PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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LOCATION: LEGISLATIVE CHAMBER, HON. GEORGE COLES BUILDING, CHARLOTTETOWN

SUBJECT: BRIEFING ON LONG-TERM CARE FACILITIES

COMMITTEE:

Dr. Peter Bevan-Baker, Leader of the Third Party
Richard Brown, MLA Charlottetown-Victoria Park [Chair] (replaces Jordan Brown, Minister of Education, Early Learning and Culture)
Kathleen Casey, MLA Charlottetown-Lewis Point
Darlene Compton, MLA Belfast-Murray River
Bush Dumville, MLA West Royalty-Springvale
Sidney MacEwen, MLA Morell-Mermaid
Chris Palmer, MLA Summerside-Wilmot
Hal Perry, MLA Tignish-Palmer Road

COMMITTEE MEMBERS ABSENT:

Jordan Brown, Minister of Education, Early Learning and Culture

MEMBERS IN ATTENDANCE:

Bradley Trivers, MLA Rustico-Malpeque

GUESTS:

Health PEI (Andrew MacDougall; Jamie MacDonald)

STAFF:

Emily Doiron, Clerk Assistant (Journals, Committees and House Operations)

Edited by Hansard

The Committee met at 10:00 a.m.

Clerk Assistant: Good morning, everybody.

I'd like to make a couple of announcements of change in memberships, so that's why I'm starting the meeting today.

For today's meeting, I have received a letter from the Premier indicating a change for the meeting on today, October 31st, with Richard Brown sitting in for Jordan Brown. Then, last week I also received notification, and I've circulated to the committee, from the Leader of the Opposition indicating a permanent change of membership. Sidney MacEwen is now a member of this committee, replacing James Aylward.

To start, I'm going to open the floor for nominations for a temporary Chair for today's meeting.

Ms. Casey: Madam Clerk, I move that Richard Brown be the temporary Chair of this committee for today's meeting.

Clerk Assistant: Sure.

All those in favour, please indicate by saying 'aye.'

Some Hon. Members: Aye!

Clerk Assistant: Contrary minded, 'nay.'

Chair: (Indistinct) might forget it.

Clerk Assistant: Sure.

Welcome, Mr. Brown.

Chair: Okay, I don't know how this runs.

I call the meeting to order.

Adoption of the agenda?

An Hon. Member: So moved.

Chair: Seconder?

We don't need a seconder?

All in favour?

Some Hon. Members: (Indistinct)

Chair: The committee will receive a briefing on long-term care facilities in the province.

Introduce yourself and start going.

Jamie MacDonald: Good morning.

My name is Jamie MacDonald with Health PEI administration, responsible for emergency health services, long-term care, Queen Elizabeth Hospital and Community Hospital East.

Andrew MacDougall: Hi, my name is Andrew MacDougall; I'm the director of provincial long-term care for Health PEI.

Jamie MacDonald: We have a short presentation that we'll take you through. There are several slides specific to the request that was put before us, and then after that if we have time, we'd love to answer the questions that you may have around the material.

Thank you.

Andrew is going to start the presentation.

Andrew MacDougall: Thank you.

Thank you very much for the opportunity to come here today to present to the Standing Committee Health and Wellness.

This is our second time here in the last six months, so we appreciate the interest in long-term care. It's a topic that usually generates a lot of discussion. I certainly hope, it being Halloween, it's not too frightening of an experience for anyone concerned, especially on this side of the table.

As Jamie mentioned, when the invitation came out for us there were three particular items that were requested that we talk about and I have them before you now on the agenda. We're going to talk about comfort allowances. We'll talk about spousal support subsidy, so essentially the approach for funding for couples or spouses in long-term care. We'll also talk about ambulance services as well as it relates to long-term care as well. Of course, we'll welcome

questions, comments, and feedback suggestions all the way through.

On comfort allowances: Comfort allowance; these are a really important source of income for a lot of residents. We issue comfort allowances pursuant to the *Long-Term Care Subsidization Act* and the regulations, and that act – the regulations call for a monthly subsidy that goes to residents that are in need, that are demonstrated to be in need. The total right now is $123 per month. How is it determined if someone is in need? Essentially, is when a resident requires additional financial support they go through an income-tested process, and if it is determined through that process that they are in need, then they'll be eligible for a comfort allowance. Essentially, if you're eligible for a subsidy in long-term care, which is the vast majority of our residents, then you're going to also get the comfort fund allowance, which is $123.

The focus of that amount is for the residents' use specifically. It's not transferable to other parties. It's for their use, for their personal comfort or the things that brings them joy, and also to help purchase what's called 'special needs items'. Comfort funds can (Indistinct) the whole range in terms of what a resident could buy. It could be haircuts; for a lot of residents, that's a big part of their comfort fund. It could be subscriptions to newspapers. It could be going to the movie; these sorts of elements, but it also can be used to help fund special needs items and that could be personalized equipment, for example, and there will be a little more on what special needs actually constitutes a little bit later.

The $123; that was recently upped by $20 this past spring. It was the first such adjustment since 2000. There have been three adjustments since 1992. Originally, I believe, it was $75 per month back in 1992, so that was a while ago. Given the number of residents that we have that are subsidized, every $1 increase in a subsidy, even $1 amounts to $10,000 across the board, so it can be an expensive proposition and so we're grateful that, for residents, it has been increased recently. It's $123 now and it's for their purpose and their use and their joy, and that's where that is.

The next slide just gives you a bit of an overview on the distribution of the balance. So residents, they have – obviously most of them are not spending all of their comfort allowances in any one month, but over half of our residents would have a balance if we checked as of the end of October – or sorry, the beginning of October, about over half – about 58%, have a balance in excess of $500, is what they'd have. It is fairly evenly portioned the rest of the way. About 17% would have balances between $206 and $500. So if you take those two slices together, we have almost 70% of our residents that would have more than a month's worth of their income on hand at any one time. Of course, as you can also see, we have an amount – about 10% of residents that are habitually using it, basically extinguishing their account on a monthly basis.

What might be also informative is the next slide. This gives you the actual raw numbers on our comfort fund stats. So 840 residents – and this applies to public and private long-term care facilities, I should point out – 840 residents are in receipt of this comfort fund allowance. When we look at the 1,141 beds we have in the long-term care system, we're talking about roughly 75% of our residents are in receipt of this. The average balance is $1,071. I note that because there was a change that was made in 2009. At one point, comfort funds were capped back in 2009. Up until that point, you could have a maximum balance of $300 and the decision at that time was taken to actually uncap it to better enable residents to be able to make purchases for 'special needs items'.

Special needs items; these are things that are beyond what we define as the basic basket of healthcare services. So, this would be hearing aids, this would be dentures. This could be glasses; it could be orthotics, these sorts of elements. So, the balances are allowed to fluctuate to be able to provide additional opportunity for residents to acquire those items. That was the logic behind the decision back in 2009 to uncap it because it used to be $300. That was the max. Once a resident got to that, then there was no addition unless it went below that level.

There's also –

Chair: I have a question.

Andrew MacDougall: Sure, go ahead.
Chair: Estate payout, 775, what's that?

Andrew MacDougall: Yeah, that's the very –

Chair: Oh, that was next?

Andrew MacDougall: Yeah, the very next thing. (Indistinct) took the words right out. You're ahead of the curb, that's good.

Chair: I don't know about that.

Andrew MacDougall: The estate payout: Again, these are estimates as of October, as of now, essentially. The estate payout is almost $800.

When a resident discharges from a long-term care home, for the lack of a better word, that usually means passing on – the amount that is left in the comfort fund allowance reverts back to the – it goes to the estate. It will go back to the estate. There is provision for that in the regulations for it to go to the estate.

Just a couple of more comments here on the comfort fund. The allowances are held in trust. You often will hear them referred to as trust accounts. They are held by the long-term care homes themselves unless otherwise stipulated or arranged. There can be arrangements – exceedingly rare where there could be arrangements where, for example, family or others will take ownership of the comfort fund to make purchases on behalf of the resident.
But, the vast majority of cases, the funds are held in trust at the home.

There's a process in place where third-party purchases – and so when I say third-party purchases, we're talking about, obviously, not the residents themselves, and particularly those residents that may have cognition challenges or those issues. There's a process in place, for example, if friends or family of residents want to make a purchase for a resident using these comfort funds, then there needs to be a validation that happens. We want to see what the items are, what the receipts and these types of elements. That mechanism is in place. The balances themselves are monitored on a regular basis. They're supplemented monthly, so they're tracked. Again, we as holding them in trust want to ensure that the funds are being appropriately used.
I guess in summary on these funds, as I said at the outset, they're a major source of income for a lot of our residents, over 75% of our residents. This is essentially what they're getting; this is all they are getting.

I find it's not just about the money, per se, having access to these funds does allow for some additional autonomy. We're trying to encourage autonomy of residents; we want to encourage their dignity and to be able to manage these accounts and to make purchases. It gives them something to look forward to. If they want to save for a special item; I can think of one resident who he purchased – he's all into robotics and he saved his money and he purchased a flying helicopter. It actually led to an incident at the old Prince Edward Home. He was outside, he was flying it and it landed on top of the old Prince Edward Home and it was quite a scene up there. We found it and it wasn't in good shape, but we found it. There was no damage to the facility, so that's good.

I mean, it allows for that for a lot of residents who like to shop and look for discounts. It gives purpose. It gives focus. Again, it helps to provide that level of autonomy for people that are quite compromised at that stage. It's more than just about the money, I guess, it's also about the values that are behind that. That, in a nutshell, is the comfort funding approach that we have in there.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

Thanks, Andrew and Jamie. Thank you for being here.

I just want to clarify about the transfer of funds from government to these comfort allowances. Are they given directly to the care facility, whether that's public or private, or do they go through the individuals?

Andrew MacDougall: Thank you for the question.

If they're held in trust they would go directly to the facility itself. I should point out that they do go to the facility, and the facility is required through its administrator to then deposit that money, obviously, into an account and the interest income is generated off these accounts is used for the general benefit of residents. So, the interest itself is for the facility, not for the individual resident. A resident can accrue interest on their own. The facility essentially takes the money, they deposit it on behalf of the residents or the public trustee, for example, if they're the ones that are managing that and they are held there in trust. The income that's generated is for the general use of the facility.

Chair: Peter Bevan-Baker.

Dr. Peter Bevan-Baker: You mentioned, Andrew, a certain percentage of people in nursing homes have cognitive challenges. Is there any way of assuring that the residents are all fully aware that this money is available to them and many of them are in there without family supports. I just want to make sure that all the residents who are receiving this comfort fund actually, genuinely, have access to it?

Andrew MacDougall: On what we call move in, the move in process, it's a part of the information that goes to residents and I'll try to address the cognition aspect of this. In terms of part of the standard information that goes, there's an information book that talks about the comfort fund as a part of the overall value proposition for residents. The residents apply for subsidy; they or their family. They're also through that process made aware of the accessibility to these funds.

Now for people that cannot essentially speak on their behalf, when it comes to their finances being managed, that is the role the public trustee gets involved in. Often when it happens, in practice that is left to the facility to – in terms of – managing the funds and to look for opportunities to make use of it. We've had certain examples before where we see some residents with really large amounts – where we have staff that will advocate to get certain elements – whether it's a quilt, whether it's a certain piece of therapeutic equipment that they might enjoy. People that have cognitive challenges that don't have family – which is not a great combination – we do have to rely upon to some extents, feedback from our staff to say: Wouldn't this be a great idea for this resident. We'd go ahead and make that purchase.

Dr. Peter Bevan-Baker: Andrew, what level of accountability or oversight exists and is exerted by government on these funds being held in trust by (Indistinct)

Andrew MacDougall: Pursuant to the act, there is to be a report that's tabled for the Legislature on the subsidy program. That would be consisting of everything that's associated with the subsidy program in terms of the payouts that come, the assessment process of the auditing of the subsidy program, including the comfort element. It would be part of an annual report that we're required by law to produce.

