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: COMMITTEE ROOM, J. ANGUS MACLEAN BUILDING, CHARLOTTETOWN

SUBJECT: BRIEFING ON LONG-TERM CARE FACILITIES

COMMITTEE:

Jordan Brown, MLA Charlottetown-Brighton [Chair]
James Aylward, MLA Stratford-Kinlock
Richard Brown, MLA Charlottetown-Victoria Park (replaces Kathleen Casey, MLA Charlottetown-Lewis Point)
Darlene Compton, MLA Belfast-Murray River
Bush Dumville, MLA West Royalty-Springvale
Hal Perry, MLA Tignish-Palmer Road (replaces Pat Murphy, MLA Alberton-Roseville)

COMMITTEE MEMBERS ABSENT:

Dr. Peter Bevan-Baker, MLA Kellys Cross-Cumberland
Kathleen Casey, MLA Charlottetown-Lewis Point
Pat Murphy, MLA Alberton-Roseville

MEMBERS IN ATTENDANCE:

Bradley Trivers, MLA Rustico-Emerald

GUESTS:

Department of Health and Wellness (Dr. Kim Critchley, Hon. Robert Henderson, Calvin Joudrie, Jamie MacDonald, Andrew MacDougall, Sherry Pickering)

STAFF:

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

Edited by Parliamentary Publications and Services

The committee met at 1:30 p.m.

Chair (Brown): All right, everybody is ready, we'll get started folks.

If I could just remind everybody to silence their phones, including from vibrate and at least if you're going to have them on vibrate, ensure they are not on the table. It interferes with the recording mechanisms that Hansard utilize to capture what we're saying here.

I'd like to welcome Minister Henderson and I will ask you to introduce your cohort here in a moment. I would like to remind guests that as we go through the presentation, to direct questions through the Chair and I'll try my best to direct traffic in an orderly fashion.

Mr. Aylward: Chair? Sorry, for the guests to direct questions through you?

Chair: No, sorry, the other members in the committee.

Mr. Aylward: Oh, okay. I thought we had changed procedure here for –

Chair: Well the guests could ask questions too, you never know they might –

Mr. R. Brown: It's a democracy.

Chair: They might have questions –

Mr. Aylward: I'm sure there are a couple here that would like to ask some questions around long-term care.

Chair: Sure.

Mr. Aylward: It's the committee members, then, that are to ask questions through you, Chair?

Chair: Anybody that wants to ask a question I'd ask that it come through me, yes.

Mr. Aylward: Okay.

Chair: Yeah. How's that for you?

Mr. Aylward: (Indistinct)

Chair: I'd like to call for adoption of the agenda before we get going.

Mr. R. Brown: Moved.

Chair: Thank you.

We have Minister Henderson and, I gather, Dr. Kim Critchley and another guest and I forget your name; my apologies for that. We met a long time ago I think, though.

Mr. Henderson: Andrew MacDougall.

Chair: Sorry?

Mr. Henderson: Andrew MacDougall, he is our director of long-term care.

Chair: Andrew MacDougall? Oh, okay.

Minister, I understand you have a presentation. I'm not sure whether you would like us to ask questions as you go through the presentation or hold them until the end and address them at that point in time.

Mr. Henderson: I guess my thinking would be it depends on how long you want us to be here, but my advice probably – let us go through the presentation. That way you'll get a lot of, probably, clarity to some of the possible questions that you might have already had and then open up for questions afterwards. But, I would not oppose a question coming to me or any of our staff here through the presentation, but I would just caution that as the presentation unfolds it may answer some questions.

Chair: Unless there are any other objections or points of order or whatever, I'll turn the floor over to you.

Mr. Henderson: Thanks very much, committee.

I appreciate the opportunity on behalf of the Department of Health and Wellness to enlighten the population and you, as a committee, representing the Legislature on the issue around seniors' health and the way we provide seniors' healthcare in the province. I would say like any good minister, I have a great support staff around me and I'll introduce some of the people at

the table as well as some that are in the audience.

We have to my right here is Dr. Kim Critchley; she's the deputy responsible for health and wellness and my chief advisor on many subjects including this. Andrew Campbell, I mentioned earlier, is the director of long-term care in the province here and he's –

Andrew MacDougall: MacDougall.

Mr. Henderson: Andrew MacDougall, sorry about that.

Andrew is director of long-term care and recently appointed to that position probably, what, a few months ago or something like that. Also, in the audience I have a couple of other people here. I have Jamie MacDonald who is a chief administration officer for emergency health services, long-term care and hospitals east. We also have Calvin Joudrie; he's the long-term care subsidization manager. Next to Calvin is Sherry Pickering and she's the program development lead with home care.

I guess the rationale is, is that if there are questions that are more specific to maybe their area of expertise, we'll do some switching up of the chairs here and have them come forward to the table.

With that, I also want to remind the committee that caring for our aging population is more than just the health department and it's much more than just long-term care per se. I sort of look at it, as minister, as I look at: This is a partnership between our Department of Health and Wellness, government and the families. It's about trying to deliver a respectful and professional delivery of services to our seniors who require care during the aging process.

I think that's sometimes where the population assumes that once a person reaches a certain age or a certain level of care, that it's our responsibility to deal with everything from that point on. I really look at it as a partnership, and families have their struggles by times and we have to try to all chip in to do what we can.

The Department of Health and Wellness and Health PEI play an integral part in that partnership. This is in conjunction with other government departments and agencies. A couple of the departments that we work quite closely with is the Department of Family and Human Services and seniors, the PEI Seniors Secretariat, as well as many community organizations like community care facilities that are privately operated or non-governmentally operated and the seniors' federation. We take a lot of roles with them that we like to play.

We have a role in providing for aging Islanders and we strive to work together for the betterment of these individuals who deserve an age and environment where they can be shown the dignity and respect that they deserve.

In today's presentation we will look at our aging population and provide you with an overview of healthcare services and we will provide to our seniors beyond just long-term care, acute care, and we'll discuss that as to what our goals and objectives are as we move forward. We will take a few questions at the end, but like I say, if somebody that has something that is pertinent to today's situation – this next slide is really – it tells a bit of a challenge that we face as a department here.

As the backbone of our community, seniors should be supported and given the best care possible. Seniors are the fasting growing demographic as per population in the Province of Prince Edward Island, and over the past decades seniors' demographic has grown exponentially and this trend will continue.

Meeting the healthcare and social needs of seniors is a high priority for our government and I have always sort of said that: If you look at that slide, really from 2020-2030, we're on a fairly steep trajectory for the challenges as we see people over the age of 85 or even 75-84. Seniors make up 18.6% of the population today and by 2025, approximately 24% of all Islanders will be seniors and that growth is expected to continue.

If we compare this to other jurisdictions in Canada, PEI has the third-highest percentage of population, 65 years of age and over, and

the fourth-highest rate of growth. That's pretty significant. Aging populations experience challenges in terms of health and wellbeing, and this important shift was discussed in the detailed 2014 chief public health officer report and I've had a number of situations where I have been reading articles and magazines and things of that nature.

I certainly recognized that during a lifetime the first year and the last 10 years of a person's life tend to be where they require the most use of health care services. When that population gets older the challenges become greater for us. We need to provide our seniors with the appropriate and necessary health care as we move forward.

In this slide here, it tells a little bit about the fiscal challenges that we deal with and what we're dealing with, with numbers. We were asked to come and talk to you about long-term care today so I'm going to provide you with an overview of our long-term care program specifically; community care and seniors' mental health programs. Later on the presentation we'll touch these services as the services we provide as far as eligibility, wait-times and approximate costs.

It is important to note that long-term care beds are only one of many health care services that we provide to our seniors. Other areas of seniors' health care include: primary and acute care services, home care, restorative care, palliative care, (Indistinct) care, prevention, wellness initiatives, and geriatric programs as well.

Specifically, long-term care is a provincially-funded program for Islanders with chronic health and disability requirements that cannot be appropriately attended to in a community-based setting, such as home or assisted-living or community care environment. Long-term care services are provided by professional support staff and range from therapeutic, clinical interventions to personal care.

Residents in long-term care facilities have significant health challenges requiring cognitive, physical, emotional supports with continuous supervision required. In general, it serves the frail senior population, but there are exceptions.

Three pieces of legislation help frame the delivery of both long-term care and community care in this province: the *Health Services Act*, the *Community Care Facilities and Nursing Homes Act*, and the *Long-Term Care Subsidization Act*.

Our long-term care budget, as I said earlier, is $87.6 million. It's inclusive of both Health PEI, long-term care homes and grants to private long-term care facilities.

On Prince Edward Island we have 1,141 long-term care beds in 18 nursing homes. Nine public manors operate 595 beds, or 52%, and those are located in Souris, Montague, two in Charlottetown, two in Summerside, O'Leary, Tyne Valley and Alberton. We also have nine private nursing homes, which have 546 beds or 48%. That's a little bit of the break down of where those 18 facilities are located across the province. It kind of gives you the general theme of it.

Things that are interesting here: we have the third highest number of beds per capita over the age of 75 in Canada. That's some of the numbers that CIHI use as a bit of a benchmark for everyone across the country. PEI has 105.5 beds per 1,000 people and the national average is 82. I think that's significant when you look at what we are doing to provide for actual long-term care beds in this province. Since 2007, we have added 145 new long-term care beds to the system.

One of the other challenges that we have seen here is we've seen a length of stay of individuals in long-term care. In 2011, not all that long ago, the average stay was 2.7 years. The last fiscal it was 2.9 years. That number continues to grow as far as individuals living and staying longer in our facilities.

One of the issues that I get a lot as an MLA from the public out there is: How does somebody qualify for long-term care? I even had to endure this a bit in my own personal situation as my mother is now in long-term care so the last two years has been quite a learning experience, not only as a minister, but as an individual as part of a family dealing with this.

Assessments are conducted by our home care or acute care staff. Doctor referral is not

necessarily required, but some situations. I know in our case, the family doctor identified challenges with my mother and suggested that she should be assessed. The doctor would make a referral for us to contact home care support and see what supports could be provided there. They did a number of assessments on my mother and over time as her situation worsened, then assessments would make her deemed eligible for long-term care.

