet, in and out of a wheelchair, into a car, getting them out of the bathtub. The CAPABLE program is going to allow us to help 300 Nova Scotians - this is just a pilot to start with - stay in their home a lot longer. Those are all strategies that we use to address the housing issue in Nova Scotia.

I know my department staff, when I first took over, I said, Okay, I have a whole slew of ideas. They said, Wait, Minister, we have ideas of our own, and they were way better than mine. I just can't thank them enough for bringing these programs forward in order to help Nova Scotians age longer into their homes.

We haven't mentioned it yet, but the frailty level starts at one and goes to nine before you pass on. What we're talking about with CAPABLE is before you get to the point of needing long-term care. We are talking about people remaining more independent, reducing their level of frailty. This is really one of the first programs of its kind in the country - it is first-in-country for the CAPABLE program. The researchers who created

this program are working with us to make sure that it is implemented to the full abilities of the program.

Those are the things that our department is certainly doing to help improve the housing accessibility and affordability issues in the province.

GARY BURRILL: I would like to suggest that an improvement in the minister's level of succinctness, I think, would be respectful.

I want to go back to the matter of this holistic view of aging well in the province. I really don't think we take this holistic view without speaking in a policy-direct way to the crisis around seniors housing. There's one particular element I want to ask about the minister's involvement in. That's this question of the 95 per cent with the rent supplement program. I'm sure the minister would be aware that there is this - certainly seems like an ageist - policy under which one's rent supplement is calculated by a combination of average market rent and income until you turn 65. At 65, it becomes calculated at 95 per cent of average market rent. Therefore, when people who receive supplements turn 65, their supplement declines. I'm aware that the department, the government, is reviewing this policy. I think it's a policy that needs to be reviewed. I just want to ask the minister if she has made any contribution to the review that's taking part in on this policy. Are she and the department advocating for any change about the 95 per cent at 65 rule?

BARBARA ADAMS: As the member would know, these questions were all asked to the Minister of Municipal Affairs and Housing, who is the appropriate person to answer these questions.

GARY BURRILL: I want to ask another question related also to this. From the point of view of the concern about the increase in seniors homelessness, we do see in some other jurisdictions that there are now programs of eviction control for low-income seniors. For example, in Quebec, if a senior has lived in their place for 10 years, and they would qualify for public housing, they may not be evicted. I wonder if the minister has any opinions about whether this might be fitting in Nova Scotia.

BARBARA ADAMS: As the member would know, we have a number of government departments that are all responsible for various aspects. I am super happy to talk about what my department is responsible for. The Action for Health plan that our government brought in crosses all government departments. There is not one single department that is not involved in and invested in working to improve the health of all Nova Scotians of all ages.

As you know, the investments that we have made in continuing care have paid dividends across the board. When you take stress off one part of the system, you take stress off other parts of the system. I want to take this opportunity to say that the increase in the staffing levels to national trends to be the leader in the country is historic. To have cut the

wait time for home care almost in half in the first year and a half is historic. To see a reduction in the injury rate in home care and long-term care is historic. Those are the things that my government department has been working on in partnership with all of the other government departments.

I certainly know that the impact - as I travel around the province - we don't talk about it very much, but we have been doing a listening tour for the last year and a half. I have gone home in Metro and around the province to speak with the long-term care agencies, the home care agencies, the Seniors' Advisory Council, those who provide the senior safety coordinators - meeting with all of them to ask how things have changed for them over the past year and a half.

I'm reminded of when the long-term care expert panel report came out. Ironically, it was a day of - I don't know how to describe it but I remember the day like it was yesterday. When we were expecting the report to recommend the staffing level in long-term care, and the board that created the report said we don't have sufficient data to make a recommendation, I remember our caucus staff - and my comment at the time was, She might not have been able to make a recommendation for what the staffing level should be, but it certainly has to be higher than it is.

When our government came on board, and my mandate letter said 4.1 hours of care, that said to the entire province and to the people working in this sector, we know that you have been struggling, we know that there is not equitable staffing across the sector, we know that there hasn't been sufficient accountability, and we know that the wages are not sufficient for what the staff demands are.

Those are all of the things that my department staff have been working on and towards. As I'm going around the province, what I am hearing is that that sector pride that that long-term care expert panel recommended needed to be promoted. We knew that we were going to need to pay the staff well. We were going to need to elevate the staffing level. We were going to need to fix things in these facilities that were broken. We were going to need to build new nursing homes. We are doing all of these things. At the same time, the injury rate in this sector, despite the number of beds being all open, has dropped for the first time. I don't remember whether it's ever dropped before. I don't believe it ever has. These are extraordinary things that our department has accomplished. What I want to say is that we're just getting started in terms of what we're bringing to this sector.

We had to stabilize a sector that was hemorrhaging staff across the board - all staff, not just allied health care staff. I know that the $350 million bonus that was given was not just given to health care staff. It was given to all of the staff who are working in this sector. That was an important step to take for our sector, to say thank you to everyone and to encourage people to take pride in working in continuing care. When you build sector pride, it becomes a first of choice.

[5:45 p.m.]

When I graduated from physiotherapy, working in long-term care was not something I ever thought I would be doing, despite working with the elderly. I was an acute-care health professional all the way. Then as the number of seniors grew and home care challenges quadrupled, we saw the need for home care. When we invest in all of the programs in my department - for continuing care, for home care - and direct benefits, we are supporting seniors across the sector, across all government departments.

We know that we need to do more. There's no question. We are going to build 34 nursing homes and add to the number of beds from 8,000, give or take, to 9,200 in the next several years. That is good for the economy. That is good for the family members who support seniors. When we have all of our beds open, we know that that's good for Nova Scotians. When you look back in Hansard at the debates on long-term care over the last 12 years - I have done that, I have gone to Hansard and typed in "long-term care" and gone over every discussion that has been there. There were times when there were over 800 people in acute care beds waiting for long-term care. That is a number that we cannot emphasize enough, that we are down to 250 people. There are plans in place, when these other facilities are open, so that when someone needs to get into home care or an adult day program or they need respite care, people are able to access that when they want to.

I just wanted to say that the changes that the department has made have brought about an improvement in all of the metrics that one can use to measure success. I could not be more proud of all of the staff and the over 16,000 staff who are working in the sector to bring about those changes. We might be the face of the sector, but it is the staff who show up every day, all through the pandemic and now, who are making the difference. I'm so glad that when we go around the province, we are hearing that there is hope that the improvements are going to continue and that as time goes on, every Nova Scotian senior will have the ability to have that continuing care in the way that they want to have that.

GARY BURRILL: I would like to ask a couple of questions going back to some things I have asked the minister about in the House this session that the format of Question Period doesn't leave very much time to unpack the answer that's needed.

The first is about alternate level of care. When I asked the other day about alternate level of care, there were a couple of things, I think, in the answer. One was speaking particularly about the policy of long-term care fees being charged for people with ALC. The answer was one, this long-standing policy has been around for a long time, and two, the new transitional units are going to address this.

I think both of these things, obviously, are true, but they probably don't fully address the question. It is likely that - although in much-diminished numbers, we will hope - there will continue to be ALC patients in different parts of the province. This is a stark inequity. You think of people having zero recreational programming being out of the

mainstream of acute-care life. You hear acute-care people, allied health people, say that basically the institution doesn't really know what to do with them. It's a disorienting time.

Through my own work in hospitals and long-term care, I have been with quite a number of families when they first learned that they would have to be paying long-term care fees beyond a certain day. They were hurt and shocked, and the hurt and shock stays in their conversation. I want to ask the minister if she will move to abolish the charging of long-term care fees to people who are in an ALC situation in our hospitals.