Dr. Peter Bevan-Baker: Do you ever do sort of random audits going and look at the books of particular individuals and check that the money is going where it should go and it is being spent appropriately?

Andrew MacDougall: Yes, particularly, I guess what we deem riskier cases. I'd find risky not (Indistinct), but risky in terms of people have fluctuating income levels, for example. We'd pay particular attention to those. And yes, we would audit those.

Dr. Peter Bevan-Baker: Thank you, Chair.

Chair: You can keep asking questions, you don't have to come back to me. When I designate you for questions, you don't have to come to me every time. Just tell me when you're done of your series of questions.

Anybody else?

Brad Trivers.

Mr. Trivers: Thank you.

Thanks for the presentation; a couple of questions. I just wanted to clarify – the payouts for a comfort allowance are about 1.2 million or so a month – a year, pardon me – to run the comfort allowance in terms of just direct payouts? It's just that 840 people times 123 a month?

Unidentified Voice: (Indistinct)

Mr. Trivers: Approximately, how much does it cost to administer the comfort allowance program, would you say?

Andrew MacDougall: The administration of that would be embedded within the role of various clerical people that are positioned in our facilities. I wouldn't have necessarily a direct cost for that because this is just a part of what someone is doing otherwise.

Jamie MacDonald: There are no direct full-time equivalences associated with administering that; it depends on the home and who is working in the home and what's – it's usually part of someone's role in that individual home.

Mr. Trivers: If you're looking at it from a provincial perspective – I guess it would be Health PEI as well – how many people outside of the facility would be working on this program? Or, is it all managed completely within the facilities?

Andrew MacDougall: Yes, it's within facilities; it's management within facilities, yes.

Mr. Trivers: You wouldn't be able to make an estimate as the number of full-time equivalents that would be administering just the comfort allowance as part of their – that would be a hard thing to do.

Jamie MacDonald: It would be really. It really depends on the number of residents in the facility and all of those kinds of things.

Mr. Trivers: My next question was: When it comes to eligibility, is it an easy thing to determine whether someone is eligible for not? Maybe I missed that, but can you just give a quick overview of how you determine who is eligible for the comfort allowance? Or, is that something you're going to do later in the presentation?

Andrew MacDougall: No, we can do it now.

I guess to put it most directly, I guess, or the easiest way to explain it; roughly speaking if you're annual income is going to be $30,000 or less, chances are real good, if not certain, that you will be qualifying for a subsidy. Hence, as a result of that, also, receive a comfort allowance. In the long-term care system – and sometimes this does get confused – but in the long-term care system in this province it is an income-based system completely. It's not assets; it doesn't matter if you have $100,000 that's sitting in the bank. All that's relevant for your subsidy is the interest that you're generating off that and the income that you get. It's completely income-based. The assessment process for that would look like – looking at the net income as defined on 236 of Revenue Canada and that's what we look at there. Generally speaking, if you're $30,000 or less, then you're going to qualify for a subsidy.

Mr. Trivers: These are the sorts of questions that we get often as an MLA. Now I'm not going to have learn to say: Okay, we're reaching that point where we think we're going to be going in to long-term care in (Indistinct) couple of years and we just want to know how it works.

Is there a package you provide to seniors that describes who is eligible? How much they're going to get? What are the different things that are happening? How it works overall? Or, is this something where they just need to call a number and get someone to describe it to them?

Jamie MacDonald: There are a couple of different methods. But on the government website, if you go to the Health PEI website, there is a long-term care section and there is a Q&A around, on planning to enter a long-term care in a couple of years and these are some of the specifics I need to know. Then there's also a number that they can call if they need further information because sometimes it's a very individual question that they may have that's not provided in the general information. There's a couple of different ways they can get that information.

Mr. Trivers: Is there a paper handout that's provided to them? Or is it just the website or a call? Is there like a package?

Chair: Control P, print.

Mr. Trivers: Control P, print, is that all?

Jamie MacDonald: If they choose not to do that or they don't have access, there is a

number they can call then we would mail out the information that would be on the website.

Mr. Trivers: Thank you.

Chair: I have a quick question then we'll go on to Bush.

If I have a million dollars in RSPs – and I don't –

Andrew MacDougall: Do you have that for the record?

Chair: – if Revenue Canada is listening – none of that goes towards my care in the facility if I choose not to take it out?

Andrew MacDougall: That's correct. If you're in long-term care in a long-term care facility –

Jamie MacDonald: Not community-based care.

Andrew MacDougall: – not community-based – when you get to a certain vintage or an age, I mean RSPs can convert into –

Chair: (Indistinct)

Andrew MacDougall: RIFs, I guess is what they call them, and then there's an income element that happens in that area. It's the income that's focused, not the asset itself. That's different though, the community care facilities in this province; it's an asset and income-based system. I can appreciate as members, the questions that you'd be receiving and it can be confusing. But there is a difference, the public maybe not – doesn't always distinguish between community care, long-term care, but it is a different system. It's asset-based in a community setting, but for us it's income. Again, you could have large savings, you could have a big house and these types of things, but that's not what's relevant for determining whether you qualify for a subsidy.

Chair: Bush Dumville.

Mr. Dumville: Thanks, Chair.

Andrew, how is the accounts handled? Say if you have 100 residents, theoretically you have 100 accounts, that's not 100 bank accounts, that's 100 administratively internal accounts, is it?

Andrew MacDougall: Thank you for the question.

It's not separate accounts; it would be the facility would hold all these funds in there together and to maximize interest potential as well. But also within the facility, the facility would keep spreadsheets and it would keep tallies on a monthly basis what the residents' balances are. It's almost like a – to some extent – it helps to normalize experience a little bit because a lot of our facilities, it's almost like a bank. For residents that are able, they'll come to the bank which is equivalent of reception. They'll say: Okay, I want $20; I'm going up to the store. Or, I want to rent a movie, or whatever. They will go to the bank and so then the money will be handed over and that spreadsheet that we have, there will be a debit made on that spreadsheet account. And then there's a reconciliation process that happens at the end of the month when the bank statements come in. There would be one collective account at the bank itself, but within the facility it's tracked so everyone's separate tallies are transparent and understood.

Mr. Dumville: When the money comes from the government to that one account, how does it come? Does it come batched? Or, like is it one cheque? You have 100 residents, that's a hundred and twenty-some five dollars, or whatever, is it just one cheque to the facility?

Andrew MacDougall: It's a global payment, I guess, that's what you call it.

Mr. Dumville: Global payment to the facility?

Andrew MacDougall: To the facility.

Mr. Dumville: Not to the individual.

Andrew MacDougall: Yes, to the facility.

Mr. Dumville: Thank you very much.

Andrew MacDougall: Thank you.

Chair: Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

The third party verification of purchasers, can you just explain a bit more on that? And, do you ever have trouble with someone coming in and trying to sell a service or trying to sell something to somebody that might buy into it a little too quickly?

Andrew MacDougall: We certainly safeguard of our residents; we don't permit solicitation. I'll say that up front. The third party element is essentially – it's anyone besides the resident looking to make a purchase on their behalf. Since we're entrusted to hold these funds, what we want to see – what we ask – we document this and we inform families of this when they come in, is they talk to us in advance first off to get a sense of: What is the balance. Then they propose a purchase and then we want to see the evidence, so we want to see the receipts.

Sometimes we get into some scenarios where purchases are made and then retrospectively come (Indistinct), here's the receipt, reimburse me, basically. That can get into some interesting conversations by times; that's not the way we'd like to have it. It then requires – an extra step is: Okay, well let's see this, let's initially see what's been purchased. All told, we haven't had major issues in this area, but given the level of cognitive impairment we have with our residents, it's something that we're particularly careful with.

But yeah, in the solicitation piece, we don't permit it. Whenever we get wind that there are attempts – and for example, some residents have phones and they choose with their comfort funds to have phones. We've had some people – there's been an occasion – I can think of one actually in the last year where there is one resident that continued to get called over and over again by a vendor. That got reported to us and we worked with the family, we changed the phone line, that type of thing.

Mr. MacEwen: Have you ever had trouble with family members looking to spend funds of their aunt, uncle, parent, on something that may not necessarily be for that parent?

Andrew MacDougall: Yes, there's been occasions where there's been some pretty delicate emotional –

Jamie MacDonald: (Indistinct)

Andrew MacDougall: – kind of conversations because –

Mr. MacEwen: Is that a staff thing that's an oversight there –

Andrew MacDougall: Yeah.

Mr. MacEwen: – it's just up to the staff in that facility to –

Jamie MacDonald: I think the staff and the administrator. That's why we request that if a family member wants to purchase something with that allowance on behalf their resident that they have that discussion ahead of time, just to ensure that it meets the needs, it meets the facilities needs. It could be a special chair that maybe we need to make sure that it's appropriate for infection control purposes, those kinds of things. But just to make sure that the purchase is made with the residents' best interest at heart. We prefer a prior discussion before that happens.

Mr. MacEwen: At the end of the day, who has the final say? Is it the staff oversight? Is it the family member? Who has the final say on that purchase?

Jamie MacDonald: I don't think there has been an incident in the past where there hasn't – where the family and the administrator, Andrew, at the time, couldn't come to some agreement around process.

Mr. MacEwen: Agree?

Jamie MacDonald: Yeah.

Mr. MacEwen: But who has the final say over that money? Can the facility say: no, you can't purchase that?

Andrew MacDougall: I would say, when it's held – when we're holding it in trust, we would take that position.

Mr. MacEwen: Bottom line the facility has the final say over what the money is spent on.

Jamie MacDonald: Yeah because we're –

Mr. MacEwen: As you say, you try to come to an –

Jamie MacDonald: – accountable to –

Mr. MacEwen: – agreement (Indistinct)

Jamie MacDonald: – how that money is spent –

Mr. MacEwen: Exactly.

Jamie MacDonald: – and to ensure it's spent for the resident.

Mr. MacEwen: Thank you.

Andrew MacDougall: No doubt, when those incidents happen, frankly, I can't recall. I recall a lot of challenging discussions in this area, but I can't recall too many where we haven't found a resolution. I suspect that you would be getting calls in your offices if we got to that point where we completely vetoed it.

Mr. MacEwen: Thank you.

Chair: Okay.

Mr. MacEwen: Thanks, Chair.

Chair: Thank you.

Brad Trivers.

Mr. Trivers: On the comfort allowance side. If someone was assessed for long-term care and that would be a level four or level five, correct?

Andrew MacDougall: That's correct.

Mr. Trivers: But then they had a loved one or someone who wanted to look after them, either in their own home, or in the home of their loved one. Would the comfort allowance still be available to them?

Andrew MacDougall: The comfort fund would only be available if they're within – if they're an admitted resident of a long-term care facility.

Mr. Trivers: Okay.

Andrew MacDougall: If they got discharged home then that would discontinue at that point.

Chair: Just one quick question. Say, it's $100,000 in the bank account; go into a facility, and they have $1 million in investments, they're eligible for a comfort allowance.

Andrew MacDougall: It depends on what their income is.

Jamie MacDonald: If they have income from the investments, or other income.

Chair: But what if it's –

Jamie MacDonald: Yeah.

Andrew MacDougall: Yeah.

Chair: But if they have $1 million in RRSPs, and they choose to keep it there until 71 –

Jamie MacDonald: Yeah.

Andrew MacDougall: At the end of the day, if you're making approximately $30,000, $31,000 or so less, or less, then you're eligible for a subsidy no matter what your asset stock is in long-term care.

Chair: What do other provinces do in terms of that?