People can also ask for self referrals, too. You don't have to have a family doctor to make a referral to long-term care. If a family feels that one of their members is a bit challenged in being able to provide the day-to-day necessities, they could contact home care. Home care could come in and do an assessment. They usually do the assessments in the home environment, just so you're aware.

Staff use a senior assessment screening tool, which we call interRAI to assess the situation and determine the level of support required to meet a person's daily care needs and to see if they can remain at home or if they require either community or long-term care. The assessment determines an individual's needs based on a scoring system of five levels. I think MLA Trivers mentioned that question.

We have, basically, five different levels and if you score at a level four or five through this assessment tool that's when you're eligible for long-term care. If a person is assessed at a four or five the care coordinator will discuss potential options and work through the process from that point on.

Additionally, to qualify for long-term care, a person must also meet necessary eligibility standards that include their age, residency and citizenship. In general terms under 60 would be a factor in this. Obviously, if not a Canadian citizen, it would be another issue. At times there are unique situations where individuals may not need all of the criteria, but they still require long-term care. Health PEI certainly would look at those cases individually and see whether they would qualify under special circumstances.

Once it has been determined that the person requires long-term care, then the admission process begins to enter in long-term care. A long-term care coordinator will discuss options. The family has the opportunity to choose up to three facilities as their top three priorities. We do whatever we can to try to accommodate that.

That's generally where there are wait times. Some situations, the wait times may be a little longer for a particular facility. It doesn't mean that the family can't change that and request a different facility or whatever. Choices are certainly given equal priority and patients are put on a wait list on each facility until a bed becomes available in that particular facility.

When a person has been deemed urgent need for long-term care they will be placed in a home and we also track the date of the individual's assessment. I want to always emphasize, and this is a question I get a lot is: Where is my loved one on the list? Well, there is a list and it does go by dates, but we also are focused on the most urgent. There are certain circumstances where individuals are much higher priority, and that's why we don't publish a list or that's why – because people can change depending on a lot of different circumstances. That's one of the things that we look at; but if all things are considered equal, the date would be the factor.

We have long-term care admission committees. One in Prince, Queens and Kings and they oversee all admissions to long-term care in this particular province. They are the ones that would determine that sense of urgency. The committees actually meet weekly and they look at all the vacancies; review the wait list; examine the types of beds available; preferences for people on wait lists, and the situations in our acute care facilities. That becomes another factor, to who might be deemed eligible for alternate care. The committee also can determine that a person has an immediate need for long-term care.

We do have two categories that we try to create as priorities. One is veterans. You may be aware of the situation that happened over in Nova Scotia where an empty bed and a certain individual couldn't get that bed. We do it a little differently. We do have priorities for veterans, but if a bed sits empty we fill it with whomever is most in need, but

when one of those beds become available we look at a veteran first.

The other is our Francophone community. We have one facility at the Summerset Manor that has a wing that's predominantly for Francophone individuals. It's the same process there. It doesn't mean that an Anglophone doesn't go into that wing; it's just that it's a separate little list for individuals requesting that location.

On top of all that we have what's called our first available bed policy. That's another one that's sort of a little different. That is when we have individuals that are patients in hospitals, who are awaiting long-term care. Health PEI makes every effort to move these patients to a nursing home of their choice; however, when a suitable bed is not available in their chosen three locations, they will be asked to move to the first available bed that might meet their needs. This also helps us free-up beds for acute care patients and promote more appropriate care setting.

That's one that I tend to get the most calls on, is that a loved one is from whatever community and they have to go to a community a lot further away. My advice in most of those circumstances is: Take the bed because then you become first on the list to transition to another location. That's always the way we kind of work that. Patients who are transferred to a facility not of their choice will be given priority to beds as they become available in their preferred home.

The one issue we get today – and I know we had it not too long ago up in MLA Perry's district: How many people are waiting long-term care in the province? As of today, or yesterday, whenever we did this slide up, currently we have 131 people waiting long-term care beds in the province. As much as that sounds like a lot, that's actually 32% lower than it was in 2012 when the numbers had peaked. There are 48 Islanders that are waiting long-term care in hospital beds at the moment; 72 from their home situation and 11 that are currently in community care that are on the list.

Wait times can range from several weeks to several months. I know just in my own mother's experience, there was seven months; her wait from being assessed at a level four to getting a bed. As much as that seems like a long time, I really commend home care and respite care and all of the services that are out there to help a family get through those situations.

Last year, the average wait-time for placements in long-term care while in the hospital or acute care bed was 23.79 days. This is a decrease of 5.14 days from the previous year and almost an 18% decrease in the wait time. Once again, we're heading in the right direction but it doesn't mean that there's still not more to do.

Also, if someone's situation worsens, and I think this is a key thing that I get as calls as a minister and MLA, while they're awaiting a bed they should contact their long-term care coordinator. They will reassess the individual's situation and determine once again if there's immediate admission required. If additional services are requested such as respite care, additional home care, supports can be put in place and I think that's key.

I know in our own family's situation, same scenario. Home care was fabulous in increasing their supports to help us get through it as well as taking advantage of the respite care that's offered across the province.

The *Long-Term Care Subsidization Act* – and if we do get into some stuff on that I have Calvin here – it can be a tad bit complicated; but in 2007, our government introduced the *Long-Term Care Subsidization Act* and this act modernized our payment program for long-term care and changed the formula for subsidization. Today, someone entering long-term care is required to pay for their accommodations, which is room and board, and their personal expenses, to the maximum of their net-monthly income. Private nursing homes can set their own rates. The accommodation cost for our public manors is $80.25 per day.

Islanders who cannot afford the accommodations fee are eligible to apply to the long-term care subsidization program. There are additional assessments done for couples. Once again, it can be a little complicated because there are situations that depend on the age of the couples and things of that nature, but I can assure the

committee that there is a process established and policy to ensure a spouse remaining in a community will not experience financial hardship. If we need more details, Calvin is here to do that.

For all residents of long-term care, government pays for the healthcare costs of the residents and for private nursing homes we established that fee to be $99.36 a day, which we would be paying to the community care facility.

Home care is a key issue in providing a level of service to Islanders and home care has a crucial role in extending people's issue in staying at home versus having to go into a long-term care facility or acute care.

According to a national poll, seniors – 90% of them indicated they would rather stay in their own homes if we can provide the supports for that. That is one of our goals and objectives as a government. Home care does tend to provide a better quality of life for many residents.

Our home care budget in this province is $16.8 million and that represents 2.4% of our healthcare budget. Nationally, the home care contributions for departments is about 4%, so PEI has the lowest per capita spending of home care of all of the provinces in Canada, and that's one of the issues that we see; that we need to provide more services in that direction.
Services are provided based on an assessed need for a defined period of time based on eligibility criteria.

Home care has a crucial role in our health care system – it feels like I'm reading the same one over again here. As you can see from this particular slide, we offer many different services across the province. We have five home care offices. O'Leary has an office, Summerside, Charlottetown, Montague and Souris, and we have approximately 2,279 home care patients currently. That number fluctuates and if you take in the past year: 4,213 have received home care this fiscal year. The whole concept is to try to allow greater independence and quality of life, and that's our five home care offices.

Also, we have a number of other services that we tend to provide in helping people stay in the home longer. We have nursing care. We have home supports which, as it says, more daily activities for bathing and dressing. Palliative care, which in some cases we're able to provide through our paramedic system, pain and management of pain symptoms, things of that life – end of life care. We have some social work, counselling for illnesses, loss of end of life issues, dietitian support services. Physiotherapy is there, occupational therapy, home dialysis, long-term care and adult programs. We have many of these types of programs to allow people to live longer.

Paramedics is another key role that we see. We've accessed their services, to not only provide emergency care, but also to do periodical checkups, blood pressures and things of that nature, checks. We also are looking at expanding that into – we're doing palliative care services with the paramedics and we're looking at possibly expanding that into home care services as well. Paramedics spend most of their day waiting for an emergency response. Instead of being stabilized and transporting Islanders, we believe there's a greater role that they can play in delivery of services that are more of a non-emergency situation.

In recent years, we've added palliative care to their list of duties in some situations and we may be able to look at home care. From December 2015 to December 2016, 498 clients were enrolled and 350 calls to EMS resulted in supporting 111 of those 350 to remain at home. Once again, we're diverting those potential patients to emergency rooms to get services at home. We continue to work at ways to collaborate.

We also have a liaison nurse in acute care at all hospital sites. There's a home care team member who regularly connects with acute care to support these transitions and the three sites in hospitals, the QEH, PCH and KCMH, where a liaison nurse has positions. The role of a liaison nurse is to monitor the patient's in-home care and who are admitted to hospital and facilitate their return to home as quickly as possible, as well as to review admissions for all seniors admitted to the hospital to determine the feasibility of returning home with more supports that can be provided by home care or coordinate an admission to restorative care.

Day programs, adult day programs, support seniors living in communities by offering relief and respite during the day for families and provide a therapeutic environment for seniors. Approximately 97 participants per day, that's a few of the examples that we have on our slideshow.

As I mentioned earlier, it's important to remember that long-term care is simply not about just beds only, it's much more. We're focusing, as our seniors' health includes prevention and wellness initiatives and this includes various screening programs, seniors' focused vaccine initiatives, like the flu shot, which is now free for seniors, as well as programs to keep seniors mobile and active. Like the living health life program, as one of the relatively new programs that we've heard tremendous feedback on this, and the new go-carts located at some of our nursing homes. These carts are stocked with activities that volunteers and family members can use for residents to improve dexterity.

I believe Andrew – one of the times I had a tour, I think it was Beach Grove Home there, there was a little old lady where she was passing the ball back and forth and she could throw it pretty good there –

Andrew MacDougall: Keeping her strong.

Mr. Henderson: Yeah, it was really good.

Provincial geriatric program provides individual geriatric assessments to older adults with complex diagnostic care and support needs. This program responds to referrals from physicians requesting assessments for patients, who may be experiencing difficulty in certain areas like cognitive and mental functions, mobility, depression, and medication management.