BARBARA ADAMS: I appreciate the question. I like having a little more time to answer than 45 seconds in Question Period.

I remember the first time I heard about this. My uncle and my mother had strokes at almost the exact same time. My uncle ended up in acute care at the Halifax Infirmary for six or seven months, give or take. I remember being surprised when I was told that he was being charged a rate to stay there. I was told then, and I believe it's the same now, that if you are medically stable but waiting for a long-term care bed, this is the rate that you are charged.

That is a Nova Scotia Health Authority policy. It doesn't fall under me. I don't charge them. It's Nova Scotia Health. I know that that question's been asked to the minister there.

The solution is for the beds to be available when people need them so that they don't have to remain in acute care. I will agree that when you're in acute care, it is specifically set up to receive acute care. The ability for somebody to have the same kind of recreational services - the entertainment, the dog that comes in to visit, the kids who come, the arts and crafts, the music - all of those other things that are part of recreation, there's no way to offer that kind of programming in acute care. I agree that what you're receiving in an acute-care facility is not the same as what you receive in long-term care.

The ultimate solution is to have the ability to go from when you need it into a bed. That is certainly the strategy that we're working on, and certainly those transitional care units are designed to be an intermediary level of care where there are those opportunities to participate in the recreational programs.

I don't like the word "recreational" because as a physiotherapist, "recreation" doesn't adequately say what they do. Once somebody is stable and medically not needing acute care, the recreational opportunities that you could get are what make life livable. It's the haircut. It's being able to go and sing songs. That matters. You can't offer that in acute care. There's not the room to provide for it, and certainly it's not the mandate of acute care. For the continuing care department, we know that the solution is to have a lower number of people in those ALC beds.

I will say just - my mother lived to be 92. Her frailty level was going up and down depending on whether she had a fall, depending on whether she had a drink of Kahlua later on at night - she'd kill me for saying that, but it's true - or depending on whether she had a bladder infection. It depended on whether she had a flu bug and didn't eat for a few days.

I know that there are always going to be some people in those acute-care beds, because frailty can fluctuate with one fall. One fall, one hip fracture - we know that there are always going to be some people who need those ALC beds because they're not stable and they need to be there.

Our department is working really hard. We've done the predictive models of how many beds we are going to need over the next five, 10, and 20 years. We are building for the future. Not every bed is going to open right away. If I had a magic wand, I would make that happen, but that's not possible.

What I can say is that there are fewer people in those ALC beds than ever. Historic highs of - I think the member himself has been quoted in Hansard, that there are 700 or 800 people in acute-care beds. One of the reasons why there are so few, although 250 is 250 too many - 75 per cent of the people on the wait-list for long-term care are getting home care. That's why we have this historic increase from around 2.5 million up to 4.1 million getting home care now. There are far fewer people needing those ALC beds right now.

The other thing, too, is that there are a lot of people - and I don't have the number with me - who, by virtue of their income, are not paying to stay in acute-care beds while they wait for long-term care. There is no fee. My uncle, he paid the fee because he worked for MT&T. He had a good income, so he did pay the amount that's there. But it is prorated depending on what your income level is. That's been historically the case.

When we have more beds open - of course, there are three new facilities opening this year. That means that there will be fewer and fewer people waiting for those ALC beds. That's short-term. In the medium term, we have those transitional care beds. They are specifically designed to address the issue that you raised, that you cannot get in acute care what you would get in transitional care or in long-term care. That is why we're making those investments. That's why multiple departments are all working on making sure that that's there.

The other thing that some people aren't aware of is that those who are in ALC beds have the highest priority for being placed into long-term care as well. We have the expanded Home First benefits as well, which is why we've gone from being able to provide care for around 31,000 up to 39,000 people. It's to get people out of those ALC beds. No one wants someone to have to sit in an ALC bed. The family members certainly don't want them there. The residents themselves don't want to be there. Our department staff want them to be where they need to go.

In some cases, we're able to get people back home because of those expanded home benefits. That's certainly the ultimate goal, to have people leave acute care as quickly as possible.

GARY BURRILL: I guess it's obvious - I understand that having a long-term care bed is the solution, and an infrastructure development program that makes more long-term beds is the path to the solution. But I don't think it changes the fact that, although we will hope that many fewer - there will be people in ALC situations going into the future. But that very fact means that the cost to the government, within a couple of years of eliminating the policy of long-term care fees being charged to ALC people, will be an awful lot less.

[6:00 p.m.]

I do understand that it's not a policy of the minister's department, but it's certainly a policy that is within the department's world. I want to ask the minister: Looking toward this upcoming period, where we are hopeful that there will be many fewer ALC patients, is this a change in the interests of fairness, that you would be willing to advocate for - no more long-term care fees for people in ALC?

BARBARA ADAMS: As the member knows, the Minister of Health and Wellness - it is a Nova Scotia Health policy, and I know they are always looking at the options that they have available to them. I thank the member for raising that concern in the House as well as here. We are in communication with that department every week on an ongoing basis, and we will certainly continue having those discussions.

GARY BURRILL: My memory from our research is that it was very close to the area of $5 million in revenue that the province had taken in last year from these fees. Can the minister provide some sense of the anticipated range this year?

BARBARA ADAMS: As the member would know, that would fall under the Minister of Health and Wellness's budget, so I wouldn't have those numbers.

GARY BURRILL: The other thing that we had spoken about in the House - I guess last week - was the path to one resident, one room. In the minister's opening statement, there were quite a few numbers of net new beds, new construction, and so on. We know that there are often discussions in the media and elsewhere about how many of these are new beds, how much is actually - and so on. I feel like, and this is what I was trying to get at with my question in the House the other day, this is probably not the most productive way to go at it. Probably the most productive way is to think about the goal. We agree that the goal is to be in a place of one resident, one room, one washroom. I don't think there's anybody coming out of COVID who has a different opinion in the world of long-term care infrastructure - provided, of course, this is for everybody who wishes to have one.

The question I asked in the House I would like to put again: Is it the government's plan that we will be in a place of one resident, one room, one washroom by July 2025?

BARBARA ADAMS: I'm a numbers person, and I frankly drive my staff crazy because I always want the numbers for everything that we talk about. Just to clarify, we have just shy of 8,000 nursing home beds. When we are done with the 34 nursing homes that we talked about, that will add a net gain of 1,200 beds. We will go from just shy of 8,000 beds to just shy of 9,200 beds. Of those, there will be 2,300 additional replacement rooms, which will all be single rooms. That's a total of 3,500, which will all be single rooms, single bathroom.

In terms of when everything else is coming online, we have three nursing homes that are opening this year: Mahone Bay, Villa Acadienne, and Kiknu. They will all have single beds, which is what we are committed to - not just because it's good for COVID but also because it's good for care as well as the privacy of family members.

There are 14 facilities that are going to open in 2025. That is Taigh Solas, Mountain Lea Lodge, The Birches, R.C. MacGillivray Guest Home, Carefield Manor and Dominion Community Guest Home, Gables Lodge, The Highland Manor, and seven new facilities in Metro: one in Sackville, one in Tantallon, two in Bedford, and three in Dartmouth.

Then, of course, we know that the demographic trends have indicated that more rooms are needed beyond that, so to bridge the gap, our government is adding about 600 additional single long-term care rooms across the province on top of the previously announced approximately 600 net new. So there were 600 and we added 600, for a total of 1,200 net new.