Andrew MacDougall: Right across – so it's not a publicly – long-term care is, at this point, not a publicly-funded service. Its income, in general, across – as a result of that, of course, as we can appreciate in the health system, we got patch quilts right across the country. In general, right across the board, it is an income-based system for accommodation-related services. The jurisdictions cover health care; what they define as health care services. But for accommodation, it is – which is room and board, your housekeeping, laundry, food, infection control, these sorts of things that would be called accommodation services, people are liable to pay for that, but it's income-tested.

There are different approaches. For example, Nova Scotia, they have, over there, they have an income test, as well. They

don't have comfort funds, per se, instead they cap. They'll cap the amount of income that is required to be directed towards a long-term care facility to 85%. Essentially, the people there can keep 15% of their income to allow for the purchases

I think our approach here on Prince Edward Island is somewhat more equitable and advantageous in that regard. At least the approach that we have is, across the board and equitable. Whereas in Nova Scotia, for example, you'd have differences because of that fluctuation they permit. There are different approaches.

Chair: Thanks.

Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

I just want to follow-up on that, Andrew. As I understand it, nursing case is income-tested. Community care is income and asset-tested. But home care – and Brad just brought this up – if somebody is living at home with the same challenges, medical conditions or whatever, that they just are supported at home, that home care is not means-tested at all.

Can you explain the rationale behind that? Why somebody, who is at home, who has equal need for a comfort allowance would not be eligible.

Andrew MacDougall: It's hard to – I mean there have been some different decisions that have been made over the years. In terms of funding approach for home care services, there is a basket of publicly-funded services that are provided through home care for sure.

There is, again, there is some income-tested, to some extent, services, as well for, you know –

Jamie MacDonald: (Indistinct)

Andrew MacDougall: – like activities, instrumental activities of daily living, I guess is what they call it, like housekeeping and medications or transportation, these kinds of things. It's a patch quilt there. I really don't think I can speak into the details on the funding mechanism beyond that for home care. Except traditionally, we've had a bed-based approach to providing health care services – well, across the country, not just on Prince Edward Island, where the bias has been towards institutional-based facilities and services and programs, as opposed to the community-based setting, which I think we're recognizing now. It has been appreciated that we need a more robust community setting to encourage people to age in place as long as possible. There are certainly some policy elements out there that favour, perhaps, institutional settings more so than community settings.

Dr. Bevan-Baker: Thanks, Andrew.

Would it be fair to say that with the review that's underway, it started in March, that this is, perhaps, one of the areas that will be looked at and, you mentioned, that the rationale really is that political decisions have been made in the past and that's how we've ended up with the status quo.

Is the review going to dig down deep enough to actually look at these sorts of questions?

Andrew MacDougall: I would say yes. I don't want to speak on behalf of the Department of Health and Wellness, who is spearheading this, but I would say unequivocally, there are various advisor groups that are actively in place right now that are looking at long-term care services; looking at home care. There is, for example, a funding and bed allocation group.

I think it's well understood and appreciated that at the end of the day, Prince Edward Island has amongst the highest level of long-term care bed allocation in the country –

Jamie MacDonald: Per capita.

Andrew MacDougall: – per capita, significantly higher than the national average. It's 105 beds per 1,000 people above the age of 65. The national average is 85.

You look at our length of stay in long-term care, it's actually going up. In the last five or six years, it's now 2.9 years, where as it used to be 2.7 years. I mean, even that point two differential means an extra 90,000 days, almost of residential care that's being

provided. The national average there is 1.8. You add these things together you can see that we have had a traditional bias towards that. Certainly, every indication is the strategy that is being put forth is trying to address that balance.

Jamie MacDonald: I think, just in terms of, just from a broader Health PEI perspective, looking at bed-based care versus home care or primary care. I think if you look, we're like the rest of the country, that we're looking at how do we further support people at home longer, or moving people from bed-based care from hospital care to home with appropriate home care supports in place. The majority of people do want to stay at home as long as they can if they have the appropriate supports in place. I think, from a Health PEI strategic plan perspective there is a significant focus on home care and primary care.

Dr. Bevan-Baker: I'm glad to hear that from both of you.

We're all fully aware of the many benefits of aging in place, both for the individual and the families and communities, and from a holistic perspective, it's, when possible, and, of course, it's not always possible, but it's, in my opinion, the way to go.

When we make disincentives like not allowing people in that situation, to access things like comfort allowances, we're actually working against that. I'm really glad to hear that that will be looked at in the review.

Thank you.

Thanks, Chair.

Andrew MacDougall: Thank you.

Chair: Chris Palmer.

Mr. Palmer: Thank you, Chair.

Andrew, you may have already covered this, I'm just looking for clarification. With the income-tested nature of the comfort allowance, is there a prorated or graduated amount depending on what you're income is? Or, is it, you either receive it or you don't?

Andrew MacDougall: It would be the latter. There is no proration. You get it or you don't.

Mr. Palmer: Okay.

Where do we come up with the $30,000 or $31,000 as the cut-off line?

Andrew MacDougall: That's essentially, that's based on the rate of subsidy. Right now – and there is a difference within the sector, but, in general, the what's considered the subsidized rate, there is a self-pay rate for those of means, what they pay in a per diem basis, but there is a subsidy rate as well.

The subsidy rate is approximately $83 a day. If your income works out to less than that then you're considered eligible for subsidy. That's where that 30,000 – if you do that math out, that's where the 30,000, 31,000 comes from.

Mr. Palmer: Okay, thank you.

Thanks, Chair.

Chair: Anybody else? Good. Continue.

Jamie MacDonald: Thanks.

Andrew MacDougall: I'm going through my water here.

Chair: Here you go.

I'm a good Chair.

Andrew MacDougall: Thank you.

The next section that we were asked to come discuss is spousal funding, or funding for couples. This is a tricky area to explain. We'll do our best here. It's a tricky area to explain how this works and hopefully this is clear.

Again, off the top, again we're referring again to the *Long-Term Care Subsidization Act* circa 2007, is when that was put into place. As we've talked about here it's an income-based system on the accommodation side, so that's regardless of what care setting you're in long-term care. It's income-tested.

For the definition of the basket of health care services, that's fully funded. In general, how a basket of basic health care services defined, is, it's essentially defined as 24-7 nursing care, medical care, so access to physicians and/or nurse practitioners; connection with generalized equipment, generalized supplies, these sorts of elements. When things go beyond what we would consider basic, there are other streams to go to try to address that.

When it comes to spouses, spouses are defined, again, in the regulations, as a formal married couple, but also people, a couple as living together as though married, I think, is how the wording goes. So, common law, I guess is the way I'd read that. That's what counts as spouses for the purposes of calculating what one will owe in long-term care.

The way it works is the combined income for both spouses is taken together. In half of that income, half of the income is what is subject to this process for determining what one pays. Although it doesn't happen too often, this could also be less than half. If there are other dependents, for whatever reason, that are habitating with the couple it would be prorated further. If there is a dependent there, then we'd be looking at a third of that resident's income, as opposed to half. The vast majority of the cases it's the couple's income. Spouse A, spouse B, it doesn't matter if one is making 10,000 and one is making 50, it's taken together; $60,000. Divide it two; so hypothetically $30,000. That's what is used to start this process.

Income, again, is defined as what's on line 236 of the Canada Revenue Agency's – what they consider income is what is factored as income. Minus – the only exceptions are, there are some minor exclusions from income associated with taxation – retroactive taxation payouts for previous taxation years, during which time, if the applicant wasn't already in receipt of financial assistance of some sort.

Outside of that, and also at the death, disability benefit, that is also excluded. In general, anything that is showing up on line 236 is subject to this.

When it's determined that for the spouse that remains in the community, who now has half that income, when it's determined that that is not sufficient for them to maintain a reasonable standard of living, then there could be what is called a variance. Essentially, the variance would be a potential reduction in what the resident in long-term care would have to pay in order to enable more income to be available for the spouse in the community.

Obviously, that's a very subject term; to have reasonable standard of living. The regulations are relatively clear on this. It references that a reasonable standard of living is defined as the combined supplement of OAS and GIS in the Canada Pension Plan act. That's what is defined as a reasonable standard of living. That's factored into these calculations.

Maybe to help – actually, before I get to that, I'll just say, these expenses here, this again is taken directly from the regulations. These are what are considered eligible expenses for the spouse that remains in the community. Various categories there, fairly broad, but in general these categories do tend to cover what becomes eligible.

In an attempt here to try to make this as clear as can be, or to highlight two different scenarios, I'll just walk through two different cases, which again, are simplistic, but I think hopefully reflect the principles at hand here.

This would be case example A. This is a couple. Spouse A has gone into long-term care. The spouse that remains in the community, these are the expenses that are noted. I'll highlight that food, clothing and personal expenses are defined as the rates that apply on social assistance.

Chair: Okay.

Andrew MacDougall: That's where that is. The rates cannot exceed what is already called for in the social assistance policy.

Then there are various allowances that have maximum limits. That's transportation, house upkeep, those elements have maximum allowable elements, or thresholds, I should say.

Right here, these are the expenses that would be in place and there would be some documentation that would be required to substantiate these expenses and they're monthly. The calculations are based on a monthly basis.

This spouse here, this is what he or she in the community has for a monthly basis for cost: $1,629, hypothetically. Trying to put this together – so we look at the table up there – so in the income section we have the spouse, the one that's in the long-term care facility, let's say, on a monthly basis makes 1,700. There's the spouse that remains at home, that person is making 1,300. There is a combined total of $3,000 on a monthly basis that is being received by this couple.

Off the top, we're taking half of that. Half of that is payable to contribute towards the accommodation costs in long-term care; $1,500. But we have just seen in the previous slide, that for the spouse that is community-dwelling, he or she needs 1,600, a little over $1,600, so, to be able to keep it together on a monthly basis.

What the staff would do at that point would be, they'd say okay: The amount payable to long-term care will be adjusted to allow for more income for the spouse in the community. It's adjusted here in this case. A variance is granted in the amount $129, because once that's subtracted off what is owed, then that will allow the spouse in the community to balance off their expenses based on a reasonable standard of living with their income. That's one scenario. This scenario resulted in a variance being granted.

This scenario is similar. The difference here, you'll note in the previous one there is no mortgage there. The only difference with this one, there is a mortgage. There is a $400 monthly mortgage in this case, or rental, or whichever way you want to define that.

In this case, there is $2,029 that's what the monthly expense is. Again, going to the same analytical approach here; a bit of a different income level, so we have the spouse in the facility is $1,700, the spouse in the community is $2,400, the total is $4,100 that's what this couple is bringing in. We'd take half, so it's 2,050. And looking at the eligible expenses, in this case, there is enough income to offset the eligible expenses so there is no variance granted. The amount payable to long-term care in this fact – in this case, is in fact, 50% of what the income was.

In either case, as we have talked about before, it wouldn't matter if they had $50,000 in savings or had a nice boat in their yard or what have you, we would only be looking at the income elements of that.

It's kind of tricky to explain. I hope that helps to highlight that element. Just a couple –

Chair: (Indistinct)

Andrew MacDougall: Oh, sorry.

Chair: No –

Andrew MacDougall: No, you –

Chair: (Indistinct)

Andrew MacDougall: Okay –

Chair: You have one more slide left.

Andrew MacDougall: Yeah, in this particular section, I think I do.

Again, assets not factors. There is a right to appeal. There is a right to –

An Hon. Member: (Indistinct)

Andrew MacDougall: There is a right to appeal decisions pertaining to the provision of financial assistance. Again, the basis under which someone can appeal is laid out in the regulations. Usually, the grounds are if the expenses weren't adequately considered, or basically the decision wasn't just or the process wasn't followed, those are basis.