In 2015-2016, there were actually 809 consultations with geriatricians and 745 follow-up consultations. For those seen by this geriatric program, 51% of those had dementia.

Seniors' Mental Health Resource Team is another one. This is a part of Health PEI's community mental health programs. Recently, that has had some good success as part of PEI's community mental health program. It recently began in Queens County and plans are underway to expand that across the province.

The Queens County team comprises of five case managers, a consultant psychologist, a geriatrician and a psychiatrist. This team provides assessment, treatment, consultation and care coordination for seniors experiencing severe and complex mental illnesses. They provide services in community care, as well as long-term care facilities.

Respite care, and I think that's a service that probably hasn't been utilized to the degree that it probably could be. It's provided to an individual whose primary caregiver requests short-term relief from providing care. We have respite beds at our various facilities across the province. Last year 47.3% of those beds were utilized. That's a factor.

I know from my own family's predicament, our situation, the respite care was a great help to us, and we certainly were willing to make utilization of any of those available bed spaces as we possibly could. I think we have to take a look at what we can do to make better use of those beds.

Restorative care is another component. It focuses on rehabilitating patients with the goal of being able to return to their own home and transition to the most independent level of care possible. I know I've seen that in an O'Leary situation, I know in Beach Grove, I believe has and Prince Edward Home –

Andrew MacDougall: Prince Edward Home.

Mr. Henderson: – also have restorative care programs. We're getting really good feedback from those once again, in slowing down the process in requiring long-term care. Staffing within restorative care includes physiotherapy; occupational therapy; rehabilitative assistance, and nursing.

You can see from the slide here, many patients are discharged back so they can return to home rather than enter into a long-term care facility. The acute care division is almost 50%, which is helping keep our acute care beds available to our acute care patients.

Community care, and this is where we get into some of the definitions – I'm sure MLA Compton is well aware of it – but it is a private system; however, government does provide licencing and inspections of these facilities through our Department of Health and Wellness, as well as funding subsidized through the Department of Family and Human Services.

There are 39 community care facilities on Prince Edward Island with 1,289 beds. The majority of these facilities are located in Charlottetown, 56%. These facilities provide services such as: housekeeping; meals; assistance; and personal care. This is where admission to the community care facilities can be through self-referral and the person must be assessed at a level one through three on the seniors' assessment screening tool.

Palliative care, this one is where patients with a progressive life-threatening illness are offered various resources through our palliative care program. We have palliative care beds at various locations across the province, as well as home care palliative services, as well.

There are so many services that encompass seniors' health care. I could go on for a fair length of time. We have our primary care; acute care, as well as our Seniors' Drug Program; dementia units within our manors; day programs; liaison nurses, as well as services that we have in place for seniors.

I do want to shorten it up a little bit and take a bit of time for more questions and give you a little bit of an idea where we're kind of heading as we move forward.

We continue to monitor, replace, review the needs of our Island seniors and the system that we have in place. We have some internal and external documents. We have a nursing strategy that we're working on, a mental health strategy, as well as a health aging strategy.

Currently, we have seen recently in the news anyway, tenders from the transportation and infrastructure renewal recently issued tenders for Montague and Tyne Valley manors. Those projects will commence this year providing new facilities in those particular communities. These new facilities will follow-up on the same model that we've been using in Souris, Charlottetown, Summerside, O'Leary and Alberton.

These manors will be made up of small communities within each facility. Their residents can eat and socialize in a more home-like setting. These designs also work very well for people who are faced with varying degrees of dementia.

We just recently hired – actually the individual started today – we have a new principal advisory for seniors' health, Mike Corman; his first day on the job and right at it. The deputy and I had the opportunity to meet him this morning. This position is a key position. I remember MLA Perry asking some questions in the House. We're finally at a point of hitting the road here. This will help develop and coordinate and evaluate strategies that support seniors' health and wellbeing across the province.

One of the first tasks that we'll be looking at is to coordinate a review of our current assessment tool assessing individuals for long-term care. As you might be aware we use, I think it's called a system called the InterRAI system –

Dr. Kim Critchley: No.

Andrew MacDougall: SAST.

Mr. Henderson: Oh, SAST

Dr. Kim Critchley: Seniors assessment.

Mr. Henderson: Anyway, on that particular case, we're the only province in Canada that uses that and we're looking at what some of the other provinces are utilizing to implement and assess seniors. That's one of our things that we want to have a review of.

As I mentioned earlier in the presentation, we use a standard assessment tool to be determining the best care for our seniors. We need to look how often our assessments take place. Are individuals being reassessed as often as they should? How does our tool compare to what other jurisdictions are doing? What are some of the questions we need to look at and determine how we can improve this process?

You're also probably aware that we just went through the federal health accord. This

is going to have some additional funding that is going to be targeted to home care. We agree with the federal government that home care is a tremendous program and it does require more support. Islanders want to stay in the comfort of their own homes and we can be doing more to enhance those particular services so they receive the necessary health care supports that they need and deserve.

Part of our commitment with the health accord is we sit down with the federal government and develop the perimeters and planning of this funding, as well as the evaluation and support and reporting mechanisms that they may require. These conversations are still ongoing.

As you can see our per capita home care spend is significantly lower than other jurisdictions in Atlantic Canada, as well as the Canadian average. We want to try to see what we can do to address that and I think there's great opportunity to expand home care and invest in some of those resources that will serve Islanders in their own homes.

With that, I thank you for the opportunity to present here, today. If you have any questions or want something a bit more clarified, we have the people here to give you those answers.

Chair: Thank you, minister.

First up on my list for questions I had Richard Brown.

Mr. R. Brown: Thank you, Chairman.

Any Islander would be remiss in saying that this is the biggest challenge Prince Edward Island has over the next few years, next couple of years. We see from the chart here, we're going from 27,000 people approximately over the age of 65 now to 37,000 and to 45,000. Over the next 10 years it's going to be a 10,000-person increase in this cohort, I guess you could call it.

I guess my first question: What is the average age of people that are in care right now?

Mr. Henderson: Andrew, would you have a more specific on that?

Unidentified Voice: Eighty-two point four.

Mr. Henderson: Okay, that question would be 82.4 years, hon. member.

Mr. R. Brown: I noticed that we have 48 beds in a hospital. I get this a lot from my constituents that you know, my mother or my father is sitting out at the QEH in a gurney on the side in a hallway. I think that is not right and shouldn't be happening. These are seniors of Prince Edward Island and they shouldn't be left in a hallway.

How much is the cost of leaving a person at the QEH as opposed to a long-term care facility?

Mr. Henderson: I guess my first comment would be is that it would be of a very rare circumstance that somebody is in a gurney in a hallway. That might have been something more in the past, but we're doing a much better job of utilizing our beds and transferring people out into other facilities to get them an appropriate level of care.

The simplest way I can answer that question, dependent on the acute care facility, you specifically mentioned the QEH –

Mr. R. Brown: QEH.

Mr. Henderson: – but it's about $1,260 a day for somebody to be at the QEH. That's just to give you an idea. That's what we would charge an out-of-country individual or something that would stay there, or another province that would stay in there, so it just gives a bit of an idea.

Mr. R. Brown: And you say that the care in a facility is about $80 a day?

Mr. Henderson: That's what we charge.

Mr. R. Brown: Yeah.

Mr. Henderson: Yeah.

Mr. R. Brown: So that's $80 versus $1,260. That's a lot of capacity there.

Dr. Kim Critchley: That's just what the individual pays –

Mr. R. Brown: Yeah.

Dr. Kim Critchley: Calvin? The price –

Calvin Joudrie: Yeah, the total price would be about $181 a day.

Mr. R. Brown: So $181 –

Chair: Just hold on here for a second. When Calvin – because the whole point of all of this is this needs to be recorded so maybe Calvin, if I could get you to come up to the chair right here at the corner to answer that question on the record so that the –

Mr. Henderson: Yeah, that's great.

Chair: – so people don't come and string me up. Maybe if I get you to introduce yourself first and then answer that question on the record then we'll turn it back over to Richard.

Mr. R. Brown: Thank you.

Calvin Joudrie: Thank you, Mr. Chair.

My name is Calvin Joudrie. I'm the long-term care subsidization manager for Health PEI. There are two costs to care. There's a health care portion and there's the accommodation portion. You add those together, it's $181 a day.

Mr. R. Brown: Thank you.

Mr. Henderson: Why don't I just clarify a little bit there? You mentioned the QEH, so each facility would be a little different staffing complement and costs. This is part of the reason why we do sometimes try to move people to, maybe, Souris or the KCMH. Our community hospitals have $576 per day and QEH is $1,260.

Mr. R. Brown: Is there any long-term care people being accommodated in the Hillsborough Hospital? Are we putting them there as an overflow area?

Mr. Henderson: I'm not sure of that. Maybe Andrew or Kim would know the answer.

Andrew MacDougall: No.

Calvin Joudrie: I can answer that. I look after the admissions for Andrew as well. Basically –

Mr. R. Brown: Hillsborough.

Calvin Joudrie: Yes, so basically what we do, we look at appropriateness of care regardless of where you're at. Hillsborough is an acute care hospital, acute mental health hospital, and there are people that are appropriate to be transferred to long-term care and we assess them when needed and we'll offer care when needed. Getting into the specifics is not appropriate because they may be able to be identified, individuals. All I can say is there are appropriate individuals there.

Chair: Thank you, Mr. Joudrie.

I said that again for the record. I'd just ask any of you, before you go to respond just make sure you identify yourself for the record so we can keep it all straight, particularly where there are so many of you answering questions.

Mr. R. Brown: We have 39 community care facilities in Prince Edward Island and you are right. A lot of them are in my district in the Charlottetown area. I understand we have been having a debate over the last number of years over inspection reports of these facilities and making them public. I for one, if we are going to inspect restaurants and put them public, we should be making these documents public also. I didn't notice you didn't have them in your report.

Can you tell me when the date is going to be that these reports will be made online? I believe they should be online because these are vulnerable people and these facilities should be accountable to the general public in Prince Edward Island. When will the date be that these documents will be put online?