The ones that I just read are for 14 facilities expected to open in 2025. Some of those are replacement beds, of course, but they will all be single beds. There are 17 facilities expected to open by 2027. I wish I could wave a magic wand and make them all open tomorrow, but you don't build things in one or two years. It takes time. So there are 17 facilities that are going to open by 2027, and they will all have single beds: Waterford Heights, Grand View Manor, Shoreham Village, Northwood in Fall River, Foyer Pere Fiset, Queens' Hillsview Acres, Dykeland Lodge, Harbour View Haven, Wolfville Nursing Home, Melville Lodge, Glen Haven, Victoria Haven, R.K. MacDonald, Valley View Villa, St. Anne Community & Nursing Care Centre, Roseway, and Maple Hill Manor.

When you look at the approximate timeline, we're looking at a number of facilities opening in 2023; an additional 14 facilities opening in 2025, which will bring a capacity of 1,250 single-bed rooms; and then in 2027, 17 facilities, for an additional 1,800 rooms.

Right now, 60 per cent of our nursing home rooms are single and 40 per cent are double. Some are double because people like them that way. They have good buddies in

there or they have a family member or a partner, and they want that to remain that way in some circumstances. By 2027, 81 per cent of residents in a nursing home will be living in a single room, so we'll only have 19 per cent who are in a double room.

Certainly the intent beyond 2027 is to reach the goal of 100 per cent of everyone who wants to live in a single room in a nursing home to be able to do that, although I suspect there will always be cases - if my partner and I end up in the same place at the same time and we have matching care needs, I would hope, depending on whether he snores, that we would be able to live in the same room. That certainly is a mandate of our government: to keep spouses together in long-term care. By 2027, we expect that there will only be 19 per cent who are still in a double room, but then with the additional facilities that will likely get announced in the coming years, we're working toward the goal of everyone who wants one having a single room.

GARY BURRILL: So 81 per cent by 2027. What per cent, and what absolute number, by mid-2025?

BARBARA ADAMS: The truth is, especially travelling around to the facilities that are building them, you cannot give an absolute number because of the pressures on the construction industry, the ability to ensure that there is sufficient staffing to build what needs to be built. There are always unforeseen circumstances that may come up, so you can't give an absolute number, but certainly the movement is to reach every single person who needs a single room to have that.

GARY BURRILL: By absolute number, I don't mean exact number. I mean the number as opposed to the percentage. If 81 per cent is the path by 2027, what is the percentage that we will have reached by mid-2025? Could that also be expressed in a number other than a percentage?

BARBARA ADAMS: As good as I am at math and how important numbers are, I don't have that exact number with me, but we can certainly provide that to the member later.

GARY BURRILL: Would the minister have, then, an approximation of looking at it the other way, the numbers of long-term care residents who would wish to have a single room who will not have one by mid-2025?

BARBARA ADAMS: I think that's the same question just rephrased. I don't have an exact number that I could provide the member with. To predict how well the construction market is going to go two years hence is not something that I'm able to do. We are going to build as fast as we can. We have our foot on the gas for every one of those facilities because we know how important it is to seniors, but I can't give you an exact number today.

GARY BURRILL: It's the trajectory, the path, that I'm asking about. There are always unknown things that have to be accounted for, but the approximate number for that exists, is within the department, and the department knows the answer to this - can it be provided?

BARBARA ADAMS: Of course, when we do projections in terms of where the population is going to grow, where staff are, where the housing is, where the infrastructure is that's going in, where the schools are being built - there are a whole lot of factors that go into play in terms of where you are building long-term care facilities in the province of Nova Scotia. We certainly know that the beds that are going to be added to the system are going to come online as quickly as possible. To that point, the ability to project is dependent on how quickly each of the facilities that's going to be built is able to move through the process. What I can say is that these needed to have been built years ago.

I would be remiss if I didn't remind members here that both the previous Liberal and NDP governments made cuts to continuing care. So we are catching up, and we having to build - 34 nursing homes is a staggering amount of builds. Ironically, when we were touring the construction sites of Mahone Bay and down in Cape Breton, it is often the same construction staff who have to move from one facility to the next to pour the concrete, to put in the electrical. Ironically, to build that many nursing homes at the same and to build schools and housing has created a pressure on our construction trades. That is one of the reasons for bringing in the MOST program to encourage young people to come back to Nova Scotia who are working in the skilled trades.

What I can reassure the member is that my staff behind me know this. They are working as fast as they can to support both the for-profit and the non-profit organizations that are responsible for bringing these facilities to build them. Of course, one of the things that we are doing is bringing in board governance training, because most people don't realize this, but in the non-profit organizations, it's the board of directors that has a huge responsibility in seeing that nursing homes move forward in terms of the construction process.

We are bringing board governance training to these facilities to help all of those newer boards, especially the ones that were decimated during the pandemic and couldn't even meet to be able to help them support the facilities that are going to be building these nursing homes. Some owners have a good track record. They know what they're doing in terms of building nursing homes, and they can move very quickly, whereas some of the non-profit organizations needed some support in terms of getting them through process as quickly as possible.

One of the things that we do when we talk about funding these new nursing home beds is we pay a per diem when the beds come online. It's not a capital cost up front. I just want to remind the members of that fact.

[6:15 p.m.]

We are moving as quickly as we can to bring all of these beds online and also expanding home care, which is why we're at 4.1 hours of home care. That was provided in the province as well.

GARY BURRILL: As the minister knows, we in the NDP have introduced legislation close to the legislation in Ontario making central air conditioning in facilities a condition of licensing. I'm hopeful to see that the government would take up this suggestion. I've been disappointed that it's not been part of the agenda of the government this Spring.

Our research indicates that - just through freedom of information channels - the government doesn't actually at this point know how many rooms there are that don't have access to centralized air in long-term care in the province. Is that information that the department is going to be collecting?

BARBARA ADAMS: When I worked at Ocean View Manor for six months, it started in April - April, May, June, July, August, September, October - I was there for the hottest six months of the year, so I understand why this is a significant question.

Just for the record, only Ontario legislates air conditioning. Just for clarification, seniors have a very different ability to regulate temperature, so not every senior needs air conditioning in their room. What we do know is that in Nova Scotia, 85 per cent of the facilities that we fund in this province have reported that they have sufficient cooling sources in their facilities as it stands. The ones who don't were like Ocean View Continuing Care Centre, that did bring in - that's a very cold building.

The facilities that we are building moving forward are much more mindful of the impact of temperature regulation on the residents in the facilities. There are certain areas like the kitchen where those needs are different than they are in a community room, which is much wider.

We do know how our facilities - because they've reported to us - are doing in terms of their cooling sources and their ability to meet those air conditioning or ventilation needs. It's not just air conditioning that you need as well.

We have 85 per cent right now, and when you're building 34 new nursing homes, there is an opportunity moving forward to ensure that the ventilation needs of the new builds are something that all of the facilities that are building in the future are mindful of.

Just a reminder: 60 per cent of our current facilities are more than 25 years old, and what was a requirement then is not necessarily what's a requirement now. It is not feasible to retrofit certain nursing homes with air conditioning systems. It is a significant issue, and

as I say, 85 per cent have indicated that they have sufficient ability to meet the cooling needs of both the staff and the residents themselves. It's not just the residents who are concerned about this.

The other thing is that we have added $25 million in new capital money this year in our budget to address some of those needs, especially for the ones that are still facing challenges in that area.

THE CHAIR: The honourable member for Halifax Chebucto with just under two minutes.

GARY BURRILL: Well, I don't have that kind of quantitative research at my fingertips that the minister does, but I know that the enthusiasm for this amongst workers in the sector, residents, advocacy organizations, and administrators is at a very high level. There is a great interest in this. When the minister says that we have a certain percentage of our buildings that, because they're old, it's not feasible, does that mean that we are not going to move in this direction because it's too expensive?