There is appeal – there actually is every year pursuant to the regulations we need to appoint a committee to hear appeals. To my awareness anyway, this committee has never met. I'm not aware of any appeals that have actually happened in this area.

One more thing to mention is, also again, with that act, there are some exemptions that are there. The first $2,500, for example, this

is at, again discharge, I guess, from long-term care. I guess we know what that means usually. The first $2,500 is actually exempt from – so if there is debt owing.

The first $2,500 is actually exempt from this. So if there's debt owing, the first 2,500 is exempt and 50% of the total value of the estate would potentially be used to help resolve debts that may be outstanding from the facility. So it would be half the estate that would be eligible for that. That's just two other little nuances that are in the act.

Fr debt recovery, first 2,500, hands are off. I think the logic behind, I think, I'd speculate, that was around aiding with potential funeral-related expenses and those elements, and otherwise, 50% of the estate is eligible for debt recovery.

Chair: Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

Thank you. Who makes the case for the monthly expenses? Can you explain that process? Is that up to the spouse to make that case, and then who is confirming that?

Andrew MacDougall: The answer would be yes, the expectation is the resident's – or the applicant, I should say, at that point – the applicants or most likely the family, it's usually the family, that needs to demonstrate or substantiate the costs that they have.

They would work with the subsidy staff. We have three individuals in the long-term care program, that is their sole responsibility is to work with families to try to make this as painless as possible, if you will, because we can appreciate it's usually a challenging time for people that are going into long-term care and stressful. If you ask for all this documentation it can be obviously an added burden and that's a big part of the role, to try to facilitate that process.

I should mention as well that on an annual basis, if one's income changes from year to year, then this would be adjusted potentially as well. In general, most of the time, that doesn't tend to happen. People are fairly predictable – OAS, GIS, some CPP – but if it fluctuates, when it comes time to reassess on an annual basis, then there could be adjustments upwards or down. As far as that goes, even some people may no longer quality for subsidy as far as that goes.

But to get back to your question, yes, there's an expectation that these expenses are documented, and the staff would verify them.

Mr. MacEwen: You're leading into my second question and it's about changes. This is an annual check-up, so to speak, on their expenses and their income? Or, is it once you submit expenses, is that it or is it an automatic checkup on the other person living at home? Or, is it just up to that person to say: My expenses have gone up, so I would need to readjust.

Andrew MacDougall: Yeah. For the spouse at home, yes.

Mr. MacEwen: So there (indistinct) –

Andrew MacDougall: We would expect them, if there's been a change in their circumstances financially, they would need to contact our staff and essentially work through this process again.

Mr. MacEwen: But there's no vice versa. Long-term care staff are not reassessing the expense of the person that's home year after year.

Andrew MacDougall: No, no. What we would look at is – what the staff would look at would be – it's kind of stratified by risk. We'd be looking for income fluctuations in particular, because that might impact this calculation.

Again, for people that – and we encourage everyone that comes into long-term care, we encourage that their OAS and their GIS is directed to the facility because that saves a lot of burden from them because then they're going to have to come in and it just is going to be stress. So when we know we've got that, we see the income, it's a very straightforward process and not even – sometimes you need to do these reviews because we see the income that comes in.

For those that have fluctuating income we would take an additional measure. But no, I wouldn't say that we reach back out to spouses that are in the community to see

how their expenses are going. We kind of rely on them to come to us.

Mr. MacEwen: Okay.

Back taxes or, say, unknown loans that have accumulated over the years and then this process starts, how is that – is that an eligible expense? So for example, say one person in a relationship basically took care of all the bills over the years and all of a sudden that person is the person that's going into long-term care, the other spouse basically finds out: Oh wow, we owe a significant portion, a significant amount in back taxes or a loan or something that they didn't know about. How does that work with the eligible expenses?

Andrew MacDougall: That would be eligible. Of course it would have to be substantiated, but taxation is definitely, and loans are legitimate expenditures that are factored into this.

Mr. MacEwen: Just one last comment: You said there are never appeals?

Andrew MacDougall: I'm not aware of any appeals; I checked. I'm surprised at that because I know there's been some public commentary in this area, but I checked with staff actually, recently and we haven't. We actually appointed the committee every year and that's somewhat surprising, but no, not aware of any.

Mr. MacEwen: Thank you.

Chair: Just before we go on to ambulance services, can you give us an update on Atlantic Baptist Home? How's it going out there? They're moving out 41 people as the media reports. It's coming due?

Andrew MacDougall: That decision, that measure is being held in abeyance right now pending the outcome of the arbitration that was just recently held between the department of health and the private long-term care nursing association. They've taken the step at this point. They want to see how that plays out. It's certainly something they've articulated previously, but I guess they're waiting to see what happens.

Chair: So until the arbitration is over, no one's going to be moved.

Andrew MacDougall: That's been their indication (Indistinct), yes.

Chair: Any other questions on this? Great, we'll go on to ambulatory –

Mr. MacEwen: Chair?

Chair: Sorry. Sid?

Mr. MacEwen: A follow-up on your point, too.

Allocation of beds to other facilities: Is that on hold until this process, that arbitration is done? For example, the 24 beds in Andrews of Stratford that are not being filled, is all that process on hold until this arbitration is done?

Andrew MacDougall: That process is on hold – to the extent I can articulate, this would ultimately be a department of health policy decision, but it seems evident that that decision, any significant developments in the bed allocation would be made pursuant to the seniors health and wellness strategy that is on the docket for a release next spring.

There is one of the groups – in fact, I was just there this morning before here – one of the groups is actually on bed allocation and funding model, so that's being looked at. My interpretation of the department's position would be that they're holding any bed-related developments –

Unidentified Voice: (Indistinct)

Andrew MacDougall: – yeah, investments, pending this strategy.

Mr. MacEwen: Thank you.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: I just want to further follow up on this discussion. As I understood it, when this hit the media a month or so ago, a process was triggered where there was a certain –

Chair: Ninety days.

Dr. Bevan-Baker: – yeah, 90 days that it –

Chair: Is it 90?

Dr. Bevan-Baker: Thank you, Chair.

Andrew MacDougall: Yeah, 90.

Dr. Bevan-Baker: So would it – just to be absolutely clear, that is no longer in play? The 90 days is no longer in play.

Andrew MacDougall: That is the case. They've conveyed that in writing to the department.

Dr. Bevan-Baker: Great, thank you.

Chair: So a follow-up to Peter's: The families can be assured that no – until arbitration is over, no families will be moved out of that facility, or not of their own choice, plus, if after arbitration Atlantic Baptist, they'll have to re-trigger the 90 days. The 90 days is still not accumulating?

Andrew MacDougall: That's correct. That's our interpretation of that. It's ultimately a decision that their management team, they're driving the bus for lack of a better word on this issue, in terms of they have the rights within the service agreement to give that 90-day notice; but they've indicated they're holding that decision in abeyance depending on the outcome of that process. Should they determine to continue down that road, then we would expect that the 90-day period would then start at that point.

Chair: Great. Thanks very much for your update.

Any questions on that?

Dr. Bevan-Baker: Chair?

I'll follow up on your follow-up on my follow-up.

Unidentified Voices: (Indistinct)

Dr. Bevan-Baker: Now I've forgotten what I was going to say.

Andrew MacDougall: Too many follow-ups.

Dr. Bevan-Baker: It'll come back to me.

Chair: We can go back at any time, Peter.

Dr. Bevan-Baker: Okay. Thanks, Chair.

Chair: We'll go on to ambulatory services.

Andrew MacDougall: Okay, sure.

Chair: Ambulance services.

Andrew MacDougall: Ambulance services.

Chair: I always get mixed up. Ambulatory (Indistinct) –

Andrew MacDougall: Yes.

Chair: You've got to rename that ambulatory care.

Andrew MacDougall: Sure.

Just one slide here really on this, because I'm not going to get into an articulation of the program here. I'll just talk about how it relates to long-term care, in particular.

The ambulance services are administered under the ground ambulance services program, and much like long-term care, much like home care and other elements, it's not covered under the *Canada Health Act*. So again, here was have a patch quilt of services right across the country, and it's exceedingly difficult to even compare jurisdictions on this because there's quite a different mix of policy on this.

On the Island here, the approach is – again, from the long-term care standpoint – the approach is there's a program in place for seniors over the age of 65 years old, it doesn't matter where. Whether you're at home, whether you're at a community care facility, whether you're at long-term care, whether you're in a park, if you need ambulance services to transport you to the hospital that fee is covered. It's as simple as that. That fee is covered.

Now, on the back side of that, when it comes time to repatriate, so return from hospital after the acute episode has been managed, at that point, a $150 charge is applicable again, for everyone, regardless whether you're in a long-term care facility or not.

Again, different jurisdictions have different approaches to this. Like New Brunswick for

example, they have a different way of handling that. The long-term care residents are covered off, but then not all seniors outside of long-term care are covered off.

The way that we handle, in general, the repatriation fee for long-term care residents on the way back is –you know, there are different approaches, but we'd look at comfort fund. If they have capacity to be able to pay for that $150, we would look at that.

There is great care goes into making sure that in so doing, if that happens that their comfort fund allowances aren't being wiped out. If we look at their – a given resident's trend of their use of comfort funds over the years, so if every month that person gets their hair cut; every month they like to go to a movie and every month they get the subscription or something, if paying for that ambulance fee out that pocket would take away that capacity for a given month, that wouldn't happen.

It's usually that the first layer is okay: do they have capacity within their comfort funds? The next layer would be to try to exhaust any other eligibilities that they could have for other supports, whether it's through income support or whether it's through some other entitlement program, we try to access it that way. At the end of the day if there is no go on either of those elements, then facilities would take approaches to try to cover that expense one way or the other. It is a bit of a patch quilt and the reason is because it depends on people's ability to pay. If you're not a subsidized resident then you'd be expected to pay that. If you are a subsidized resident you'd look at comfort fund allowance and we'd look at, again, are there any entitlement programs that you could get into. Then, if not, then certainly facilities are not going to prevent its residents from being able to use that service coming back from hospital.

Again, it's a bit of a patch quilt on the way back, for sure. It's very clear on their way there pursuant to the program; anyone over the age of 65, it's covered regardless of where you are in the province.

Chair: Darlene.

Ms. Compton: Thank you, Chair.

Thank you Jamie and Andrew for coming out. I haven't asked too many questions, yet.

Unidentified Voice: Haven't yet.

Ms. Compton: But you're answering some that I wanted confirmed.

Andrew MacDougall: Good.

Ms. Compton: Ambulance services definitely a challenge. Andrew could relate to that being an administrator.

One of the concerns that I would have is for someone whose spouse is at home and you've already done their assessment – tends to be the spouse at home you look to for paying if you've exhausted the comfort fund, and obviously they're not making any more money and they're just getting by, so there is a real patchwork there. There is that option. There is going to social services and trying to convince them that – and I mean some residents do need an ambulance on a regular basis, so it is a concern, and I'd just like to point that out; that if there was a way of making that path a little smoother for residents and their families, it would take a lot of stress away.

If you have an administrator who is going to the family and saying: we've got five ambulance trips that aren't covered and we have to find a way to pay those. You can say: well, we'll get the money from somewhere, but that somewhere is sometimes really confusing for the residents and for the family. I'd just like to make that comment.

The other question I have and I think that this was the case, that if you were sent to a facility that's not your number one choice, the ambulance ride is paid to that second or third choice and then if you get to get to go to where you want to go, you actually have to pay the fee to go from one nursing home to the other even though that's out of your control.

That was also another concern that was brought up to me in the past. It's not my choice that I'm going to Souris, or wherever I want to be in Stratford, so now when I get that choice, I'm paying the $150 ambulance ride to get to where I want to be.