Mr. Henderson: Just from my perspective as minister, it is part of it. We've had a couple of situations just recently and that is our goal and objective. Do we have a date? I'm not sure. I don't think a specific date, but –

Mr. R. Brown: Do you –

Mr. Henderson: − it is a goal and objective (Indistinct)

Mr. R. Brown: Do you have inspection reports right now that are in the department?

Mr. Henderson: Yes.

Dr. Kim Critchley: We do.

Mr. R. Brown: Why aren't they online now? What is holding up the inspection reports from going online that you have right now? I could understand if you didn't have inspection reports, but you have inspection reports and why aren't they online now?

Mr. Henderson: I guess from my perspective, the first issue is we do work with the community care facility association in the province and we are trying to – we have given them notice that that's something that's a goal and objective that we have as a department; but I guess at this point in time I'm not aware that we're of a set date that when that will happen.

Chair: Mr. Perry, you're next on my list.

Mr. Perry: Thank you, Mr. Chair and thank you for the presentation.

Most of my questions have been – I have been writing them down. They have been answered, but a few more. Just to go back to that 48 are in hospital waiting for long-term care?

Mr. Henderson: Yes.

Mr. Perry: That's right across PEI?

Mr. Henderson: That's correct, yeah.

Mr. Perry: How many would be in Western Hospital awaiting long-term care?

Mr. Henderson: I think about 20, but maybe Andrew has a more specific –

Mr. Perry: So why would half of them be at Western? I don't understand that.

Mr. Henderson: Once again, if you look at Prince County and the QEH, those tend to be more acute care facilities where services are a bit more acute so the goal and objective is to try to move patients out of those facilities to go to these community hospital locations where, once again, the cost is a little lower in operation. That's the goal and objective.

But it comes with the challenges because sometimes families – especially if you're around Summerside or Charlottetown and you now have to go to O'Leary or to Souris or to western, those become the issue. We try to, once again, put people where the most appropriate level of care, but also to be as cost-effective as we possibly can be as well.

Mr. Perry: Those 20 that are in at the Western Hospital, are they all from the West Prince area? Or are they from other areas of PEI?

Mr. Henderson: My understanding is not necessarily, but predominantly the majority would be.

Mr. Perry: If I look at it that way, if there are 20 waiting of 48 on the Island, waiting for long-term care beds, and they're from the western end of the Island, then to me there is a great need for more long-term care beds in the West Prince area.

Mr. Henderson: Exactly −

Mr. Perry: Okay.

Mr. Henderson: − which is part of what we're dealing with, with this new position that we have in seniors advisory, is to look at that where –

Mr. Perry: That's part of your strategy moving forward?

Mr. Henderson: Exactly, yeah. Calvin, maybe you had something –

Unidentified Voice: (Indistinct)

Andrew MacDougall: Andrew MacDougall, director of long-term care. The number certainly has been fluctuating quite a bit at Western Hospital. It had peaked considerably recently. Recent data has the number of people waiting at seven –

Mr. Henderson: Okay.

Andrew MacDougall: − in Western Hospital out of its total bed complement.

Mr. Perry: There are only seven there now? Okay.

Andrew MacDougall: As of March.

Mr. Perry: Okay, but that can go back up to 20 or plus 20 quite easily? I know it was raised in the House last year about an activities director. Has there been any movement on that for these individuals who are awaiting long-term care who may be in there for an extended period of time who are just – who don't really have any activity? I mean, are there any plans to put an activity program or director at Western Hospital?

Mr. Henderson: Specifically, just from my understanding is that, once again, we try to accommodate persons that are admitted to Western to take them over to Maplewood Manor to the daycare program that's over there by times and some people are able to do that, some are not. I'm not just sure, specifically, if there are individuals – Andrew might know that.

Andrew MacDougall: Well, there wouldn't – at this point, there's not a director there per se, but I know there has been meetings and dialogue from the activity director from Maplewood Manor to meet with the staff and work with them to help devise what types of recreational therapy things that they could do for the patients over there, that they can integrate into the daily cares that they provide; but there's not an activity director, per se, that's stationed at Western Hospital.

Mr. Perry: There was a conversation, but has there been anything done with that? Has the activities director from the manor – other than a conversation with the staff, have they done anything in that hospital, do you know of?

Andrew MacDougall: I can only speak to that the activity director from Maplewood Manor has given them a feedback and suggestions on what they could do. But in terms of her actively going over there and delivering services, because she is fully deployed with Maplewood Manor, I don't believe she (Indistinct)

Mr. Perry: That person can't go over and share time?

Andrew MacDougall: Yeah, but she provided her insights and her perspectives, whether the staff at the hospital have – what they have done with that from there, I can't speak to that.

Mr. Perry: To go back to the beds, you said there were131 on a waiting list and where are my numbers – 1,141 beds total, that's public and private on PEI, 131 are on the waiting list? Are there any beds that are not occupied?

Mr. Henderson: That would vary too, but usually there is and that's the challenge, I guess. In some cases some families choose not to go to those locations and all we can do is provide the service and recommend people take the first available bed and then go from there; but in general, there are not many vacant beds, but it does happen.

Mr. Perry: Following that with the first available bed policy, if a family decides: No, we're not going to send our loved one to Montague if you live in the West Prince area. Where do they go on that list, then, afterwards?

Mr. Henderson: It will depend on where their level of care and urgency would be. So I mean −

Mr. Perry: That won't change, but I meant would they be up for the next available bed?

Dr. Kim Critchley: No.

Mr. Perry: Okay – and just one more, Chair.

This is about a question I get quite often from seniors in the community and it was mentioned earlier: How does it work whenever – if it's a couple? The spouse goes into long-term care, so they're always concerned about they have to sell the house and that spouse may not have a place to stay or whatever. You mentioned about the spouse remaining in the community and there are some –

Mr. Henderson: Exemptions, yes.

Mr. Perry: Yeah, so how does that work? How does it work overall when someone goes into the manor if they have assets?

Mr. Henderson: I think we'll refer that to Calvin Joudrie because he knows this way better than most others.

Calvin Joudrie: Okay, yes. Thank you for the question.

The key thing that where some people have confusions – there are two different programs that confuse individuals. Community care beds through the family and humans services division looks at assets for community care. In long-term care we do not. We look at income only.

When there's a couple involved and they need to have long-term care our program – somebody looks at their combined income, divides it in two as the first phase and says half your income belongs to each spouse and half the income then can be considered for nursing care costs.

Then, we look at the individual living at home. They may have more expenses than half the income can cover. Then we have a process to ensure the expenses are appropriate through our regulations. If they are we'll vary the income split to allow more of the income to stay at home with the individual keeping that at home.

If they have assets, we don't look at it. They can have money in the bank. They can keep their house. We actually look at mortgages as being an appropriate expense; rent, appropriate expenses; food; clothing, other expenses in our calculations. We try as much as possible to ensure they have as much of the income needed to stay at home in their current location.

Mr. Perry: Calvin, what about if it was just, so I have a parent, one parent. My other had passed away several years ago, let's say. They were going into long-term care. They live in a home. How does that work with their assets going into long-term care?

Calvin Joudrie: Right. If you're an individual, you can only live in one place, so as long as the income actually stays with the individual we don't consider the assets. If you're by yourself and you're living from your home and you're going to long-term care where that asset is managed and how it's used is off the table for us, but the current income can go towards supporting that home.

Mr. Perry: Thanks for that clarification.

Thank you.

Chair: Thank you, Mr. Perry.

James Aylward is next on my list.

Mr. Aylward: Thank you very much.

Several questions; my first would be, you mentioned that there's currently approximately 48 seniors or individuals currently occupying acute care beds in the hospitals across Prince Edward Island –

Mr. Henderson: – today, yeah.

Mr. Aylward: – today. I think you said as of March –

Andrew MacDougall: Yeah, they were March statistics.

Mr. Aylward: Can you give me the breakdown by facility on that?

Andrew MacDougall: Yeah, sure can. Just a moment here –

Chair: Andrew MacDougall, too responding, just for the record.

Andrew MacDougall: By facility, this is dated March 1st, of this month. At the Queen Elizabeth Hospital we have 23 people waiting as of that date. At Hillsborough Hospital there are two. At Prince County Hospital we have seven; Western Hospital, seven; Community Hospital in O'Leary, two; Souris Hospital has seven and Kings County Memorial Hospital has two –

Mr. Henderson: Six.

Andrew MacDougall: – six, sorry. There are 73 people currently waiting on a home and also another 10 from community care settings.

Mr. Aylward: That would actually be a total of 54?

Mr. Henderson: Probably as of March 1st. I think my understanding is my numbers here are as of yesterday.

Mr. Aylward: On page 5, and Mr. Perry asked some questions around this. It's just I found your slide around long-term care "Paying for LTC" a little bit confusing or misleading where it says, "Residents pay for accommodations and personal expenses to the max of their net monthly income." I think, if I'm not mistaken, it should be rephrased to say: combined net income?

Mr. Henderson: I'll refer to Calvin Joudrie on that one.

Calvin Joudrie: Say your question again, please.

Mr. Aylward: Page 5, the slide where it says, "Residents pay for accommodations and personal expenses to the max of their net monthly income" for long-term care. Shouldn't that read: to the max of their combined net income?

Calvin Joudrie: If it's a couple, yes. If it's an individual it would be their income.

Mr. Aylward: I'm in the situation with my parents where I've just gone through this in recent months. The people I dealt with at Health PEI, the finance side, I have to say the young gentleman is great to deal with and he sort of helped us, or guided us through the whole process. Including applying for a separation beyond their control, which I thought meant that my father was going to be able to keep more of his income; but then I quickly realized that no, the province is just going to claw all of that back.

Calvin Joudrie: Well, it's not a clawback. The program that you're referring to is under the federal government, of course. Eligible individuals can get more guaranteed income supplement if they're living in two separate locations for reasons beyond their control.

When you agree to have a subsidy from the province, what you also agree to in the contract is to maximize your potential income from sources other than the province. As part of that when you would get more guaranteed income supplement, 50% of it would go to the spouse living at home and 50% would go towards supporting the cost of a facility because it adds to their combined income. Unless, of course, as I explained earlier, in a couple scenario if the expenses are such that more than half the income has to remain home that's fine, too.