BARBARA ADAMS: Just on that particular question, there is a process by which a facility that wants to make improvements in those areas applies to our government for the . . .

THE CHAIR: Order, please. That concludes this round of questioning for the NDP. We'll move on to the Liberals.

First, we'll take a short recess.

[6:21 p.m. The committee recessed.]

[6:24 p.m. The committee reconvened.]

THE CHAIR: Order, please. Now it is time for the Liberal caucus.

The honourable member for Bedford Basin.

KELLY REGAN: The Seniors Care Grant just closed. You don't have any numbers yet on what the uptake on that would be, would you?

BARBARA ADAMS: This data is as of March 5, 2023. At that time - of course, that's over a month ago - there were 39,710 Seniors Care Grant applications approved, totalling approximately $19.53 million. In addition, there were 28,333 home heating grant applications that had been approved, for a total of $7 million.

Of course, the same number of people who got the Seniors Care Grant of 39,710 also got the Hurricane Fiona grant application, for approximately $9.82 million. The total budget spent at that time, March 5th . . . (interruption) Sorry. The total spent to date as of that date was $36.37 million, and our forecast was $39.2 million.

KELLY REGAN: Can you just say those again? I was crossing out the $19.53 million.

BARBARA ADAMS: As of March 5th, there were 39,710 Seniors Care Grant applications approved. That's a total of $19.53 million for that. Then in addition, there were 28,333 home heating grant applications that were approved as well, for a total of $7 million. Then the additional $250 for Hurricane Fiona was the same number of people who got the original Seniors Care Grant, which was 39,710, for a budget of 9.82 million. The total budget spend as of March 5th was $36.37 million.

KELLY REGAN: So the exact same number of people got the Hurricane Fiona grant as got the Seniors Care Grant?

BARBARA ADAMS: Anyone who applied for the Seniors Care Grant and got it was automatically sent the money for Hurricane Fiona. We did not make people come back and reapply for that.

KELLY REGAN: I think I asked about this the other day - hospice and palliative care. We're hearing they're facing significant challenges. Are they in any way associated with seniors in long-term care?

BARBARA ADAMS: As the member would know, Nova Scotia Health is responsible for in-home palliative care. That is a program that they are responsible for. One of the things that I'm acutely aware of, and it always bears repeating, is that every single person who goes into long-term care, with almost no exceptions, passes away in a long-term care facility. That's why this sector is extraordinary, because they're all palliative care workers in terms of what they have to do to provide support not just to the person who is palliative but also to the family member. I certainly know that 40 years ago, no one taught me how to help families prepare for a decline in function, let alone how to help them prepare for when someone passes away.

We know that palliative care starts in home care in the sense that people may have been receiving home supports from our staff. Then they may have gone into hospital, and now they're receiving palliative care services, which is a very unique specialty. It takes significant training in order to be able to do it well. I used to work in palliative care at the old Halifax Infirmary, and the amount of training and experience to do it well is significant. The actual palliative care service in the home is provided through the Department of Health and Wellness and oftentimes, it's because people were in an acute care bed. They've made

the decision - "I want to pass away at home" - so acute care arranges for those services for them to be able to go home and pass away with dignity at home.

[6:30 p.m.]

KELLY REGAN: I want to ask about something that I think kind of shocked people when it first came out. I think it was in the U.K., and that was a loneliness strategy, and there was a minister who was responsible, et cetera. One of the growing issues is that our population as a whole, but particularly our seniors, I think, is losing touch with their social networks and community ties.

I know that the minister spoke earlier about programs that have started up - the money that went out the door to help various communities restore some of the social networks that were maybe lost during COVID. I'm just wondering: Is there anything else that the minister thinks we should be doing to ensure that seniors have some assistance socializing, staying involved, et cetera?

BARBARA ADAMS: The social isolation that comes with aging is one of the biggest determinants of health that predicts how well you're going to age. What we saw during the pandemic is community groups and organizations step up to ensure that our most vulnerable were able to get the food, the medications, and other things that they needed.

I know in my own community we started the pandemic community action committee the first time around. Every organization and group sent a representative. We all met. We all identified those who were most vulnerable and made sure that the community reached out to them.

Then things settled down, and when the next wave came, the pandemic community action group got together again, and as it turned out, the community had independently adopted those in the community who were most vulnerable, the people who needed the food, who needed the transportation, who needed the medication. We even started a food delivery program through our food bank, and we had dozens of people willing to deliver groceries, and then we didn't need the delivery drivers because the community had surrounded the members.

One of the things that addresses that is our adult day programs. I forget the exact location of where we were when we went down to open up one in Queens - do you remember? In Liverpool. There was an organization there that got a significant grant from our department. I'm going to write a number down just so I don't get it wrong. Is that it? Sorry - $300,000 for a new adult day program there. It's an extraordinary program where people are able to bring a loved one there and drop them off. They're there for the whole day. They get a meal. In this case, they get a shower, which is a different take on adult day

programs. It is also a wellness check, both for the loved one as well as the family member who's dropping them off.

Those kinds of programs address some of the social isolation. The Meals on Wheels program - we've said all along that it is not a meal program. It is a wellness check with the provision of a meal at the same time. That Meals on Wheels program is expanding across the province.

The CORAH program, where you have community-based supports for seniors, again, brings people out of their homes and into the communities. The Age-Friendly Communities Grant - I've travelled around the province to meet with groups who are providing the programs and services through the Age-Friendly grants. Those things are addressing social isolation as well. There are assessments of seniors in the senior centres that we have around the province. We have Seniors Centres Without Walls.

I know even Northwood - and this was years ago - they have a friendly phone call. You can register yourself or a loved one and Northwood will have volunteers call you up. There are other volunteer organizations that will do your taxes, that will help you prepare a will or power of attorney or alternate decision-maker.

The challenges that we face - I certainly have experienced it myself. I have two sons and two stepsons out west and in Ontario who are not going to be here to look after me when the time comes. They have indicated as such almost in writing. I know that I can't count on them. I should have had girls. I said it. I won't take it back.

The social isolation is there for all of us of all ages. Technology is one of the solutions. One of the grants that happened in my community: A music for mental health group donated iPads to teach seniors how to FaceTime, to teach kids how to communicate directly with an older person. Those are parts of the solution to the social isolation.

It is a societal trend that kids are moving away from home. They visit, they text, but they're not here, so we are calling on community members to continue the great work that they do - the Lions Club, the Legions, all of the service groups, the Kiwanis, and all of the other agencies that provide care. It's one of the reasons we gave double the money to the Alzheimer's Society, because a lot of the people who are most socially isolated are those who have someone at home who has either a mental or physical disability where they can't just leave them with someone. They need special training in order to leave somebody with advanced dementia for a few hours to go out. The $1,000 a month for those with dementia is just one of the strategies that allow the person who is looking after them to get out of the house for their own social isolation. It's not just the seniors themselves. It's also the family members who are looking after them.

The other thing is we have the CORAH program. It's a partnership with NSCC. In the one CORAH group that was down in the Valley - in Middleton, more specifically -

there were over 5,000 users of that expanded program. We are going to bring that to another couple of communities around the province.

These are just some of the ways to try to deal with social isolation. We'll never have it licked. I know when I was a physiotherapist, whenever I was in someone's room, if a dog came to visit or if kids came to visit, my session was done. People wanted the socialization more than they wanted to have me in the room making them do things they didn't want to do.

We're going to continue to work on finding ways to bring people out of isolation because we know it's good for their mental well-being as well as their physical well-being. The adult day programs and CORAH programs like that are just some of the solutions we are focused on.