Can you just confirm that? Are there any changes to that since –

Jamie MacDonald: Sure, I can probably speak to the ambulance piece because we do have that on under our portfolio. I think you're correct. I think there is confusion out there because the total cost of the ride is $600 and then everyone is subsidized to $150, and then seniors on the way to the hospital are subsidized further at the zero dollar value.

I think over the past couple of years what we've tried to do is look at each of the elements of the ambulance service and how we can make it more efficient. We've looked at some programs in the east because their coverage or their wait times were longer so we've made some improvements there.

Then in terms of moving people out of facilities to, perhaps, the facility not of their first choice, that is something else we're looking at. Andrew and I are working with our ambulance folks, looking at what is the right thing to do. What is the right policy to proceed around seniors coming back and forth to hospital?

I think some of the policies that are in place are a little bit legacy. I think, also, in terms of looking at where we move people and how we move people around, if we want to move people around, we need to look at maybe restructuring our policy so it makes it easier for the patients and families to, perhaps, move from Charlottetown to Summerside or Charlottetown to Souris and those kinds of things, so duly noted.

Those are two of the three or four pieces of transfers that we're looking at. I appreciate those comments.

Mr. Palmer: Chair.

Chair: Chris Palmer.

Mr. Palmer: Thank you, Chair.

I think you may have answered my question. The full cost, you said, of an ambulance trip is $600?

Jamie MacDonald: Six hundred.

Mr. Palmer: If we back that up, and you said you're looking for some efficiencies; do we, kind of, do a jurisdictional scan to see how much it costs in other places to see that we're getting the value?

Jamie MacDonald: We do actually; we've looked right across the country. As Andrew said earlier, it's a little bit difficult because everybody's model of service delivery with ambulances is difference. Alberta, for example, they have just moved from sort of a contractual obligation to one where the ambulance service is actually embedded in Alberta health.

There are some differences in that that are not necessarily easily identifiable when you're kind of just doing a search on a website.

New Brunswick, we have looked at as well. We usually use them as comparatives, as we do Nova Scotia because we do have the same – we have Medavie, and they all use the same ambulance service, as well.

Efficiencies, so just what we looked at, how do we move people around? What we've done in the last couple of years, some people don't necessarily need to be moved in an expensive ambulance. Then, we looked at rapid transfer units. You see those rolling around the province. Those look like an ambulance. They're outfitted just like an ambulance, but they don't have a stretcher in them. That is a much more cost-effective way to move people when they don't need stretcher transport.

There are several of those across the province. I think there are three right now across the province that move people back and forth. That's another efficiency.

We're also looking at comparing ourselves to Nova Scotia, New Brunswick in how we charge for out-of-province transfers; both our own residents and people that are non-residents. There are a number of efficiencies that we're looking at right now.

Our number one is really looking at how we best serve our patients; moving them around the most effective way, and also most cost effective.

Does that answer your question?

Mr. Palmer: It does.

Jamie MacDonald: Okay.

Mr. Palmer: The second part of that is; our ambulance services is operated by Island EMS.

Jamie MacDonald: Correct.

Mr. Palmer: Does that go out to tender every couple of years or how does that work?

Jamie MacDonald: Yeah. There was a long-term contract agreement and the contract is up, I believe, it's March 31st of this year, 2018.

Mr. Palmer: So a new tender issue and –

Jamie MacDonald: That would be up to government. Government holds that contract to make that decision, but –

Mr. Palmer: Okay.

Jamie MacDonald: Yeah.

Mr. Palmer: Then we go back to the data that we received from other provinces to get a good understanding of those costs –

Jamie MacDonald: Absolutely.

Mr. Palmer: – as we're evaluating any of those tenders.

Jamie MacDonald: Yeah.

Mr. Palmer: Okay, thank you.

Andrew MacDougall: I'll just say, to Jamie's point, as well, the efficiency, the efforts that are being pursued there to enhance the efficiency of the services, it's well justified.

Since 2008, there has been a 70% increase in the volume of non-emergent transfers since the policy went into place; the program change went into place. That's obviously, a diversion of a significant amount of resources for unintended purposes essentially.

Chair: Peter, did you remember your question?

Dr. Bevan-Baker: I did remember (Indistinct) thank you, Chair.

We were talking about the 90-day period triggered by the incident at the Baptist home. You said that it's on hold until arbitration is completed.

My question was: Do we have a sort of an idea of how long that arbitration will take and is whether there is a specific date, so the people who are, you know, waiting for this, do they have a sense?

Andrew MacDougall: I fear as soon as I say this then there'll be an announcement that will come right tomorrow.

Based on previous timeframes from previous arbitrations, usually we can anticipate a one to two months minimal. We are expecting it will probably be potentially in January that we will be able to hear something.

Now, watch, something happens tomorrow, but the hearings were just held last week.

Dr. Bevan-Baker: Yeah.

Andrew MacDougall: We anticipate, informed by previous experience, that it's probably going to be January that it comes through, but I guess we'll find out.

Dr. Bevan-Baker: Thank you.

Thank you, Chair.

Chair: Sid MacEwen.

Mr. MacEwen: Thank you, Chair.

Our manor replacement program, we're replacing our manors with the same number of beds. We often hear that we're trying to increase resources to home, to keep people in their homes longer, the benefits, that type of thing.

Obviously, the trends are saying that we will have more people in long-term care. Obviously, we'll be relying on private care to do that.

I'm curious about the formula, the extrapolation method that the province uses

to decide what are we going to do for the next 20 or 30 years? What is that strategy?

How do we determine how many beds we're going to need? And to say: okay, we're going to go private for this percentage because we know we're not internally building any capacity.

Can you speak to, I guess, whose coming up with that extrapolation? How are we doing it? What type of model is that? That type of thing.

Andrew MacDougall: Okay, in terms of the model and the methodology that is being used behind that, the department of health under the auspices of Dr. Mike Corman would be looking at that in particular.

For example, there is the funding bed allocation group. Just this morning we were talking about a model that Dr. Keefe over in Nova Scotia has been working with other people. It's very – you get a lot of academic people together to try to work out this rigorous methodology that's based on geographical trends about local capacity, the length of stay, and all of these influence what you could see.

If you looked at the work that she did, for example, she projected this at different time horizons. At 10 years, 20 and 30, and if we're on the same trajectory we're on now, it would be a substantial number increase of beds that we would need. Just based on, we see the demographics, right? You know there was a recent investment a couple of years ago, 55 extra beds were added to the system and that provided us support, but that wasn't felt for very long before the pressures went back up again.

If we want to go on that path then we would have to add a lot of beds. We don't think that is, necessarily, what Islanders want. Long-term care is a wonderful place to be when it's the time to be there.

There is a group; it's called the funding and bed allocation group. Part of its mandate is to determine based just on a credible projection model what would be – the requirements are. That can't be looked at in isolation though; that needs to be linked up with the work that's being done to determine what community supports are needed.

Per that model I just referenced, yes, if nothing changes we're going to have to add a whole bunch of beds, but we don't think that's what people are looking for, so they'll have to be linked together.

There is a group that is looking at that very point that you're asking.

Jamie MacDonald: I think it's part of one of the working groups that is developing the seniors strategy. There are a number of different areas that they're looking at. I know they do have some of the gerontologists that are working in the province working on those groups, as well.

One in particular who has, she's relatively new to the province, but she has lots of experience in geriatrics, and looking at what is the best model or combination of models that will work for this population, this demographic. What does home care need to look like and what does the bed-based care look like, not only in long-term care, but community-based care and hospital care, for that matter, for the seniors.

That will all be part of the seniors strategy.

Mr. MacEwen: That's good and I assumed that was happening.

Who is on this funding bed allocation group, and do we have – and I understand the variables that go into it. As far as the investments we're making in health, hopefully that makes people healthier, it makes them at home longer, all that type of thing.

We must have an end goal in mind to say: this is our model; we can adjust it as we move on. I guess, who is part of this group, and when do we expect their model to be finished?

Andrew MacDougall: This would be part of what comes through with the strategy. The strategy, which is on a timetable for next spring, I mean one of the elements – as a part of the picture for the improving and expanding the continuum of care for seniors; the continuum of care, it's not just long-term care, like in the community and in various settings, I mean that's part of the puzzle.

It's difficult at this stage to say: well we're going to add 50 beds in the next two years and then we're going to add 80 by – in 10 years time. We have to make a determination on the relative prioritization of how investments are going to be made in our health system.

It's kind of a challenging question to answer, except to say that it's one of the key parts of the strategy. It's almost a little bit premature to speculate exactly what the number of beds is until we have a sense of what kind of investments are going to be made in the community.

The important thing right now is to find a legitimate, credible – which hasn't been easy – model that can help forecast that. That's what the focus of the work is right now. The work that Dr. Keefe has done over Nova Scotia, that's one such model that doesn't net unanimous support in the literature, I guess. But, just trying to find a model that will actually give us a reliable objective answer to the question you're asking.

Jamie MacDonald: Then, in terms of the question: Who is on that committee? You're on that committee, and (Indistinct) members?

Andrew MacDougall: Yeah, we have, well the representatives, we'd have Eileen Larkin would be there from the community care facilities board. We have David McMillan representing –

Jamie MacDonald: The private sector.

Andrew MacDougall: – the private sector in general. It's a broad grouping. Dr. Michael Corman chairs it, we have Joe Coade. Joseph Coade is his name. He is the provincial housing services manager over on the family and human services portfolio. They have a very important role to play in this as well because the whole swath of residential care supports, not just long-term care and community care, it's group homes and other types of housing and services, so that person is there. We have Mary Sullivan, who is director of home care and the gerontology program is there as well.

Mr. MacEwen: (Indistinct)

Andrew MacDougall: And a few others.

Mr. MacEwen: (Indistinct) you're welcome to submit that group back to the Chair if we're missing anybody on that.

Andrew MacDougall: Yeah, okay.

Mr. MacEwen: I guess I'll speak to as our role in opposition obviously is to hold the government to account. We're going to come up with some sort of a model and internally in government we're going to have a proposal, basically to the people that control the purse strings, to say: we believe that we are going to want this many public beds and this many private beds in the future.

It's not going to be an easy formula to get to, but we're going to get to some sort of projection that is going to be presented to government. Then they're going to make a decision to say yes or no or modify it. It's our job to hold those people to account on that decision because they have the numbers.

That's why I'm asking you – and I know it's not done yet – but I think it should be public when that time comes to say: this is what our model is showing. And then, this is the decision that the government is going to make on that model, and then we can hold them to account.

I'm looking for some reassurance that the public will see that proposal to government at some point. I'm wondering if you guys can speak to that today.

Jamie MacDonald: I can't speak to that. I know Dr. Corman, who is with department of health. He is leading the seniors strategy.

Mr. MacEwen: Yeah.

Jamie MacDonald: At that point we are involved, certainly, as are many of the other departments. I think it's fairly early on in the process but there certainly will be – they have committed to a timeline to have that strategy ready by.

Mr. MacEwen: All right.

Andrew MacDougall: We certainly feel the pressure, and in the community it's evident.

I guess sometimes it's not a whole lot of reassurance when you're saying: well, we're looking at and we're developing strategies and we're doing these things. I guess what we want to get away from is the short-term knee jerk type of things that tend to happen for understandable reasons sometimes, that's kind of what we've done. If the pressure is there (Indistinct) do this, do that.

We're putting a lot on the strategy, I guess. We want to make sure that we're following rigorous approaches and doing the best we can for seniors in a proactive way that envisions, not just the needs of today, but what's coming up front in the future.

Mr. MacEwen: I understand that. I guess that's maybe a role of this committee going forward is to monitor that and to have yourselves in, or the – probably more likely the funding bed allocation group at some point, too, but we can discuss that in the new business.

Thank you. I appreciate it.

Chair: Any others?

Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

Really interesting discussion around this because there have been questions asked in this House, of course, about the size of facilities that are being planned and built and about to be built.

We all know where the demographic projections are going and, as you said, Andrew, we know there is going to be an increasing need for continuing care.

You also said something interesting earlier that I was not aware of; that the number of beds here compared to the national average is considerably higher, 20% higher if I remember the figures.

Do I hear from you that there's going to be a shift in emphasis or focus here on Prince Edward Island when it comes to seniors care and continuing care from long-term facilities in beds to, perhaps, more community-based collaborative models, where aging in place is going to become a more important aspect of that?

Jamie MacDonald: I can speak to, again looking at working with department on the seniors' strategy and looking across the country at our own Heath PEI strategies for long-term care and seniors care in general, the trend across the country is more emphasis on primary care and home-based care.

If you talk to a large majority of seniors they want to stay home. Most do, not all, but most do, or in a home-like environment. What would that look like? That would be more emphasis then on home-based care –

[Electronic bells ringing]

– with the supports that are needed there, whether it's 24 by seven support or what have you, specialized supports. That is part of what we are looking at.

Now, in conjunction with, if we have that, then what would the bed-based care numbers look like?

If you look across the country per capita we do have the higher number of long-term care, but you can't look at in isolation because other provinces have more of an emphasis on home care. What is that happy medium between the two?

Chair: You probably hit the button, Andrew.

Jamie MacDonald: Time's up.

Andrew MacDougall: Yeah –

Chair: No, underneath.

Unidentified Voice: (Indistinct) back here.

Andrew MacDougall: Oh, is that what that is?

Jamie MacDonald: We thought that was our cue to times up.

Andrew MacDougall: Yeah, I was like, oh geez.

Unidentified Voice: (Indistinct)

Andrew MacDougall: Yes, I didn't know that was an option.

Chair: (Indistinct) watch the MLAs coming in from (Indistinct)

Andrew MacDougall: Interesting –

Jamie MacDonald: That's a seat ejection –

Andrew MacDougall: At the end of the day, the telling figures are the length of stay in long-term care on Prince Edward Island, the telling figures are obviously, our bed complement, significantly above national average.

The length of stay is almost three years now. Nationally, it's about 1.8. Jamie has mentioned the home-care level of funding. This is the basis of the seniors health strategy, but for long-term care into the future, for us it's not so much about beds, per se, it's about how can we continue to develop and grow the value proposition for residents in long-term care and provide more care on-site to prevent admissions to hospital and to provide more caring in place.

There are various measures and initiatives on the go and contemplated in that regards. Obviously, if the seniors health strategy delivers what, I think, everyone wants, that length of stay is going to shrink; it's going to go down. But then, that just means residents in long-term care are going to be that much frailer, and they're already frail and sicker. It means long-term care needs to raise its game, as well, to be able to meet the challenges of tomorrow.

Dr. Bevan-Baker: Thank you for that, very interesting. I, personally, am really happy to hear that.

We have some facilities across the Island, I'm thinking of Andrews of Stratford, the South Shore Villa in my district, and the Gillis lodge, actually, who have all built or expanded their facilities with the assumption that this increasing need is going to inevitably lead to more – increasing numbers, more need for nursing-care beds. I think they're 24 in Stratford, six or something in South Shore and 19 at the Gillis lodge.

All of these facilities that are preparing for more people, is that a concern? Are we going to end up with a mismatch here?

Andrew MacDougall: It's hard to speculate. Certainly, our partners in the private sector have made calculated investment decisions based on projections that they foresee.

I think we have a long way to go yet to – in terms of catching up to the demographic surge that's coming. I guess we'll see in terms of what level of investments and what level of changes are going to happen through this strategy. It would be difficult to answer that question for sure, but there is quite a gap in terms of right now where we stand on community-based funding versus the national average.

I wouldn't suspect, I'm just speculating, that that gap is going to be met all of a sudden right off the top. Probably there will be a transitional period where you'd anticipate pressures on the long-term care beds as we build our community, but hard to answer definitively.

Jamie MacDonald: I think, too, we've met with some of the private service providers, as well, just looking at: What are your plans? What are your ideas? What are your suggestions? I think they're looking at the demographics, I think they're also looking at the fact that there are a number of people, maybe Islanders that have lived – moved; lived worked elsewhere for a long time and a lot of those Islanders are now coming back here. They have disposable income. They have income, but they're mostly retired. They're looking at that population. I think they're building for future needs.

That's not to say, again, that even if we look at home-based care and more investments in home-based care, I think there will still always be that need for community-based care, long-term based care because you look at some of the demographics and they're not people that will be able to be home with home-care supports without some type of institutional support whether it's community-based care or psycho-geriatric care, dementia care, those kinds of things.

I think they're looking. I think they're looking at the demographics and we're starting discussing needs and wants with them.

Dr. Bevan-Baker: Thank you.

Thank you, Chair.

Chair: Brad Trivers.

Mr. Trivers: Thanks, Chair.

We've got private long-term care facilities and we've got public long-term care facilities, and we also have hospitals that are being used for long-term care.

I was wondering if you can give a breakdown today of where the beds reside between hospitals, public and private long-term care facilities. If that is not something you can do off the top of your head, if you can provide that as a report back to the committee.

Jamie MacDonald: Sure. In terms of total long-term care beds – and Andrew can add to this – there's 1,141, I believe. There is almost a 50/50 split between –

Andrew MacDougall: Fifty-two and forty-eight.

Jamie MacDonald: Yeah, 52% and 48, so 52% are the private –

Andrew MacDougall: Public.

Jamie MacDonald: – are they public?

Andrew MacDougall: Public.

Jamie MacDonald: Fifty-two percent are, of those 1,141 are public, 48 are private.

Andrew MacDougall: It's right here, actually.

Jamie MacDonald: Then – yeah –

Andrew MacDougall: It's right there, the numbers (Indistinct)

Jamie MacDonald: Then, in terms of hospital beds. We don't have designated long-term care beds in hospital. However, we do have residents waiting long-term care that are in hospital.

Is that your question?

Mr. Trivers: Well, so they're receiving long-term care in hospital –

Jamie MacDonald: They are awaiting –

Mr. Trivers: (Indistinct)

Jamie MacDonald: – long-term care and they are medically discharged from hospital, is the term that we use.

For example, at the Queen Elizabeth Hospital today there are 21 patients that are coded awaiting long-term care. That means they're acute episode is over and they are medically discharged from that service awaiting long-term care.

Mr. Trivers: That was QEH? How about –

Jamie MacDonald: That's QEH. I have them all right here, actually–

Mr. Trivers: That would be great.

Thank you.

Jamie MacDonald: Yeah.

Andrew MacDougall: (Indistinct)

Jamie MacDonald: No, I have today's numbers actually –

Chair: Jamie would get it every morning.

Jamie MacDonald: So, today we have, actually, sorry, I said 21; there are 25 at Queen Elizabeth Hospital.

Mr. Trivers: Okay.

Jamie MacDonald: Now, those would be split between what we consider a regular bed and a designated dementia care bed, which would be a little bit higher-level care. There are a total of 25.

Hillsborough Hospital, three; Prince County Hospital nine; Western Hospital 10; Community Hospital O'Leary three; Souris Hospital eight; Kings County hospital 14.

So, 164, no that's (Indistinct)

Mr. Trivers: Would those numbers be included in that 1,141?

Jamie MacDonald: No, they are not included in those –

Mr. Trivers: So they're on top of that.

Jamie MacDonald: – the 1,141 are the long-term beds only in the long-term care facilities. Correct.

Mr. Trivers: My next question was how the costs breakdown between the different public, private and hospital? Just more for the record, I know we've talked about this in the past at standing committee, but it's always been a little bit of a hodgepodge. It would be nice to get all the facts and figures in one spot. I don't know if that's something you can provide today, both the cost to the government as well as the cost to residents in the long-term care facility.

Jamie MacDonald: You can answer that (Indistinct)

Andrew MacDougall: If we look at our private long-term care partners, and of course this is subject to arbitration right now, so the rates basically break down: There's a health care rate and there's an accommodation rate, and there's also a premium for dementia care.

That's for the operating funds, and there's also a capital fund that has a maximum amount per year that can be accessed. Based on the most recent version of the agreements, it's approximately $185 per day. That translates to about roughly $75,000 per resident.

That's in the private setting, so on the public side it's higher than that. It's different. It's not exactly apples to apples when we compare the two; there's different overheads, obviously. In some cases there's different services being provided. So it doesn't quite neatly break down the same way. It is more. It's definitely more, but –

Mr. Trivers: Well I mean, you must have some sort of number you can put to that.

Andrew MacDougall: It'd just be a figure. I think it's something like – it's over 200, but you'd just be taking a global, what the global budget is. Health PEI, we know we have a $65 million budget for long-term care in Health PEI facilities. That'd be portioned out amongst the facilities based on a global budgeting process, but trying to break that down into the micro-level of the resident, sometimes it can be a little bit challenging to provide an accurate figure. You can get an estimate.

Mr. Trivers: Well, an estimate would be useful as well, especially when you're trying to make decisions about whether you're going to build more facilities or whether you're going to build more private versus public, these sorts of things.

Your estimate, you're saying over 200 a day –

Andrew MacDougall: Yeah.

Mr. Trivers: – or do you have a more accurate estimate than that, do you think? More precise, I guess I should say.

Andrew MacDougall: Well, the –

Mr. MacEwen: (Indistinct)

Andrew MacDougall: What's –

Mr. MacEwen: 280?

Andrew MacDougall: I think it's more along the lines of maybe 225, 230 roughly. Again, not the same denominator is being used, though.

Mr. Trivers: So we've got the private and the public long-term care facilities, now how about the hospital beds that are being used for long-term care?

Jamie MacDonald: So what numbers we use for long-term care or just general care, the cost is – depending on the facility – it's anywhere between 900 and 1,200 per day. Then if you look at a resident or a patient whose medically discharged, so it's the same bed, the only difference there is that when they're medically discharged, then some of their services are not as high as if you were acutely ill. So physiotherapy, those kinds of things, but we just look at the standard day-bed charge, we don't start taking apart that.

Mr. Trivers: What's the premium for the dementia beds?

Jamie MacDonald: (Indistinct)

Andrew MacDougall: It's $10 per day, 10 –

Jamie MacDonald: In long-term care.

Andrew MacDougall: – dollars per resident per day in long-term care, yes, just in long-term care.

Mr. Trivers: Ten dollars per resident a day.

So does this mean if I'm someone who goes to a private long-term care facility and I've got lots of income coming in – I did well in my life and I've got this huge amount – and so I might be paying the full $185 a day, versus if I'm in a public facility I'm going to be paying $230 a day?

Andrew MacDougall: No, see, those figures – for example, like the Health PEI estimate, the range of estimate, that includes the overhead and everything.

There's two rates in long-term care; there's a self-pay rate and there's a subsidy rate. There are differences right now between the public and our private partners in that regard, so you're going to pay a different rate. For example, I think the self-pay rate can fluctuate, and there's no cap in the private side what that rate could be.

Mr. Trivers: I don't know. I think it would be useful if you have some of those numbers, to find out at committee here today.

Andrew MacDougall: Well, I can say that the numbers that we'd have, for example, in the private sector, it's approximately – it's a little north for the average. Now this is an average, self-pay rate would be probably 103, $104. The subsidy rate would be approximately 83, $84. That's a subsidized rate.

Contrasting that, both those rates on the public side would be less than that. The subsidy rate in the public sector I think is around $82, $82.59 I think. No, sorry, the subsidy rate in public sector is 77, 69 or something like that, and the self-pay rate is $82 or thereabouts. So there's definitely a difference between the two, which has been highlighted in various forums.