I'm pleased to hear that the young individual helped you and was clear because that's what we hope for. If there are any comments you want to bring back to the program we're more than willing to listen.

Mr. Aylward: I'll be quite frank and up front right now. There is another individual that I'd like to sing her praises and she works in the home care program, Shirley Kennedy. I couldn't say enough great things about her and the visits to my mother in her home and things like that. She was incredible to deal with.

You talked a little bit about the money coming from the federal government for the health accord over the next 10 years. How much is that, again? Can you remind me?

Mr. Henderson: I think it's about 1.2 –

Dr. Kim Critchley: I can –

Mr. Henderson: – but Kim maybe can be more specific.

Dr. Kim Critchley: For this year for the 2017-2018 fiscal year it is $800,000.

Mr. Aylward: Okay.

Dr. Kim Critchley: But that increases to $2.4 million in the next fiscal year –

Mr. Aylward: Okay.

Dr. Kim Critchley: – and then, escalates up. It's a 10-year plan.

Mr. Aylward: Of course we talked about how important home care is. I mean right here: 90% of seniors want to stay in their homes.

Have you looked at any additional programs or targeted that money to go to something towards home care?

Dr. Kim Critchley: I can speak to that. One of the major initiatives that we are looking at is how do we enhance the home care services that we provide so that seniors can stay in their home. We're never going to stay ahead of the need for beds. We know that the quality of life for seniors is best served in their own homes. Really, the goal is to provide additional services so seniors can live safely longer in their own home.

We have been working with paramedicine program looking at what services they could provide. This is not to take away from the home care that is being offered, but it's actually to enhance those services. The view is that paramedicine will do some of those lower acuity visits that would enhance the quality of life of a senior. Provide better coverage. Provide better safety, and then that would allow the nurses to deal with the more complex issues in the home.

Mr. Aylward: Thank you.

The other question I have, and you talked about the great announcement that was re-announced from previous re-announcements and campaign promises with regards to two manors. One in –

Mr. R. Brown: It's great.

Mr. Aylward: – Montague and one in Tyne Valley. I guess my question would be, we know the demographic, we know the aging population, we know what's happening and we can see the future already. Why are we continually replacing these manors with virtually the same amount of beds that we currently have?

Mr. Henderson: (Indistinct)

Mr. Aylward: The Prince Edward Home was that way a couple of years ago, the other manors, now these two manors that have been announced and re-announced and re-announced are, again, the same number of beds.

Why aren't we forward-thinking? We know we're going to need more beds. Is the government essentially going to get into more of a partnership with private to provide more beds on PEI?

Mr. Henderson: I would say, in general, there are a couple of issues on that. I guess the first issue is, is that we are adding actually one more new bed and a respite bed to Tyne Valley –

Mr. Aylward: Oh.

Mr. Henderson: – and Montague the same as it currently exists there. One of the challenges, like I said before earlier, there are locations on Prince Edward Island where we have empty beds. It's really about part of this assessment is to try to determine where those demands are greatest and where beds can be located.

Even though Tyne Valley might be considered West Prince, it may not be the first choice of other people to do that.

I think the other general statement made by my predecessor in this position was that after the completion of those two beds in the public system, any future long-term care beds would be assigned to the non-governmental system, I guess, for the other 46%, to try to have a better balance there.

That's where this position, Mike Corman will be doing some review of that issue: Do we need more beds? Where would we need them? What style, what type of bed should they be? We're talking long-term care, but is there something that can be a new version of this?

We have community care and long-term care. We have situations where people wind up in long-term care. Their situation stabilizes significantly. Is there a situation where those people could be reverted back to community care? Or, if you're in a community care facility, another challenge that we have and it's been brought up a number of situations: You might have a couple that's in a community care facility.

One of the members gets to a point where they are requiring long-term care services. If you are in – we don't provide a situation in our public facilities that you can have community care and long-term care cohabitating. That can be a problem. I get calls that so-and-so has been married for 65 years and now they have to separate.

I think the point is, is that that provides us more flexibility, should we add more beds to the private version versus that.

But anyway, Andrew, would you like to add anymore to that?

Andrew MacDougall: There are some, as the minister pointed out in his remarks there, we do have some pockets of innovative things that are happening within the health system. If we're able to build on those, hopefully it would reduce some of the pressure and needs that we have for beds.

We look at the statistics and we do have a high level of beds per capita when we look at our peers in the country. We do have a length of stay that's going in kind of the opposite direction of where you'd want to see length of stay. It's 2.9 years now, and I don't have the specific number in front of me, but I believe the national average is probably more along the lines of 1.7, 1.8 years when someone's in long-term care.

That speaks obviously to some of the robustness and the availability of community support. I'll point to one such particular innovative program that if scaled to a larger extent could have impact on our pressures that we have in beds and that would be restorative care service that we have.

For example, at Prince Edward Home, that's a 12-bed program, so that entailed the conversion of long-term care beds into restorative beds. Instead of having those beds filled up with 12 people requiring long-term care services and being there for three years, possibly, with the way the data is, we've been able to provide that service to a lot of Islanders.

For the last year, for example, we had about 150 or so people that were able to access that service, people that were taken from the hospital that were at risk of being institutionalized and they were given a restorative program and over 80% of these people were able to go back home into a community-based setting either right home with home care support or to a community care setting, at least delaying their entry into long-term care.

Again, that's one example, but if we're able to have a larger program in that area, I think we'd have a bigger impact on the system and help alleviate pressure on the hospitals and hopefully reduce, if not delay, the need for long-term care services. Get that length of stay down and help people stay home longer where they want to be.

Dr. Kim Critchley: If I could just add to that?

There's some fundamental problems that need to be addressed. One is the tool that we're using to assess seniors for their suitability to long-term care. The tool is a tool that was developed at UPEI in the 1990s. It's never been validated. It is only used on this Island. So the tool that is used, the InterRAI tool that's used by other provinces is the validated tool and it has been proven to be the best for assessing seniors.

As well, there has to be ongoing assessment to determine at what level does a senior need to be referred to long-term care. So a one-point assessment isn't enough, it needs to be ongoing.

The other concern is we have 72 people at home awaiting long-term care beds but they're not receiving any home care services, so they're not requiring any care. So how is it that a senior in their own home goes from absolutely no services to requiring total care?

There's a little bit of a disconnect, so this is – the advisor for seniors health is going to take a real hard look at all of this, because the answer may not be more long-term care. The answer may be better resources at home, better way of assessing, ongoing assessment, regular checks in to ensure that –

Mr. Henderson: Different supports.

Dr. Kim Critchley: Different, that should – maybe it looks different.

Calvin Joudrie: Mr. Chair, can I just add one thing –

Chair: Sure.

Calvin Joudrie: – to the deputy's – InterRAI stands for Resident Assessment Instrument, for Hansard, so it's InterRAI, Resident Assessment Instrument.

Chair: Thank you.

Mr. Aylward: Thank you for that, Dr. Critchley.

I guess my question on that would be: You're saying we have 72 seniors currently living in their homes but have been assessed or validated through the current process of needing –

Dr. Kim Critchley: Long-term (Indistinct)

Mr. Aylward: − long-term care, but they are currently not having any visit from homecare or any –

Mr. Henderson: Well, there could be –

Mr. Aylward: − any supports of any kind. Is that what you're talking about as far as the program that was developed at UPEI as compared to the national validation?

Dr. Kim Critchley: It may be when they were assessed. Perhaps they were admitted to hospital. They had fractured their hip, they were assessed, determined: Yes, they need long-term care. They go home; family may be picking up the care. But they may recover to the point where with extra services they wouldn't need long-term care and that's why I'm talking about the assessment needs to be an ongoing assessment to determine at what stage the senior is at.

Mr. Aylward: Okay.

Chair: Yes, go ahead.

Mr. Aylward: Minister, you brought up an excellent point with regard – and I think one of these two gentlemen brought it up originally – but with regards to a couple that are living in a community care facility, and I have that exact example over at Andrews of Stratford. Actually, there are several couples that have been residing together at Andrews of Stratford for a number of years.

Tragically, one of the individuals, his wife was transferred out of the facility last year due to, she needed a nursing care bed and she since passed just before Christmas. This gentleman actually reached out to me and he is still extremely frustrated that his wife had to live her last – the last of her life away from him. But yet, Andrews of Stratford for almost two years now has 24 beds in a completely renovated wing, nursing care beds.

I have toured the facility. I know the facility inside and out. State-of-the-art, it's beautiful. Can you explain to me why those 24 beds, when we have 131 people currently waiting for long-term care? Now, I know that these are nursing care beds, but that would be 24 beds that we could put into the system – why they haven't been licensed yet and I have asked this several times in the Legislature as well, of your predecessor and all I got was –

Mr. Henderson: Well, I guess there's –

Mr. Aylward: − his (Indistinct)

Mr. Henderson: − the reality, we're trying to get that. That's what we want to try to find out: Where would beds be allocated if they were required if we are doing them in the community care/long-term case concept? I know I was in Clinton and there was a couple from the Tignish area and I was surprised to see them in Clinton, but that was their reason why they went to Clinton, was that because they had both services and that couple could stay together in the same buildings, in fact, in the same room. We need to try to emulate that a little bit more and that's what we're looking at in trying to have this assessment to do that.

But like I said, we have added the 145 more long-term care beds into the system recently and we now have to reassess the whole situation and determine how many beds we would require, what are the assessment tools to determine who should be eligible, and where should they be located and what communities and regions would they be located? There are a lot of factors that go with it so it is something that we're there –

But when the private sector or non-governmental sector decides to build community care facility beds, they so can choose to do that. It's just that if they get the designation of long-term care, that's

something where our department allocates that number at some point and we hope to have a review of that recently, with Mr. Corman who has just commenced.

Mr. Aylward: One more –

Chair: All right, final question.

Mr. Aylward: – for now.

Minister, you talked a lot about reviewing the need geographically across Prince Edward Island and the different levels of care. Can you give us a date when that review is going to be complete so we can know once and for all the needs assessment, the number of beds geographically here on PEI?