KELLY REGAN: I would just like to let the minister know that the Dartmouth Meals on Wheels, which operates out of the seniors centre in Dartmouth, their stove is on its last legs. They need some help with that. They need more funding, and they can't keep up, and they also need a new stove. I will just share that with the minister. I'll move on to my next question, but if she wants to comment on that after I'm done my next question, that would be great to hear, too, because I would like to hear a commitment that we could take back to them.

We're all sick to death of COVID, but the fact is COVID is still with us. We comb through the COVID reports, and from them we know that between May 10th last year and the end of February this year, 199 Nova Scotians over the age of 70 died in that period, an eight-month period. Just shy of 200 Nova Scotians died; 87 of them were living in long-term care. I find that astonishing, considering that COVID has been with us for three years, and we know how to keep people safe from COVID. We have vaccines. We're not protecting our most vulnerable Nova Scotians - 87 is more than died in the first year under our watch. With respect, the minister had some choice things to say about that.

I'm wondering if the minister could outline how it is that we are actually protecting senior Nova Scotians who are living in long-term care - how we're actually protecting them from COVID - because the numbers are not good.

BARBARA ADAMS: I will agree with the member in terms of the seriousness of the issue, but I will disagree with the characterization of it being worse than it was in the past. The reality right now is that there are only five of our facilities that have outbreaks right now. That is a historic low since COVID-19 began.

The member is indicating that it's not. When you have a total lockdown, that is one way of living with COVID. But right now, we are living with COVID. We do not have a total lockdown, for obvious reasons, because we do know a lot more than what we knew back then. We do have vaccines. We do have a robust public health policy.

Just to remind everyone here, an outbreak is when there are two or more cases. In the first wave of the pandemic - and this is a crass word, and I hate even saying it, but I don't know any other way to say it - the fatality rate in long-term care was 22 per cent in the first wave. It has consistently declined since the first wave. It is now at its lowest percentage ever. It is at 3 per cent.

Any death for any reason is tragic, but I want this member and all members here to know that having our long-term care facilities open and allowing family members to come in and allowing people to move freely throughout facilities with the most frail and vulnerable people in the province, who are at the greatest risk of passing away from every disease - not just COVID-19 but from the flu or any other communicable disease - is always going to be a possibility. Those who are working in long-term care know that they are doing everything that they can. They are doing exactly what Public Health would ask them to do. They are following every mandate that Dr. Strang and the government have asked them to do. To characterize things as being different than what they actually are is we have the lowest fatality rate percentage that we've ever had.

Now when you talk about numbers, there were over, or almost, 500 beds closed. So when you talk about the number of people in long-term care and the number of people who pass away each year, when you have over 500 beds closed, the number who pass away goes down, because pure numbers-wise, that is the case.

What I want to say again is that the fatality rate is the lowest it's ever been, at 3 per cent - zero per cent would be ideal, but that's not reality or a realistic expectation. The staff are doing exactly what they are asked to do by Dr. Strang and by the department of Public Health. They are always monitoring. They know exactly what is happening in all of their facilities. Given that we have 16,000 staff working in our continuing care sector, the amount of outbreaks that they have had to deal with has consistently declined, other than possibly during a complete lockdown, which is not something that the government or the public are looking at.

Just to remind the member, there were a number of recommendations that were put in place. Having long-term care assistance there to take off the pressures was part of the COVID-19 strategy.

We have infectious disease nurses who work in these facilities and not just for COVID-19. These are infectious disease nurses who are highly trained to be able to deal with any circumstances that would involve public health issues. I'm extremely grateful to the staff, but I want to be sure that when we're characterizing what is happening in long-term care, it is accurate and that the fatality rate of 22 per cent in the first wave steadily climbing down to the current 3 per cent is a fact, and it's a reality. Are we going to continue to strive for improved rates? Of course we are. That is a commitment that the staff have all made. It is also certainly one of the reasons why we are going to build so many new

nursing homes: so that people can have those single-bed rooms. That is a commitment that this government has made.

[6:45 p.m.]

KELLY REGAN: One would certainly hope that in fact the mortality would go down, given that we now do have vaccines, and we didn't in the beginning, and we didn't know how it spread, and we didn't know whether masks worked, and all of those things. One would have expected that. I have to say that in that same eight-month period - by the way, I'm not making up numbers. I took them from government reports - not that they're easy to find, but you can find them. We had 87 people die in an eight-month period in long-term care; 200 Nova Scotians over the age of 70 died at that same time.

What I keep hearing from seniors is that they quite frankly feel abandoned by this government. They feel like people have just said, You're old; it doesn't matter. COVID is here, we have to live with it, and you're the sacrificial lambs. The median age for death from COVID in this province is 84, which means, if you rank people from the oldest to the youngest who die, the halfway point is 84 - as many people over the age of 84 dying from COVID as below. It is not good.

I take the minister's point that they are following the rules as this government has determined, but let's be clear. Right now, I'm hearing from seniors - unbidden, just writing out of the blue - saying, I feel like I have been abandoned by this government on COVID. I feel like we're sacrificial lambs. They have just decided we have to get on with life, and away we go. Quite frankly, the 500 beds closed. Who closed those beds? The minister closed those beds because they had so many people out sick that they couldn't keep them open. Let's be clear on that.

Anyway, let's move on to something else. The national standards of care were recently released federally. Is the department looking into those?

BARBARA ADAMS: What I can tell the member is that these recommendations came out a couple of months ago and our department is actively reviewing all of those. What we already know is that one of the recommendations was an increased staffing level. We are already leaders in the country by bringing about that staffing level in Nova Scotia, by putting all of the investments in place to raise that staffing level there. We are also bringing about the single room, which was one of the biggest recommendations that came from that organization.

When you look at all of the other recommendations that are coming through, they're all around things like accountability. Things like protected envelopes, mandatory reporting of staffing. When I took over, I didn't know how many single or double beds we had. I didn't know how many CCAs we had. I didn't know how many staff we had. That was the reality of what I inherited.

We are making those changes. That's part of the recommendations federally.

The second thing they're talking about is equity. They want to be sure that what is happening at one end of the province is the same thing that's happening to another end of the province. I remember when I was working at Ocean View, they had a long-term care OT/PT group that got together. That was when I found out that one nursing home that had a hundred beds versus another nursing home that had a hundred beds had different staffing levels for OTs and physios. No equity across the sector.

When I was in Opposition and I met with CEOs of nursing homes, one would have had a different contract and different services in the ability to provide recreation and various things that was very different from another CEO.

These standards are talking about accountability, which we are bringing. I want those numbers and I want to know that we are moving things in the right direction. Equity, of course, is also part of those long-term care standards. Safety of staff, both mentally and physically. We are already leaders in working toward those things.

The standards themselves are focused on resident-centred care. The $1.33 billion is all designed on resident-centred care, but it starts with an adequate staffing level. Those beds that were closed were because of cuts to long-term care in the past. I was working as part of the Ocean View Continuing Care Centre Foundation when I sat with one of the staff from Ocean View when they found out that their budget was being cut again. We are undoing that legacy of budget cuts now.

One of the other national standards recommended was a meaningful quality of life for all of the residents. Well, Janice Keefe published research that talked about the three things that contributed most to the quality of life of a resident in a nursing home. I'll never forget it, because it wasn't physiotherapy, and I was a little - there you go.

The top three things: Number one is the facility that I'm living in - does it look like where I grew up? Does it look like my home environment? Does it look like Ocean View Manor, in terms of is it old and outdated or new and looks like a home? You walk in and there's a fish tank and a pole there where you go to the barber/salon. What the facility looks like is one of the top three things in terms of quality of life for residents, which is the federal recommendation.