Mr. Trivers: So just to be clear, it actually costs less to stay in a private facility than it does for a public when you look at the estimates per day (Indistinct) but the self-pay rates and the subsidy rates are actually lower for the public?

Andrew MacDougall: That is the current reality, yes.

Mr. Trivers: Why is that the case?

Andrew MacDougall: Why is that the case?

Mr. Trivers: Yeah. Why would you set the rates lower for public if it actually costs more to be there?

Andrew MacDougall: Well, on the one hand, the rates with our private partners are a negotiated process that happens. So there's the private long-term care nursing home association that we'd negotiate on behalf of all its members and they arrive at an arrangement so that every couple of years it comes up for renewal and there just simply hasn't – on the public side, there hasn't been an update in its rates over the last successive renewals of the service agreements or the private partners. There just hasn't been as of yet.

Mr. Trivers: Do you think there's an opportunity there to perhaps take the rates and make them similar so that there's no advantage one way or another?

Andrew MacDougall: The disparity would suggest that.

Mr. Trivers: I have another set of questions, Chair, but I can give the floor to someone else if they want.

Chair: You want to go, Bush?

Mr. Dumville: Sure. Thanks, Chair.

Jamie – Andrew, I guess – I know the department has a budget envelope and we've got these private health care facilities that have increased their capacity – opportunistically, probably, but that's the way business works.

Has any thought been given if – the hospital stays we know are very, very expensive – you're putting people in the hospital on a

temporary basis awaiting for long-term care. If there's extra capacity out there, have you ever thought of negotiating a short-term contract with these private providers if they have capacity?

In other words, if it's $1,200 a day in the hospital, if a private facility can do it for half the rate on a short term basis, have you ever thought of entering into three or six or 12-month contracts to pull them out of the hospitals?

I understand that if you go there on a long term the private operators are going to want to keep and extend those contracts permanently, but a contract is a contract. Have you ever thought of moving them out in short term contracts to save money?

Jamie MacDonald: I can probably answer that. The short answer is: Yes, we've thought about that; not only in terms of the long-term care piece, but also in terms of acute care piece and bed flow and having the appropriate person in the right bed at the right time and so on and so forth. We all know the issues associated with keeping people in a hospital longer than they need to be there.

So the answer is yes, that is one of the things that we're looking at, and there are a number of others as well. Home care we talked about, that's another piece of it. There's probably not one ideal solution; I think there's a number of them depending on the population.

Some of the individuals that we're looking at – again I'll go back to hospital – are more difficult to place than others. Psycho-geriatric and those kinds of things, you really need a different type of environment for that. We are working with our geriatricians and a number of other people to look at what is the right solution or solutions It is not just a long-term care problem for sure, it's a systemic problem, but it's also a hospital-based problem also.

Mr. Dumville: Thank you.

I'd like to compliment you, just in case it doesn't come back to me, on your presentation. You were well prepared today and thank you for your presentation.

Andrew MacDougall: Thank you.

Jamie MacDonald: Thank you.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

I'm going to follow up on what Bush was saying, come at it from a slightly different angle and perhaps push a little harder.

Jamie MacDonald: Sure.

Dr. Bevan-Baker: You said yes, we have been thinking about this. I can't remember the exact numbers, but there are 40 or 50 people, I believe, in hospitals at the moment in long-term care who could be shifted to –

Mr. MacEwen: Seventy.

Dr. Bevan-Baker: Seventy. Thank you, Sid.

Chair: He's (Indistinct) today (Indistinct) with the numbers.

Dr. Bevan-Baker: And part of the reason that's not happening is that government has not issued any more nursing care licenses, too, whether it's in Stratford or Gillis lodge or anywhere else. You say yes you've been thinking about it, but why – I mean let's imagine that half of those 70 people could be moved, and I realize not everybody is appropriate to move, but let's imagine half of them are going to be moved. That would save the province $30,000 a day if that were done.

There must be a very compelling reason why you're not issuing these nursing care licenses to place that have the facilities there, sitting waiting to be used.

Jamie MacDonald: I can answer a little bit of that. The $30,000, do you mean the $30,000 a day in bed-based, in hospital-based care? We have looked at this, as well. The only way we save that is if that bed is then empty. We could move that long-term care resident out, for example, but the way that then you would save that $30,000 if you actually close that bed because there is always somebody waiting for that bed.

That's one piece of it. It's tricky in that way because the only way we actually save the

money is to close the bed on a permanent basis and we don't have the – we have people waiting for those beds, right? That's one thing.

The other piece is why haven't we done it? Because we want to make sure – and I think Andrew alluded to this earlier – what is the best fit? Not necessarily just the short-term solution, but what is the most appropriate long-term solution? The easy solution, I think, is move people out; contract a bunch of beds and then those 20, 30 beds are filled.

Then, 12 months later, we haven't made any other changes. Those beds are filled and then what's the next step?

We want to, not only, rely on just the bed-based care, but what other things in the system can we use so that we're not always relying on a bed somewhere.

Again, I'll go back to home-based care, primary care, those kinds of things. Is that a better model or should that be part of the model moving forward and not just those beds that are out there.

Andrew MacDougall: I would say that in support of the sentiment that's being expressed, that there certainly have been various initiatives by Health PEI to try to reduce the reliance on long-term care services.

When we think of beds, sometimes it's not just about long-term care beds, but it could be other types of services that are provided in long-term care settings. An example of that would be restorative care.

At Prince Edward Home there are 12 beds. There are 12 beds, that a couple of years ago an initiative was undertaken to convert those beds into restorative services. To help to illustrate the potential impact that can have is, I remember a scenario a few years ago at the old Prince Edward Home where there were intense issues and pressures that we were experiencing in our hospital, and two beds at Prince Edward Home – because there used to be a convalescence service there like a little convalescence services. Two of those beds, just to meet the pressure of that day, two of those beds were temporarily converted into long-term care beds. That was fine. That was fine and dandy that took the pressure away for that day, but then those two beds were gone from the system for the better part of two years.

Contrast that with when the new Prince Edward Home opened up there were 12 beds that were established, instead of being long-term care beds, they were restorative-care beds, and over the course of the past year we have run through probably 130, 140 different frail senior Islanders through that program and 80% of them, approximately, have been repatriated. They have been able to go back home as opposed to waiting in the hospital where they could become more frail.

That's kind of the balancing you have. Yes, the pressure of the day would have been at us to make them all long-term care beds, but that's an example at a small scale.

Now, the discussion could be how can we build on those kinds of initiatives? If we're going to have certain beds, maybe we look at what kinds of services we're providing those beds to reduce the pressure on the hospital and to keep people in the community longer. That's an example of that.

We can also point to some other examples, such as the coach program we have in Health PEI and the extended advanced care paramedics that are providing supplemental supports for frail seniors to wrap a basket of services around them to divert them from hospital or if they're there to try to pull them out quicker.

These are promising initiatives. Perhaps the scale is not where they yet need to be, but that's an example of maybe thinking a little bit differently with the type of services we want to provide.

Dr. Bevan-Baker: I don't want to underplay the complexity of what's going on here; I absolutely appreciate that.

When we're talking about value for money, Islanders' tax dollars being used as efficiently and as effectively as they can, I appreciate that those beds, if they were empty the saving would be there, but that's not really the point when we have waiting lists here on Prince Edward Island for

almost any medical service you would like to imagine.

Those that require inpatient care afterwards, surgeries for examples, and other things. Those waiting lists are in part caused because – and mental health as well – because we do not have access to beds in hospitals.

For long-term care patients there are choices, they could be in the hospital, but they could be in these nursing homes. For those things that I have just mentioned, the medical situations, there is no choice. Part of the issue here is not just dollars, it's access to services.

I appreciate your argument that the bed is not going to be any cheaper unless it's empty, but the fact that we're spending this money on keeping people where they could be moved elsewhere and reduce waiting lists at the same time, can you respond to that argument?

Jamie MacDonald: Sure, there is no argument there; I totally agree with you. We see it every week. Every Thursday we have bed rounds at most of the hospitals and that's what we talk about. Who are the patients in our beds? Who can move? Where can we move those to? Can we move them to restorative care? What about a bed in Summerside? We look at every bed, every week, in the province.

With that, though, however, that's where we're looking at what is the best long-term solution for that patient or resident? Is it adding more long-term beds so we can move them out of hospital so then we can get people in for their surgical procedures? Or is it a combination of restorative care, home care, enhanced primary care, chronic disease clinics, are those a better group of services to provide a long-term care resident rather than just moving them to an empty bed in a facility?

I certainly appreciate what you're saying. We're trying to look at more longer term – I guess it's short-term pain for really longer term gains, and where we need to be.

It is, as we talked earlier, the demographics are such that it – people are getting older here. People are living longer, and they're sicker when they come to hospital, sicker when they get to long-term care.

What is the best fit of all of the services we provide? Is the best fit more bed-based care or is it a combination of different things?

Dr. Bevan-Baker: One final question, Chair, on that.

As you're doing your rounds every Thursday do you wish that there were more nursing care licenses available to move some of the people, who could quite easily and appropriately be moved out?

Jamie MacDonald: Do I wish? That's a tricky question. I'll go back to what I previously said. I wish there were more services in the community or additional services in the community that would support the needs of the Islanders so they don't always have to rely on bed-based institutional care.

Dr. Bevan-Baker: Okay, thank you.

Thank you, Chair.

Chair: Brad.

Mr. Trivers: Yeah, thanks, Chair.

I was wondering, this is a question more about staffing. For example, there is a new home being built in Montague.

I wanted to confirm, first of all, what the plans are for the Stewart Memorial home in Tyne Valley. Are there plans to keep it open in conjunction with the new Montague home?

Andrew MacDougall: No, not from a long-term care standpoint.

I understand that there is some discussion happening in the community about potentially acquiring Stewart Memorial home, possibly for community-care level service or some other type of supportive housing, but that's a dialogue the community is having.

From a Health PEI standpoint, once the new Stewart Memorial home opens up we'll be transitioning those residents over there and then Stewart Memorial home will go

through a disposition process pursuant to government policy at that point.

Mr. Trivers: Is one of the reasons you're planning to potentially close the Stewart Memorial home because you'd have challenges with staffing it along with the new Montague facility?

Andrew MacDougall: No, not at all. It would be based on our mandate for the number of beds that we have as an organization.

Mr. Trivers: It's all based on the number of beds that you feel you need at this point in time?

Andrew MacDougall: Yeah.

Mr. Trivers: Are there any other concerns with the existing facility at Stewart Memorial home?

Andrew MacDougall: Concerns from –

Mr. Trivers: Like, why would you replace it with a new facility instead of keeping it open?

Andrew MacDougall: Stewart Memorial home, I got to be careful, part of my family is from Tyne Valley (Indistinct) here so, and I was administrator there at one point, too, very proud of that.

It's an old facility. Essentially, it's a repurposed hospital for long-term care. Despite the many great efforts of the staff and the community in their support of that home, and the various initiatives they've done to make it feel like a home, it's still, at the end of the day, is a repurposed hospital and it no longer really truly reflects the modern thinking when it comes to design principles for long-term care.

Especially design principles for people with dementia, in terms of how these facilities are laid out and the look and feel, and even from a work flow standpoint, for sure, staffing as well. It supports what they're doing as opposed to making them do workarounds for everything that they want to do.

It's certainly – this building, it served its purpose, but we don't feel – it no longer fits the mandate for long-term care services going forward, so we're looking forward to a new facility.

Mr. Trivers: The other question I had was at the last standing committee meeting that I was at talking about long-term care in March. I believe there was some talk about improving the assessment process.

I just wanted to get an update on any changes to the assessment process. You had talked earlier about trying to take people who might be a level four and rehabilitating them back to a level three so they could go back out.

Do you have any updates?