Mr. Henderson: Yeah, I don't have a date at this point. Mr. Corman has just commenced his position today so for the five minutes that I had a chance to welcome him, we did have a very brief conversation and these are the types of things that he understands what his role will be to determine.

I think I will have to hold out a little bit more to give you a more definitive answer, but I'm going to say hopefully within the next year or somewhere in that vein. We should have it maybe sooner than that, but just to give more specifics.

Mr. Aylward: So less than a year?

Mr. Henderson: Well –

Mr. Aylward: But not to exceed a year?

Mr. Henderson: It's hard to get specific, but I'll just say it shouldn't be years, let's put it that way.

Mr. Aylward: Like the manors?

Mr. Henderson: Yes, well –

Chair: We're going to move on; I think you got a pretty good answer to that question. You can come back later.

Mr. Dumville –

Mr. Dumville: Thank you, Chair.

Chair: − I'll turn it over to you.

Mr. Dumville: Some of my questions have been answered, but just curious: We have nine public manors and we have nine private nursing homes, 52% are public and 48% are private. Do we have cost comparisons? Can the private sector do it better than government?

I know you probably are not looking at their profit and loss statements; however, what does the private facility charge you for a bed versus what we do the beds for ourselves?

Mr. Henderson: I'm going to refer eventually to Calvin. I'm just going to briefly explain it.

Once again, we negotiate with the community care facility association the rates that we pay, okay. There are two. There is the accommodation rate and there's the health care cost. So, we negotiate that. We're currently in negotiations with that organization at the moment. I'm going to refer to Calvin Joudrie.

Mr. Dumville: You use our costings that we're finding actually in your negotiations to how much you will pay privately?

Mr. Henderson: Basically – maybe Calvin can explain it in much more detail than that.

Calvin Joudrie: A little bit sensitive to the question currently, we're under negotiations with the private nursing home association –

Mr. Dumville: Sorry, Calvin.

Calvin Joudrie: – so I just want to be careful in terms of how I answer this. We know the cost per day in the public manors. It's more than the cost per day that we currently pay the private facilities. Of course, a benefit for having private facilities is that there's a value to government by providing a service at a lower cost.

What we do, or what we have done in the years that we look at these contracts, is we try to look at what had existed as rates, and look at a reasonable increase to provide the service at the best cost to Island taxpayers. That's the process we use. We compare it, also, with the services being rendered in our sister provinces close to us and try to look at

a deal that would be, hopefully, beneficial to the private nursing homes, as well as to, again, mindful of the taxpayers' dollars. That's the process we use.

The cost per day per resident is different because we have a base cost in each one of our facilities for the health care portion. That's $99.36 a day we pay for every Islander. Then, what we also pay to each facility from the government purse is the difference between their actual income and that $82.59 a day that's being charged. That's varied on each resident because everyone's income is different.

When I look at each facility I could, and I can provide to the minister, give a cost per day per facility for share if the minister wishes. I don't have it with me, but we do do that.

Mr. Dumville: I'm just curious: If a gentleman is living at home, he hasn't sold his home, his wife has gone into long-term care – do you attach RRSPs? Do you take away both couple's RRSPs?

Mr. Henderson: I'd better ask Calvin to answer that.

Unidentified Voice: (Indistinct) guy.

Calvin Joudrie: RRSPs, what we look at for – and again, it's only income – when you're a certain age, RRSP is converted to a RRIF. That RRIF, you're required to take a certain percentage of it per year as income. Anything we actually look at is the required amount that's been converted to income as required by the federal government through the Revenue Canada Agency as income.

The only other caveat in that is if someone has a history of taking out, for the last five years, a certain percentage of their investments at a standard rate, we would consider that their base and we would say: Why are you deviating the base to lower it if you're going into long-term care? If there's not a reasonable reason why they're reducing it, then we would expect them to maintain that level of withdrawal.

Mr. Dumville: I had a constituent say that he had to cash in all of his RRSPs.

Calvin Joudrie: See, again, one of the things that is confusing sometimes for folks, and I don't know this constituent, but sometimes community care facilities and long-term care facilities are mixed up and thought as the same.

A lot times in my office I get calls saying: Why are you making me cash in my RRSPs? I come to find out that it's because someone is in a community care facility and it's an asset-based system and they require it.

Whereas, in our office for our long-term care beds whether they're in licensed nursing care homes, which can also be a community care facility, that's where it gets confusing, right, because they may have both types of beds. Where, in our public manors, we only look at income only.

Mr. Dumville: Another question, if you needed home care to change a dressing, etc. will the home care people go out or do you have to have a doctor's note or do you have to report to emergency?

Mr. Henderson: I'll have to ask Jamie MacDonald to come forward and answer that question.

Calvin Joudrie: I'll trade you.

Jamie MacDonald: Thank you.

Mr. Henderson: This is Jamie.

Jamie MacDonald: Jamie MacDonald.

Mr. Henderson: She's the Chief Administrative Officer for Emergency Health Services and long-term care for Hospital Services East.

Mr. Dumville: I want to go on record to say she's great with handling (Indistinct) like, I want to give – Aylward can advance his people –

Some Hon. Members: (Indistinct)

Mr. Dumville: Jamie is my angel when it comes to answering these questions.

Some Hon. Members: (Indistinct)

Chair: (Indistinct) districts are they in, Jamie?

Mr. Trivers: Really good MLA.

Mr. R. Brown: Now we got her down pat.

Jamie MacDonald: Thank you very much.

Just in terms of home care: the two different ways, and Sherry can speak to this as well, but in terms of if you're in a hospital and you want to be connected with home care. We have a home care liaison nurse in all of the hospitals so that person would go in and assess that patient, speak to the doctor, they have a little bit of a family meeting type thing. Then, that person can go home with home care. That's if they're in the hospital already.

If they're already in the home, that's a different process and then that person can apply directly to the home care offices. They come out and do an assessment. Again, looking at what your needs are, those kinds of things. There's two different pathways for that.

Mr. Dumville: Thank you very much. Thank you for all of your help. You've been great.

Jamie MacDonald: (Indistinct) time.

Mr. Dumville: I don't know if she's in the district or not, tell you the truth.

Chair: You're just (Indistinct)

Mr. Dumville: Just one last one and I'll let you off the hook, minister.

In the past we've been closing beds in the summer. Do we still have that policy that we close beds at the QEH in the summer? Are we going to close them this summer?

Jamie MacDonald: So –

Mr. Henderson: I'll ask Jamie to answer that.

Jamie MacDonald: I can answer that one, as well, for sure. Closing beds: Typically we do. We have a bed closure usually around Christmastime and mostly because a lot of the patients go home, as many as we can. In the summertime to allow staff off and typically at March break, as well. It really depends.

This year, however, we're looking at it a little bit differently just in terms of bed utilization at the QEH and across the province we're at over 100% bed capacity. The reasons for that, we talked about some patients waiting for long-term care. Some are difficult to place when they're out of their acute kind of episode. We move people to Souris. We move them to Montague, we move them and because of the demographics we have a large number of people in the hospital sick. They are getting sicker.

We are looking at what we need to do to ensure that they are safe. Typically, we look at that first before we make a decision on moving – closing beds.

Mr. Dumville: As there are increasing tourism numbers –

Jamie MacDonald: Oh, yes.

Mr. Dumville: – (Indistinct) this policy in regards to maybe we can't close beds in the summer?

Jamie MacDonald: Absolutely. Typically, at least at the QEH emerg, we have been seeing over the last number of years about 100 patients a day through emergency. In the summer that goes up to about 125 or 130 a day.

Consistently, since the early part of December, we've been seeing about 125-130 a day and that's without the tourism influx that's going to start in June.

Mr. Dumville: Thank you. Thank you, minister.

Thank you, Chair.

Chair: Thank you, Mr. Dumville.

Darlene Compton.

Ms. Compton: Thank you, Chair.

I've had a number of conversations with Mr. Joudrie before and with you, minister, but I want to thank you for coming and Doctor and you, as well.

One thing I look at, the $60 million we've spent on replacement of facilities basically, and increasing the number of beds by 145

mostly, or maybe entirely that number of beds are in the private sector versus public sector as far as the increase.

Mr. Henderson: Yeah.

Ms. Compton: You know where I worked before and you know what my constituency is and it's definitely a rural community. My former boss would say it's something we can do really well in rural communities.

I can speak to this with my mother-in-law and a number of people who lived in our community. They want to stay in their community. In her case she had to move to Charlottetown, and then she moved back.

The model of community care and long-term care combined works really well. I would urge you to continue to look at that because couples can stay together.

Mr. Henderson: Yes.

Ms. Compton: It's really important. You've heard me talk about the first available bed policy, and how I don't agree with that policy because it does not – it's not person-centred care. It's not quality of care and anyone who understands the long-term care facilities.

It's great to give someone a bed, but they could be there 24 hours and then they're moved somewhere else. They could be there a month and then they're moved somewhere else. It's just so confusing and I know you know that story, but I just want to go on record as saying that to be able to have someone go where they want to be is so much better for their health.

The assessment wait times: I'm wondering about – and I'm not quite sure what the assessment wait times are for community care and for long-term care – if you get a call, someone gets a call and they say: I want my mother assessed or my father assessed. Do you know what the wait time is for that?

Mr. Henderson: From my perspective I don't think it's very long, but maybe Andrew has a better handle on that.

Andrew MacDougall: You're referring to the –

Mr. Henderson: The assessment to get determined –

Ms. Compton: Assessment, yeah.

Mr. Henderson: – whether, so if somebody were self-referred or a doctor referred to get assessed, do you have any idea –

Andrew MacDougall: The time to get actually –

Ms. Compton: Yeah (Indistinct)

Andrew MacDougall: – assessed –

Mr. Trivers: (Indistinct) request (Indistinct)

Andrew MacDougall: Yeah.

Ms. Compton: From the time you get a call until someone actually comes to their home.

Mr. Henderson I just know – in my mother's case it was very short, like probably a few days –

Unidentified Voice: (Indistinct)

Mr. Henderson: Yeah, I have never had calls on that.

Ms. Compton: (Indistinct)

Some Hon. Members: (Indistinct)

Ms. Compton: I don't remember it being an issue but someone brought it to my attention, so I thought I'd ask it.