Number two is the food. I remember being in Opposition and talking about the fact that with the budget cuts - I think it was Janet Simm from Northwood who was quoted as saying that that's $5 a day for food in long-term care. That wasn't good. So making sure that the residents in our facilities are getting quality food. One of the grants that we gave through the Minister of Agriculture was through Northwood to bring about a greater purchase of homegrown foods in the province and to make sure that the quality of food did not suffer.

When you cut budgets, food is one of the things that gets sacrificed. I got phone calls from people saying, They're taking away mashed potatoes and they're bringing in boxed potato mash. Even my own nursing home - I got calls before I became a minister. They were going to take away yogurt, cheese, and a couple of other things. They have changed their minds, but these are things that impact quality of life.

It's what your home looks like and what you eat. The third thing that adds to the quality of life of residents is a staff that is happy, that is fully staffed, and that are able to treat you and your family members with respect. I guarantee you that under COVID, all of those things were strained beyond breaking point. But by raising the staffing levels to 4.1 hours of care, that by itself is adding to the quality of life of the residents.

Another national standard recommendation was high-quality and safe care. We are already achieving those goals because we have implemented an awful lot of things to ensure that our staff are safe. When I was working at Ocean View, and I joined the physio OT long-term care group - an advocacy group - there was a grant that you could apply for to get safety belts to go around your waist or sliding sheets or transfer boards. I forget who was there presenting it to this group, to let them know if you need those safety pieces of equipment, you can apply for it. I asked the question, "Why would physios have to apply for safety belts to make sure when they're walking clients don't fall? Why isn't that just standard operating budget?" We made sure that our staff have the safety equipment that they need. That includes the Hoyer Lift program in the homes.

Those national standards recommendations, we are already moving on those. The WCB report showing that the injury rate days lost in long-term care has dropped by 15 per cent and in home care by 8 per cent - we are leaders in the country on that. When it comes to the national standard recommendation of a healthy and competent workforce, I could go back over all of the things that I have already mentioned. I won't because frankly, there are so many of them I don't want to run the risk of missing any. We are making sure that our staff are healthy, that they are able to move if they want to move from CCA to LPN, that we have a competent workforce. There are training programs and there is additional funding to make sure the staff who want training in wound care can get that kind of training, or in other aspects that they can get that kind of training.

Under the national standards for promoting quality improvement, every single thing that I read in this budget is designed to improve the quality of care that our staff are able to provide to the family members as well as the residents. The other thing that doesn't get mentioned often enough is when you work in continuing care or long-term care, you don't go in and do your thing and then go home in isolation. You have to work with everyone else who is involved in that person, whether it's the family doctor, the family themselves who are coming and needing help and learning how to transfer. We have put an awful lot of actions in place to help improve the standards of care in both home care and in long-term care. When it comes to the national standard recommendations, our department

was well on its way to meeting the recommendations that the federal government and the organizations put out.

The final thing that I want to say is that - maybe not the final - there are a lot of recommendations in there. We're always reviewing. We're always comparing what we're doing with what is recommended. We are certainly committed to the highest level of care, which is why we had - I think it was a 15 per cent increase in the budget last year and 11 per cent this year. That is a dedicated commitment to achieving those standards. We are leaders in doing that.

The other thing is we are investing in the right direction and our metrics show that.

[7:00 p.m.]

The other thing that I want to say is as a health professional and a researcher, we want evidence to be making the decisions that we're making. We are using this evidence-informed decision-making. One of the things that hasn't been mentioned is the implementation of interRAI into our long-term care facilities. It was a system that should have been put in place a decade ago. That's fair enough to say.

That would give us data that would be able to go to help us compare ourselves to other provinces. I used to work in Ontario, and they were always bragging about how much better they were than every other province, and it used to annoy me. But in this sector, there really was not the data that you needed to be able to compare one province to another. We need that data because we need every province sharing what their best practices are in order to bring about change. The opportunities that I have had to meet with organizations and ministers from across the country is we were sharing what we were doing because we were making historic investments, and they wanted to hear about those because they certainly wanted to bring that back to their provinces.

The last thing I'll say on this is that it is all resident-centred care. I will add I'm equally focused on staff and the family members as well. The mandate of our department is always compassion and respect and to give everyone including the family, the volunteers, and the educators the highest quality of life. I'm super proud of all of our department staff who know what those national standards are, who are always looking at innovative ways like CORAH, like the CAPABLE program so that we can actually set the standards across the country and be able to demonstrate when you make changes like CORAH or the CAPABLE program, which is the first in the country, we will be seen across the country as the leaders.

That's also going to be a recruitment tool. When people know that we are doing these kind of innovative things - we gave that $350,000 to the health care and continuing care sectors, we did what we did for the CCAs, we raised the national standard in terms of the staffing levels - these are also going to be recruitment tools as we go around the country

and around the world. That's going to help us to achieve the highest standards in the country, which I'm not shy saying is the absolute goal of our department.

KELLY REGAN: I would like to pass the rest of my time over to my colleague the member for Halifax Chebucto.

THE CHAIR: Note that we have 37 minutes left of our time, minus a minute or two for the minister's closing statement.

The honourable member for Halifax Chebucto.

GARY BURRILL: I was wanting to ask about a proposal that we had put forward in the NDP for some time now, a seniors' advocate office. There are other jurisdictions that have very positive experience with this. The idea of having budgeted dollars for a dedicated position for the assessment of the adequacy of government's programming in long-term care and for the seniors population as a whole. I just want to ask the minister: Why doesn't the government establish such a position?

BARBARA ADAMS: The needs of seniors were so important to our government that we created an entire ministry devoted just to the care and support of seniors in the province of Nova Scotia. Just for clarity for those who are also here, only B.C. has a designated seniors' advocate; New Brunswick has a youth, children, and seniors' advocate. We have an entire department and a ministry devoted to seniors in the province of Nova Scotia. We have a lot of mechanisms in place to interact and have people advocate for those who are wanting to support and to protect our seniors.

We have a Seniors' Advisory Council, which we work very closely with on a regular basis. We also have our seniors' safety coordinators across the province. We have an Ombudsman, whom we have a good working relationship with, who is the person that people can go to when they have concerns. We have a designated Ombudsman for anyone who has these issues. There's a report that's available that summarizes the concerns that are brought to the Ombudsman.

We also have our adult protection as well as our protection for persons in care. These are extraordinary staff. When I first met them and we did a sort of round table on where they all came from, a disproportionate number of them came from child protective services. We have a designated group of individuals within our own department whose responsibility it is to protect and promote the safety of seniors in the province of Nova Scotia. We have increased the staffing level in that department as well, to make sure. There are a lot of robust processes and policies in place. The biggest change that the Premier made was when he designated an entire ministry to the Department of Seniors and Long-term Care.

Just to go back to adult protection for a minute, we don't talk about that very often. These are the staff who are faced with the most challenging of circumstances. The staff themselves have indicated that they needed some support in certain areas of the province. We listened, and we added three additional full-time equivalent staff in order to make sure that we were able to respond to any phone calls or inquiries or reports that came through the door. Of course, those reports are available online.

Although there is one province in the country that does have a seniors' advocate, we have an entire ministry devoted just to seniors. Having met with other provinces, that is certainly something that they stood up and took notice of. I'm certainly hoping that our successes will mean that other provinces will start to see the value in having an entire staff dedicated to those who are most vulnerable.