Andrew MacDougall: We still have the same assessment systems in place right now. What you're referring to though, I would say, strikes to one of the cores of what the seniors strategy is going to be all about. We feel it's a fundamental aspect to have an objective, modernized, evidence-based assessment system to support seniors at home living, wherever they are in the continuum, in long-term care or in the community or wherever.

It's called an interRAI system is what it's actually called. It's internationally validated. It's the standard. It's something we feel is an absolute, fundamental element and we're advocating for that through that strategy.

It's the status quo for now, but high priority to try to hopefully get that reflected with the changes upcoming for seniors care.

Jamie MacDonald: In terms of the seniors' strategy committees that we were talking about earlier, one of the committees is looking at assessment tools and that specific interRAI is the name of the tool.

Mr. Trivers: One final question, Chair.

It has to do with the ability for people to look after their loved ones within their own home, their home, not necessarily the home of the person that needs the care, and helping come up with a model where they can do that even though they might be a level four, let's say. And be able to make that choice.

We talked earlier about the fact that there is

no funding for comfort allowance, for example, that's available for people that choose to do that. My understanding, really, there's no supports, no financial supports of any kind, really, at this point, available. There is some home care that's offered.

I just wanted to find out if that's something that you're looking at doing as part of this new strategy, or perhaps, maybe not even as part of a strategy, but sooner?

Andrew MacDougall: We see the strategy as a great way to advance this. This has been something that's been looked at for a long time, frankly.

These assessment tools, they allow – they're phenomenal, really. They allow you to get to a much more precise level of plan of care for residents, or people in the community as well. When they're done, they pop out. They can pop out, for example, different care packages or different recommendations for things that could be done, that you could do. That alone, so it has decision-support elements with it, too.

For example, if you're recommending something that might be actually contraindicated. You could say: Whoa, don't do that or you should check this first. It has that level of intelligence to allow us to get much more precise and of course that would permeate the basis of how we interact with family, people in the community, how we facilitate their connections with resources and how they can support their loved ones. We feel that the interRAI system is the foundation for advancement, really.

We see the strategy as a key way to move forward with that. We're pushing it. We're advocating it.

Mr. Trivers: I just wanted to voice my support for something like that. If I choose to look after my loved one in my own home and perhaps even have to cut down my employment or leave my employment there are some supports there that will enable me to do it.

It should be a win-win-win scenario in terms of for the patient, the person who needs the care; the person who is being able to spend the time with their loved one and keep them within the community; a win for the community, as well as a win, potentially, for taxpayers and for government from a cost perspective. I just want to voice my support for that.

Andrew MacDougall: You're also speaking in terms of caregiver support, like for informal caregiver –

Mr. Trivers: Yeah, that's –

Andrew MacDougall: – (Indistinct)

Mr. Trivers: – what I'm talking about, caregiver support.

Andrew MacDougall: Yeah, okay.

Mr. Trivers: Yes, not necessarily just assessments.

Chair: Darlene and then Bush (Indistinct) off.

Ms. Compton: Thank you, Chair.

I'll be quick. Just two comments: We talk putting a lot of weight on home care, which is great. I know there was a funding announcement in the spring, I believe, $800,000. I'm not sure where that's at. I don't know if you can elaborate on that. I know we hired someone, I don't know if this someone is part of the input to the strategy, but people are waiting.

Home care versus long-term care, we know the impact it has on the caregiver. It's usually another senior whose health rapidly declines because they're care giving. You look at quality of care; that definitely impacts. Staying in the hospital versus going to a long-term care facility –

Jamie MacDonald: Yeah.

Ms. Compton: In both those incidents we see such an improvement in the health of the resident when they come to the long-term care facility and I think that we cannot lose sight of that fact. Regardless of the cost of a bed in a hospital and whether we just close it and we're saving money or keeping them at home because we're saving money, it's about the care of the resident.

I'm wondering if you can comment about the home care part of the strategy and how

you perceive that $800,000 going forward; how much more funding we're going to get? Is it a one-time thing and if it's part of our strategy, how do we make that work?

Jamie MacDonald: I can comment on that. In terms of the federal funding that came for home care and mental health and addictions, they are definitely part of the seniors' strategy, no question.

They are also part of – home care I mean – is also part of our strategies in terms of acute care and long-term care because we don't move a resident or a patient without all of those pieces in place.

They do have some programs that they're working on in terms of where that money's going or how that's being spent. They are working on several programs to support the appropriate patients to keep them at home or in the community with home care and community supports.

Does that answer your question around where the funding is or has gone to?

Ms. Compton: I guess.

Jamie MacDonald: Okay.

Ms. Compton: Are we –

Jamie MacDonald: More to follow, (Indistinct)

Ms. Compton: – implementing any of that yet for the person who's staying at home and really can't be at home? Have we implemented anything to make a difference in that person's life?

Jamie MacDonald: Those are – there are a number of initiatives underway. Not just at home, but one of the initiatives I can speak to briefly is around emergency rooms. Having a home care liaison nurse in the emergency room working with the emergency room staff, so I as a senior focusing on the frail elderly at the moment, can come into emergency and we have the home care liaison person assess that particular individual and try to develop a care plan around that person so they could go home if appropriate. They could go home with their – home care supports, enhanced home care supports is what we call it.

That program is underway, but they do have a number of other programs that are being developed.

Ms. Compton: Just one more, Chair.

Andrew MacDougall: It bears to mention it – is this on?

Jamie MacDonald: (Indistinct) program as (Indistinct)

Andrew MacDougall: It bears mention, as well, in the past, within the past – was it last spring the province has added a geriatrician, a new full-time geriatrician to the complement, her name is Dr. Martha Carmichael.

Part of her role is also to serve as medical director for the geriatrics program. She has a huge role to play. There's frontline service delivery that she's providing, in addition to helping to build the program, which would include the coach model.

Which has, you know, where you have a care team, with health professionals including; nurse practitioners, geriatricians, nurses, social workers. Actually, the model started in Kings County where there is a list of people that are deemed to be particularly frail as defined typically by their health status, their history with acute care interactions. There's is a team that wrapped around them that follows them in the community.

If they're admitted into the hospital, they're right there. They're aware of it and they're trying to essentially pull them back. That's all in the past year, the additional developments that are happening to support community-based living.

Ms. Compton: So, just one more question.

That's all great. What it comes down to: Are there more home care workers who are able to go out to the home to help seniors?

It's great to have experts. It's great to have –

Jamie MacDonald: Sure.

Ms. Compton: – development of strategies, but for the senior who is at home looking

after their spouse, are there more home care workers is the bottom line?

Jamie MacDonald: That would be a question for home care, for sure. Certainly, I know with the funding they have received the plan is to add services to their home care, current services offering.

In terms of numbers of staffing and things like that, that would be a home care question.

Sorry, I can't answer that.

Ms. Compton: No, that's fine (Indistinct)

Jamie MacDonald: Okay.

Chair: Bush.

Mr. Dumville: Thanks, Chair.

When you license private facilities for extra beds, how permanent is that? When you license a bed to a facility, the funding, how permanent is that licensing? Is it forever?

Andrew MacDougall: Well, it'd be for the – well, a couple of things: There's a service agreement that's established between the private entrepreneurial association and the department of health. Those terms of the agreements are usually three to four-year periods. They would be, if it's a permanent license that is issued, provided that the facility can demonstrate through the inspection processes that it can continue to meet the standard of care as outlined in its license and in operating standards, then it would be permanent from that standpoint.

Of course, the operators themselves have always had – if they choose to make other decisions, reduce their complement, that'd be their choice.

Mr. Dumville: So if you enter into a contract for services for a private facility, is there a license goes with that, or does the license for the whole facility – do you have to license the contract? Is the license a contract?

Andrew MacDougall: The license would be for the beds.

Mr. Dumville: Right.

Andrew MacDougall: And the contract that'd be established would have within that what the – because that could change over the life of the contract. From one year to the next, one facility might actually, through an RFP process, may well get different beds that way provided it can demonstrate it can meet the standard.

That's happened on occasion where, within the terms of a service agreement, there's beds that are put out to tender and they're bid upon and then the successful vendor, if they meet the standard, then adds to their complement.

Mr. Dumville: Does it get in the way of you offering a particular facility a contract that would suffice, say, taking somebody out of Montague and putting them in, say, Gillis because it's close by?

Andrew MacDougall: You mean in terms of –

Mr. Dumville: Yeah, does it have to go contract to everybody, like a facility in Charlottetown or Summerside, or could you specifically say Gillis because that person's in Souris or Montague and lives in that general vicinity?

Andrew MacDougall: Well, every facility would have a service agreement; but if there were to be changes within the bed complement, that's something that would have to be discussed with the licensing board if there's going to be shifts between what – one facility wants to reduce their beds, another one's increasing them. That'd have to be discussed and it would have to go through a licensing board. I guess to go back to (Indistinct) I wouldn't see it as an impediment, per se.

Mr. Dumville: I can see the department wanting to keep their options open in terms of relying on some restorative care or home care versus getting into long-term beds tied up, but if we're going to move, say forward on a temporary basis, I'm not so sure that we're saying that: okay, we take somebody out of the hospital and put them in and somebody's going to in-fill it.

Has there been any thought given to, if we in-fill that bed, that okay, we're moving the health process along to the point that maybe,

whether it's somebody that has mental health issues or whatever, that there's less trauma on the community or on families so that there actually is a dollar return?

I guess in health care it would be nice to spend all the money up front and get all these benefits at the back end, but that's pretty hard to do when you have a budget envelope. Has there been any thought given to the fact that that bed is in-filled to help the health care move along in all capacities? Is that measurable?

Jamie MacDonald: It is. It is in some senses, and I totally understand what you're saying, and there is thought to that. Again, that's part of this whole – and I don't want to say we're working on this, we're working on this.

This is very complex because even though it's long-term care, it is the whole long-term care, community-based care, home care, acute care piece, so there is thought to that. Yes, we move a resident out and yes, we fill that bed again, and what's the benefit to the community, things like that.

That is all part of this, not only the seniors' strategy discussion, but we have our own Health PEI ongoing discussions about what is the right fit. What do these services need to look like based on our current population and our demographics five, ten years down the road?

Mr. Dumville: Thank you, Chair.

Chair: Thank you.

Any other questions? Okay, it's 12:00 p.m.

Thank you very much, Andrew and Jamie, for your presentations today. It's great that now that we're on the web and being broadcasted out people can learn a lot of how our system works, and you gave an excellent presentation today. I think a lot of people can learn a lot from you've said today.

Thank you very much.

Jamie MacDonald: Great.

Andrew MacDougall: Thank you.

Chair: I'll give you two seconds to get out of here and we'll go on to new business.

An Hon. Member: (Indistinct)

Jamie MacDonald: Thank you.

Chair: Thanks.

We can go right to new business?

Clerk Assistant: Yeah.

Chair: We can go right to new business.

Any new business?

Okay, Sidney.

Mr. MacEwen: Thank you, Chair.

I'd like to move a motion that we invite the funding bed allocation group into committee, probably in early 2018, to give them a few months. I think it's an important idea to find out how it's going.

I understand that they are aiming for a spring 2018 –

Chair: Yeah.

Mr. MacEwen: – but I also think it's important to keep on the group because, as we heard today, time is of the essence with that many number of people sitting in hospitals and open beds, as well.

I think it would be good to have them in prior to the final release of the report just to see how things are going.

Chair: You mean the group that's doing the seniors strategy or the group –

Mr. MacEwen: No, sorry, the funding bed allocation group.

Chair: Okay, good.

All in favour?

An Hon. Member: Yes.

Chair: Good. Send a letter.

Anything else?

Ms. Casey: Motion for adjournment.

Chair: Great. Thanks, let's go. It's 12:00 p.m.

The Committee adjourned