Another point that was made was we're the third highest with the number of beds.

Mr. Henderson: Yeah.

Ms. Compton: Great, but have you looked at other provinces and what they're doing to mitigate that? If we have the third highest number of beds, which – great for us, but are there ways or things we can look at in other provinces that are going to make a difference here?

Mr. Henderson: That's precisely why we have Mr. Corman started. The two things that stand out right off the bat is the lack of home care services here compared to other provinces, and the other would be the

assessment tool. Those are two factors that we're different than other provinces so that would tend to tell why we would have a higher amount of long-term care beds per capita but less of the other services.

It's not generally – that's why we need to get a real good handle on that and we have to make this decision appropriately and with good evidence to follow up on that.

Dr. Kim Critchley: Do you want me to –

Mr. Henderson: Yeah (Indistinct)

Dr. Kim Critchley: I can add – I've been watching closely what Nova Scotia are doing because they've eliminated their wait list for long-term care beds and they've put policies in place to say that anyone who is being put on – demonstrating a need for a long-term care bed must be receiving home care services. Okay?

Unidentified Voice: Oh.

Unidentified Voice: Yes.

Dr. Kim Critchley: That's in place, so the services are being offered in the home, then the assessment; and through this regular visit from home care, the assessment is continuing to say: No, they're safe this week, no they're safe this week. No, I think –

Mr. Henderson: More accurate.

Dr. Kim Critchley: − we need more care and then: No, I think it's time for them to go into long-term care.

Jamie MacDonald: May I make a comment on that as well from a hospital perspective?

Chair: Okay –

Jamie MacDonald: We also do assessments in hospital and we're looking at that to see if that's really the right thing to be doing because if you have an elderly person that's been in the hospital for whatever reason, they are medically acute, and they're assessed in that state. That could change. We could send them home with enhanced home care supports or go to restorative care and then all of a sudden you have those people that were assessed at a level four or five while they're in the hospital, assessed at a much lower level when they're back at home or back in the community or at another facility. We're looking at that as well to see if we can improve on those assessments.

Ms. Compton: And I can (Indistinct) –

Jamie MacDonald: Yes, for sure.

Ms. Compton: − from my previous career, that once they get to a facility their health does improve and another reason for them not to be at Kings County Memorial Hospital or any of the other hospitals because they are not long-term care facilities and you do see their health improve greatly when they do get that care and again, yeah. So –

Mr. Henderson: Andrew would like to weigh in on that a little bit too.

Ms. Compton: Certainly.

Andrew MacDougall: I was just going to concur with what Jamie was saying. Hospitals are a really bad spot for assessing people. It tends to be at their lowest moment and unfortunately, there's been – once someone is assessed that way there's been – once (Indistinct) assessed to be long-term care, you tend to be on the long-term care track. So that's why it's important when we've talked about having assessments at the right time and at the right place.

I'll mention there was a comprehensive study that was done in Ontario, their long-term care wait list I think a year or two ago, and it was found that it's a very significant portion of people that were on that list, I think upwards to 40% or 50%, didn't necessarily need long-term care services.

They were there because either there was a breakdown in the care giving situation or there were not sufficient supports for the informal caregivers, you know the heroes that we have out there, the husbands and wives and children. There wasn't enough there to help them prevent burnout or to support them, or it was more the activities of daily living like in terms of being able to look after themselves personally with more basic type of care requirements.

It was those types of things that was often becoming a tipping point and so there's various initiatives that, again, I think that are of a smaller scale that we're trying to do to make some significant inroads in there.

One such area we do note that our respite service utilization is lower, surprisingly lower. That can be an important tool in the toolbox to help prevent burnout of caregivers and so I think there's some work we can do in promoting that and promoting that as an option.

There is a bit of stigma, and stigma associated with respite care. You know? Once you start taking someone to the manor, it can almost be seen as a defeat of some sort. I think that's part of it, but there are some supports there and we need to build on those.

Ms. Compton: Chair, just one more.

Chair: Sure.

Ms. Compton: Just around the expanded scope of home care, I'm guessing Mike Corman will be an integral part of that.

Mr. Henderson: Yes.

Ms. Compton: We know we have another $800,000 in the next fiscal year to put towards that. I guess my question would be: When I get a call from a constituent who hears that, what's – how can they access that? What is going to be better for them? Or can you answer that yet?

Mr. Henderson: Well, I guess stay tuned. I mean −

Ms. Compton: Yeah, stay tuned.

Mr. Henderson: − in the respect that we know the money is coming. We are now commencing a plan. It hasn't been all that long ago that we just signed on with the health accord so we have some discussions ongoing with the paramedic system to see if there's some potentials of having them provide some extra home supports, like the deputy had suggested earlier, to maybe that would free up some of our other resources to deal with more of the psychological types of issues and things of that nature for nurses to deal with.

Anyway, the deputy −

Dr. Kim Critchley: I can expand – so what we really don't want is, say, a fragmented service. We don't want nurses doing one thing and Paramedicine doing the other. I think it's really important that whatever plan for home care and that will be determined through the primary care provider and then it's carried out by who is best qualified to deliver that service so that we've got people who are delivering the right care by the right person, right time and right place. It really, whatever this looks like in the end, has to be a coordinated home care service.

Chair: Thank you, Dr. Critchley. You –

Ms. Compton: I'll just extend an invitation to the minister to come back to Belfast in the near future, yeah.

Mr. Henderson: Yeah. Well, I had a tour there once and how's construction going?

Ms. Compton: It's closed in to the weather right now –

Mr. Henderson: That's good.

Ms. Compton: Anyway, thank you.

Chair: MLA Trivers.

Mr. Trivers: Thank you, Chair.

Thank you for this excellent presentation. It's been very informative; and thank you for all of the great questions, too. I learned a lot from them and you asked a lot of my questions.

One of the things I hear about is people look at the high cost. You mentioned $181 per day and then you've also talked about this fine line between being assessed level four and five versus level one, two and three and they say: I would like to keep my level one in my own home. They can't stay in their home, but I can build an in-law suite on.

They say: Is there any help for that? How does that work? You talked a lot about home care: Is there help to actually set up people so they can look after people in their own home, their loved ones?

Mr. Henderson: Not to my knowledge through our department. There might be through family and social services and seniors, but I'm not aware of something.

Mr. Aylward: No, there's not.

Mr. Henderson: Okay.

Mr. Aylward: (Indistinct)

Mr. Trivers: Okay, I guess – I think that is something you should really take a look at. Not only would it be better for the people who need the care, but I think it could potentially save the taxpayers some dollars as well, so I wanted to make that point.

Jamie MacDonald: I just want to comment on that. There is a really good model in Manitoba and that follows that pathway.

Mr. Trivers: Okay, yes.

Jamie MacDonald: They're looking at (Indistinct) and I think they've implemented it in some areas across the province.

Mr. Trivers: I'd love to see that.

Mr. Henderson: I'd also add that we do have the – family and human services has two programs: The Seniors Home Repair Program as well as the Seniors Safe @ Home Program. Those are two things that they deal with to help seniors be more safe and comfortable in their own homes.

Mr. Trivers: The next question I had, it really had to do with how you work with family and human services when you do your assessments. That's another thing that I found for some constituents, is they feel like they're in a tug of war. They'd say: I just did an assessment here and now I have to do another assessment there.

Do you work together with them so that it's the same people doing the assessments? Or is it a complete handoff? How closely do you work with family and human services, especially on assessments?

Mr. Henderson: To my understanding, that might be more of a question for Calvin here again; but when you're dealing with community care – and the service that provides support for community care, that would be dealt with with family and human services, right? They're getting the assistance through there and they can become long-term care is when we take over and –

Mr. Trivers: Yes.

Mr. Henderson: I'm sure there's communication from one to the other, but once again we would look at it differently. Like I say, asset issues would be different. We deal with income, they deal with overall assets. So it's a component there. I don't know if Calvin – is there more you wanted to add to that? Maybe, Calvin, come forward? Musical chairs.

Calvin Joudrie: Your question's very appropriate and we do get a lot of frustrated individuals that do go through combined processes and where the rules aren't quite aligned. One's asset, one's income-based, and we do use different staff. I have staff that do the assessments for long-term care.

What we try to do to streamline it in our shop is we ask them to sign a paper that we can share their information with social services. If they agree, and they're going in for services there we will provide our file to social services because it's, of course, their right, but we always ask that question to try to minimize it.

Mr. Trivers: That's good. I definitely would like to encourage you to continue to break down the silos, right, and how a client-focused approach to dealing with the assessments so that the client, as far as they're concerned they're just working with government. They don't really care if they're working with five different departments or 23 or whatever. So please continue to improve that process. That is something I hear from my constituents.

Chair, one more question.

Chair: Sure.

Mr. Trivers: Sorry, my phone is vibrating. I apologize, Chair.

I've had this case come up a few times where I have seniors that do have mental health problems and this is something I'm pretty sure you're aware of. They're taken

out of their homes, but they don't want to be taken out of their homes. Right now, they're put in a hospital setting, which we've heard today is extremely expensive and is a very poor place for them to be.

Right now, apparently, the way I understand it, the legislation doesn't allow for them to actually be put into a long-term care facility, which would be cheaper, as well as much better for them, because they can't legally give their consent.

I wondered if you are working on new legislation so that this can happen so that it's a win-win for everybody concerned, the government, the individuals, the clients, their families.

Mr. Henderson: Are you referring to adult protection issues? We do run into seniors we have to remove based on they're not safe in their environment. They could be living by themselves, but due to a number of factors they're not able to provide a reasonable level of care for themselves.

Also, we've seen situations where we have couples that – one isn't providing the level of care for them that they should be and –

Mr. Trivers: I'm –

Mr. Henderson: – but maybe Calvin –

Mr. Trivers: I'm referring to the *Adult Protection Act.*

Mr. Henderson: Oh, okay.

Mr. Trivers: The way I understood it was that there's, indeed, the consent for treatment act can't be applied in this case. There would have to be a new guardianship act, or something like that, that would – I wanted to make sure that you are pursuing that. Really, it's a piece of legislation that's going to save everybody a bunch of grief and save taxpayers money, too, I think, in the end.