GARY BURRILL: I was wanting to ask a couple of questions about human resources in the sector. There was a demonstration at the one publicly funded long-term care facility in the constituency I serve, Saint Vincent's Nursing Home, last week. CUPE had held it. It had nothing to do with Saint Vincent's - another issue related to some things in the union. I was struck, in the time that I was there, by the number of signs that people had made about their parts of the care team, whether it be laundry people or environmental services people. The basic idea of the signs was we're part of the team too - dietary people. These weren't pre-printed union signs. These were signs where people expressed what was on their mind. There were maybe 30 or 40 people there. I had a chance over an hour and a half to talk to most of them. I really left with a sense of how the needed CCA increase has had a negative impact on a lot of other parts of the care team, in terms of morale - people feeling left out, people feeling that their part of the care team isn't valued or recognized.

I want to ask: Are there also significant raises that are going to be coming through to these other parts of the care team? Laundry, dietary, environmental, and related parts of the team?

BARBARA ADAMS: Sorry, could you just repeat the question? It cut out for me.

GARY BURRILL: There have been necessary increases for CCAs. Are there going to be parallel increases for other parts of the care team, like dietary, environmental, laundry, and so on?

BARBARA ADAMS: I appreciate the feedback about the 23 per cent pay raise for the CCAs. I've been travelling across the province and going into all the long-term care facilities and having the ability to meet with all the staff, not just the health care staff. Everybody who works in one of the facilities or in home care is equally important.

When we did the historic 23 per cent pay raise for CCAs, our sector was drowning in shortage. We had hundreds of beds closed, primarily - as I've mentioned before, we have over 16,000 staff. More than half were CCAs. When you have beds closed, you need to do

targeted investments in order to right the ship. That was the beginning of righting the ship. We had a critical shortage - far too many beds closed. Home care, as I said - I think they had over 500,000 fewer home care visits that year before we became government, and it was continuing to decline.

I remember when I was first getting oriented to my department. I forget the exact number, so I won't know it exactly, but I was given a summary by one of the nursing homes as to how many people they had to interview in order to get one staff person. It was a crazy-high number. I think it was in the hundreds of people they had to interview just to fill one position.

Then we got told that 50 per cent of all CCAs - this is prior to our government - 50 per cent of all CCAs, which is the majority, or over half of those in long-term care, were leaving the sector within five years. Free tuition sounds good, but not if half of them are going to leave within the first five years. So that 23 per cent increase was targeted because of a critical shortage, because of hundreds of beds being closed. Because of that investment and others, we have zero beds closed because of staffing shortages.

The second thing to address is that every single person in long-term care, in acute care, or in home care, is equally as important. That is why - I forget how many weeks ago - the government announced the retention bonus of $350 million. We had been hearing from the sector, What about us? We've been here as well. So $350 million is a significant way to say to staff, We appreciate what you are doing.

That retention bonus went to everyone, including people who are ward clerks, housekeeping staff, kitchen and food services staff, engineering, clerical, shipping and receiving - people you don't think about, but their roles are critical. If a wheelchair breaks down in a long-term care facility, everything comes to a stop, and I have had that happen. The security staff, respiratory therapists, the people who are managing the technology - they all received a retention bonus.

Just for comparison, of the $350 million, $98 million was to our sector. That is one of the ways that we recognized the value of the staff. It will be $26 million next year for that same retention.

I just want to say that everyone who knows me knows that every single person is equal in my eyes. I got taught that by my father. One time, I was about 12 or 13, and I called my dad, who ran MSI in the province. I needed to talk to him because I wanted to go somewhere, and I wanted to drive, and I wanted to know if he was going to be home on time. I spoke to his secretary, and she wouldn't put me through to him. I don't know exactly what I said, but I know what happened when he got home. He said, "How dare you speak to someone on my staff like that? She is as important as any other person in my department, and you will never, ever treat anyone as if they are less important than you." I'm tempted to tell a story. That taught me a lesson at age 12.

[7:15 p.m.]

The second thing, and it was ironically my dad - I was practising for my interview to get into physiotherapy school, and they gave you the list of questions they were going to ask you. I was practising, and one of the questions was: Who is most important to a patient, the doctor, the nurse, the physiotherapist, or the patient? (Interruption) I'm not going to repeat that, Minister Comer. (Laughs) I said to my dad, well, of course, it's the patient, but physiotherapists are important as well. He said, No, you know who's important? The person who brings that person their meal, the person who is there when you press that button and you need to go to the bathroom. That's who's important to that person - the person who's going to empty out the wastebaskets to make sure that that room is clean. That person is important to them. He said, Are they going to shut down a hospital bed if you don't show up for work as a physiotherapist? And I'm like, oh, I was slightly offended by that. I said we're pretty essential. He said they're not shutting down a hospital bed if you don't show up for work.

It is that attitude that our government and my department, and I as the minister are bringing to this sector to rebuild sector pride: that if you're someone who empties out the wastebaskets, if you're someone who cleans out that tub, I care about as much about you as I do that person who operates and fixes my hip when the time comes.

I appreciate that everyone is always looking to advocate for their own profession. Of course, I fully respect the bargaining process that is in place. I forget how many union contracts are negotiated every year, but my understanding from the Minister of Finance and Treasury Board is that it's a weekly event that the minister is working. I believe that the investments we have made and will continue to make are demonstrating, and it is what I am hearing when I go around this province talking to home care and long-term care staff and those in adult protection, that people know that our government is committed to the employees. We respect the bargaining process, as always, and we will continue to make sure that our employees feel that they are a priority for us and that they will continue to feel that way under our government.

GARY BURRILL: I want to return to the subject that my Liberal colleague raised earlier: the question of the 4.1 hours. There is really, in the long-term care sector, a major disagreement about this. Those unions that have been most closely and long associated with this demand speak of it as 4.1 hours of hands-on direct care. I believe I understood from either the minister's previous answer or maybe the introductory comments that the direct care has been increased from, I think it was said, 2.1 hours to 3.1 hours, but we are not at the place - and this is why the unions in the sector have not embraced the government's 4.1 - we are not at a place of the government now implementing 4.1 hands-on direct care.

I think it's important to remember how old a demand 4.1 is. I mean, this is several years that this has been on the table, and they've not been static years in the world of

long-term care. They've been years when the level of acuity of the long-term care population has been intensifying and increasing yearly.

I want to ask the minister: Is it not the case now, in light of the increased frailty of the population that has taken place over the years since 4.1 was first put forward - is it not at the point now where we actually need not the 3.1 that the minister's talking about but the 4.1 hours of direct hands-on care?

THE CHAIR: The honourable Minister of Seniors and Long-term Care.

BARBARA ADAMS: Thank you. Can you just remind me how much time is left?

THE CHAIR: It is 7:22, so we have 16 minutes.

BARBARA ADAMS: How many?

THE CHAIR: Sixteen minutes.

BARBARA ADAMS: Thank you. First, I just want to clarify that the HSO recommendation, which I was asked about, is 4.0 hours of care. At 4.1, we're exceeding that level of care.

What I do want to say is, as a health professional and researcher, you need evidence to make decisions. I understand that the request and the promotion of 4.1 hours of care - it has been a long time. The unions have been calling for that for a long time.

What we are short on but moving towards is an ability to collect the data that will allow us to make better-informed decisions. I remember when Janice Keefe brought in the long-term care expert panel recommendations. The first words out of people's mouths were, "Well, what about the hourly rate? How come you didn't give an hourly rate?"

I have all the respect in the world for Janice when she said, "We don't have the data to make that determination." She is a researcher. She's not a government official. She doesn't need to spin anything a certain way. She said that we, with the data that we are collecting in Nova Scotia, cannot make a determination. I respect that. You need evidence.

She did reference British Columbia, and someone said that they've indicated it should be a certain ratio, and she indicated that they collect sufficient data. I believe it's B.C. that she referenced.

So there are two things that are happening. One is interRAI, which is a system that's put in place now. I think all of them are up and running. By the end of this month, every long-term care facility in the province will have this system in place, which is going to start giving us the data that you need to assess a level of frailty.

The Premier - he's heard from me for six straight years the difference in what it costs to look after someone who's frailty level 2, which is that you have a health care need but it's stable and you don't need active care, is very different from somebody who's a frailty level 7. What we know is that the care that we are giving right now is based on the recommendations of 4.1 hours that our government is listening to in terms of the unions. But interRAI is going to give us some of that data. Ironically, the fact that we didn't even know the number of beds we had, we didn't know the number of CCAs we had, we didn't know how many staff we had - there was no way to possibly give a number. Janice Keefe would have had to make a best guess. She wasn't prepared to do that, and I respect her for that.

One of the things that our government just did a month ago, I guess, is Saint Mary's University was given $25 million for a health data analytics program. For those of us in health care, you know that most of the research that happens is often specific to your own profession. In nursing, they would have a very different body of knowledge that they would be able to draw on. In my own profession, there are more research studies on the knee joint, because it's the easiest joint to measure, than there are on shoulders or backs. When you want to talk about, Should it be this level or care or this level of care?, you need the science behind it.

When we were a government, we didn't wait for the science. We said, what is currently in place is not enough. We made the commitment to go with what was recommended. As a researcher, I can tell you that we want the evidence to make sure that we are providing the right level of care in each of the facilities that is there. One of the things that - just to remind everyone - is that we have put another $10 million in this budget to help us make sure that we are getting to the highest level of care in the country. As we have more data, as we actually know how many staff are in our facilities and what that impact is when you combine it with the interRAI data that we are going to have, and when you are able to compare one province to the next in terms of level of acuity, then we are going to be able to make better decisions moving forward.

One of the other things that we just want to talk about is the 4.1 hours. In terms of direct patient care, there are a lot of staff who are involved who aren't mentioned in this 4.1 hours of care that we have enhanced. There is increased occupational therapy, physiotherapy, recreational therapy. That all adds to the treatment capacity or the care capacity in our nursing homes. Of course, one of the things that we also have to do, and certainly because of COVID adds to that stress, is we are also adding on extra care for wound care above and beyond what used to be in the past. There is drug monitoring in a way that wasn't there in the past. For people who haven't seen it yet, there are nursing homes where you can use a scanner on someone's medication. The nurse grabs the medication and scans it. If you're given the wrong medication, it won't let you scan it. It won't let you give it two hours early.

These are all systems that are being put in place to improve the staffing time to make them as effective as possible. As we bring in technology like the drug monitoring and the scanning of that medication - I forget exactly how much quicker an RN can give out medication because they have that scanner system, but things are going to change over the next 5 to 10 to 20 years that we can't predict right now that we are working towards. There is catheter management training that was not there in the past. There's skin integrity reviews that are far more effective and efficient than they were in the past. There is differences in terms of who's doing what in terms of infusions and IVs and medication prescription. Of course, with the Patient Access to Care Act, the scopes of practice of some of our allied health professions, in partnership with the regulatory bodies, are going to change over the next 5, 10, and 20 years. To say that you need to go from 4.1 hours to a certain number, I want to know what that number is. I also know that whatever that number is, it's going to have to be flexible. As we continue to improve home care, we are also going to have different demands on home care and we're going to need to improve the technology there.

[7:30 p.m.]

While I agree that we need to always be evaluating the standard level of care, it is really important that we know what the data are telling us. Our government is committed to making sure that that happens so that people in home care and continuing care and acute care are getting the right care by the right person at the right time.

GARY BURRILL: Chair, is there enough time for me to continue with questions and still leave the minister time to make a closing statement?

THE CHAIR: Yes. We have almost eight minutes left, and that will leave two minutes for the minister to make her closing.

GARY BURRILL: I'd like to ask about the Work and Learn program. One of the things that people are so positive about the program has to do with its pretty good record on retention. These are people who are not surprised by what CCA work is like. And yet there is this pretty considerable problem that - whatever the number is: 280 hours of work, I think, without being paid - it's a pretty daunting thing to be able to think about.

I understand that not all facilities are in a position where they are able to pay the people who are in that program. This is particularly difficult for smaller facilities, and there is an inequity in how much facilities are able to avail themselves of the program.

I'm wondering if the government is thinking of doing anything to address this.

BARBARA ADAMS: It was years ago when the Work and Learn policy was in place, and then it went by the wayside. The nursing homes themselves - I actually, when I was in Opposition, recall the conversations I had with CEOs who said, "You know, we

used to be able to train people in-house, and then it went by the wayside." We have the capacity to do that.

Now, obviously, the larger the facility, the more capacity they have to do that. We did not hesitate to wait for everyone to have the capacity. Those who had that capacity, we certainly facilitated that process. Of course, it took off like gangbusters, if I can use that terminology, so certainly the smaller facilities are looking at that and going, Oh, I might have a smaller facility, but if I could only have that program in our facility.

We are certainly evaluating all of the opportunities around the province in order to make that happen, because we know that there are staff who, because they are able to get paid while they're doing their on-the-job training, that has allowed them to take advantage of the free course.

I can guarantee you that we are looking at all opportunities in order to help all facilities do that. But we also know that if you got trained at Northwood - I'll use them as an example, because they're one of the larger ones - they may have done the training there, but that certainly benefits other long-term care or home care facilities who also want to hire those who are taking that program. We are still working with the smaller organizations in order to help bring that about, but we weren't going to wait until they could all start before we started with the ones who were ready and raring to go and, in fact, had already been doing it in the past and were able to get up and running extremely quickly.

GARY BURRILL: No doubt the minister is aware of the correspondence that came to, I think, the Premier's office from Michele Lowe of the Nursing Homes Association to the effect that the recent thank-you bonuses to front-line health care workers have brought to the front this issue of the discrepancy of pay for managers in acute and in long-term care. The issue that has been underlined there is that this is a core matter of retention for people in leadership positions in long-term care. What are the government's plans to address this issue?

BARBARA ADAMS: We have had communications back and forth, and we have responded to those concerns. The bonus structure that went to not just health care staff but went to non-health care staff as well certainly had the impact that we were hoping for in terms of recruitment and retention. The department itself is always looking at the remuneration of everyone who works in that sector. Those conversations are ongoing.

GARY BURRILL: A short question about respite. It is recommended sometimes. You hear people speak about an expansion of respite and the number of beds per facility. Providing additional support to caregiving families would cut down on the number of hospital stays. Is consideration being given to this?

BARBARA ADAMS: Ironically, when I went back in Hansard, the discussion on respite beds has been going on for at least a decade. Unfortunately, the trend that has

happened over the years is, as the demand for long-term care beds has risen, the ability to provide respite care has diminished. That has been a conversation for the last 10 years. When COVID hit, all respite beds were closed because you could not have people coming in and out of the facility at that time. That reduction in respite beds was to protect residents in the facilities. Our government has responded by dramatically increasing respite in-home. I don't want to go through all of the programs that we talked about before, but the ability to provide home care to a significant increase compared to previous years is one of the strategies . . .

THE CHAIR: Order, please. That concludes the questioning for the Minister of Seniors and Long-term Care.

Shall Resolution E37 stand?

The resolution stands.

That concludes the time allotted to the subcommittee for the consideration of the Estimates referred to it. Please return to your seats in the legislative Chamber. We are adjourned.

[The committee adjourned at 7:39 p.m.]