Calvin Joudrie: What's really happening – and I query the admissions for the province with the committees – what happens is there are individuals who are not capable of making decisions, who are not able to say yes to long-term care. In fact, they refuse long-term care when you ask them. They want to go home. In those circumstances the consent to treatment act doesn't cover us to allow them to come to long-term care without their permission.

If they're willing to go to long-term care and there's no resistance, we bring them into long-term care. It's when they're actively resisting that we don't have the capacity to make that choice. The matter has been referred to our legislative specialist. It's on the agenda in the department to actually take a look at. I can't give you more than that. It is in Nichola's hands.

Mr. Trivers: Great to hear, thank you. That's all, Chair.

Chair: Thank you.

Mr. Brown for a quick question.

Mr. R. Brown: Thanks.

This is a great discussion we're having over this very important issue that's facing Islanders in the future. There was a discussion earlier about Andrews having 24 beds of long-term care facility.

Does government say: You can't go into a long-term care bed if you want to pay for it yourself?

Mr. Henderson: We, once again –

Mr. R. Brown: If they then want to open those up as long-term care –

Mr. Henderson: We designate –

Mr. R. Brown: – and then –

Mr. Henderson: – we only designate – we have 1,141 designated long-term care beds throughout the province and at locations that were previously mentioned; but that's a question I've actually asked. We'll be asking Mr. Corman the same thing because we do have a certain percentage of people that are self-payers –

Mr. R. Brown: Yes.

Mr. Henderson: – but then we're starting to pick who can afford to get a bed and who not and so that's a whole big question that we have to get a better handle on but –

Mr. R. Brown: (Indistinct)

Mr. Henderson: When these facilities are building extra beds, they're community care beds they're building. They're hoping to get a designation –

Mr. R. Brown: Yeah.

Mr. Henderson: – of a long-term care bed at that location. I can go, probably, all across the province. I mean, Belfast would be one, Stratford is another, and O'Leary. They all have community care designated beds and they're trying to get long-term care designations. Tignish is probably the same, but Calvin, maybe perhaps (Indistinct) more.

Calvin Joudrie: Perhaps, minister. There is preclusion. I know the *Community Care Facilities and Nursing Homes Act* and regulations; you must be licensed to provide nursing care, a nursing care bed. The minister, with the board, defines if the bed is licensable, so there is a process and there is a requirement to be approved through the board and the minister.

Mr. R. Brown: But if Andrews wants to open those 24 beds as long-term and have them self-paid, what's the problem?

Mr. Aylward: They're not (Indistinct)

Ms. Compton: (Indistinct)

Mr. R. Brown: Long-term care –

Mr. Aylward: They're nursing care beds.

Mr. R. Brown: Yeah, that's what I mean. If they want to open them up as nursing care beds, why aren't we allowing them to open them up as nursing care beds and it's self-pay?

Mr. Henderson: If we did license them, but then we're getting into a situation, do we designate a certain amount of beds for self-payers only? Right now, we do not. We assess based on need, and then we'll determine where they go within the beds (Indistinct).

The question becomes – really what you're asking is how many more long-term care beds should we add into the system to provide the service? That's a question that Mr. Corman's going to look at. Once again, not only to determine the amount, if there's an amount, where they would be located.

Mr. R. Brown: Can I get Jamie back to the table just for one final question, and I won't ask any more.

Unidentified Voice: (Indistinct)

Mr. R. Brown: You're in charge of the QEH?

Jamie MacDonald: I am, yeah.

Mr. R. Brown: We heard earlier today, tourists and the amount of tourists that are in the summer and the potential of closing beds. I've had one question in my mind for a long time: If a tourist goes to the emergency room and they're American and they pay for it themselves, who gets the cash?

Jamie MacDonald: It goes to general revenue.

Mr. R. Brown: Good, thank you.

Some Hon. Members: (Indistinct)

Mr. R. Brown: That's where I want it to go.

Mr. Dumville: That's where it should go.

Chair: Mr. Dumville, I had you on for one more.

Mr. Dumville: It's okay, just a clarification of respite care, maybe –

Mr. Henderson: Yeah.

Mr. Dumville: – if somebody said, I thought it was okay, it was to relieve the caregiver, okay, but then you mentioned something about that there was actually respite beds.

Mr. Henderson: Yeah.

Mr. Dumville: Can you explain that one to me?

Mr. Henderson: I'll start and Andrew might have a bit more. In a number of our facilities we have what's called respite beds. They're beds that are there for the public to utilize, usually referred from home care. The

fact is, is that of the amount of respite care beds we have, there are only 47.3% of them were actually used. There is a fee structure for that.

I think the thing I found about it, just in my own family situation was, is that it did sort of stabilize, in my mother's case, some of her problems. It stabilized that to the point where she could come back home for a period of time, then have to go back to respite care.

Mr. Dumville: Yeah.

Mr. Henderson: It's a step along the way, but we have to look at how we use our respite beds and what's the impediment, why people aren't using them; because if there's 100 or whatever the number was there of people awaiting long-term care, is that a tool that they could utilize? I suggest when people – I said: Utilize all of the supports you can get like home care, respite. But they are beds that we charge a fee for.

Mr. Dumville: But besides home care going into the house, are there respite people going into the house that don't require the bed? To give somebody a break, I want to go to a movie or something –

Mr. Henderson: That's what home care does. There would be a certain amount of hours that would be considered respite hours, and in fact –

Mr. Dumville: In the home care –

Mr. Henderson: Yeah, they would actually tell the family: You can't be there.

Mr. Dumville: Yes.

Mr. Henderson: You have to leave because – I know in my father's case, he didn't want to leave, but: No, that's why we're here to provide respite and support for your mother and you have to go and get a coffee, or go out and visit people or whatever.

Mr. Dumville: It was mentioned here earlier and we've all had – I've gone through this with two parents, okay. One day they're one, two, three; the next day, within 24 hours, they're four or five. Then, all of a sudden they're back to one, two, three and we've been going through this back and forth. Will this new tool of assessment prevent that?

We were meeting with the doctor: Doctor, well, are we going to do it? No, she's fine. She came around, you know.

I don't know what I'm asking.

Andrew MacDougall: The tool –

Unidentified Voice: The tool.

Mr. Dumville: This new tool, will this prevent some of this?

Andrew MacDougall: The tool, itself, is very robust. It's used in most Canadian jurisdictions. Yes, the tool would allow us to get to a much more precise and accurate level of planning of care and allow us to evaluate how effective that care is. Any tool – that's only a part of the equation. It's when it's used and how often it's used.

Again, if the tool is just used once, then it might not catch the variation because people, especially frail seniors, they're subject to a lot of cycles. The tool is important, but in terms of integrating it at critical junctions in someone's care pathway, it would be important to try to prevent what you're speaking of.

Mr. Dumville: As a family, we were just trying to get it resolved, but it kept slipping away from us. It was hard to get it to a conclusion.

Dr. Kim Critchley: Mr. Dumville, that's where continual assessment would be so important. The tool is just a tool. It's how it's used and where it's used is really the critical piece. If you had that ongoing assessment in your own home, then you get a much better picture of what the situation is, rather than, sort of, an intermittent at the doctor's office.

Mr. Dumville: One of our cases, my father was hospitalized and we were trying to decide where he was going out of the hospital, but he wasn't well enough to go to community care –

Dr. Kim Critchley: It's the absolute worst place to test.

Mr. Dumville: (Indistinct) test.

Thank you very much for – I really appreciate your help here, today.

Chair: Mr. Aylward for one more quick one.

Mr. Aylward: Thank you, Chair.

You've talked a lot about this new hire, who just started, I believe, you said, today –

Mr. Henderson: Yeah, today's his first day.

Mr. Aylward: What was his name, again?

Mr. Henderson: Michael Corman.

Dr. Kim Critchley: Dr. Michael Corman.

Mr. Aylward: Dr. Michael Corman.

Mr. R. Brown: He'll be getting a lot of calls.

Dr. Kim Critchley: Corman.

Unidentified Voices: (Indistinct)

Mr. Aylward: He's going to do this review, but if I'm not mistaken, back in January of 2016 a tender went out looking at doing a comprehensive review on long-term care here on PEI. Was there anything ever done with that or –

Mr. Henderson: Yeah.

Mr. Aylward: Was that (Indistinct) –

Mr. Henderson: We have this internal document that identified some of the things that you just mentioned like the assessment tool –

Mr. Aylward: Yeah.

Mr. Henderson: – and beds of that nature. That's what Mr. Corman's responsibility will be, to take that and do some verification and start to put in, like say, if we are adding more beds, where would they be? If we are changing the assessment tool, what is the most appropriate assessment tool, either the A or the B? An obvious choice, but once again, to determine, and making sure that staff are prepared to change; be prepared to do the assessments differently.

It's about taking that and implementing it to a greater degree. Then, if there's government policy that's going to change form that, once again, recommendations will come forward for our government to decide if and where and when we'd add more beds to the system, or should they be specialized around dementia. We have challenges there.

Dr. Kim Critchley: I'll just add to say that there is so much that is being done around seniors' care; however, it does tend to be fragmented. So this advisor for seniors' care, the responsibility is to start coordinating those services and determining the priorities and how they should be done.

We don't have a seniors' strategy for the Island and we definitely need one –

Mr. Henderson: Yes.

Dr. Kim Critchley: – so that all of these services can be led by the larger vision for seniors' care.

Mr. Aylward: Thank you, Chair.

Chair: I have a couple of questions, myself, too, or questions/comments.

One thing I heard quite a bit when I was out canvassing and since from, particularly, our seniors that are kind of getting on in years, but still relatively healthy, that may suffer from mobility issues or whatever, was that they needed – as much as they would need home care, which a lot of them did not or would not have home care, they'd need somebody to help them go get the groceries, or help them shovel the walkway to get out to the cab, or you know, help them to get a meal, or whatever.

I'm wondering if there's any consideration being given to those kinds of little things that really, and the reality I would think would be a lot of people would have to move out of their own homes because they can no longer do those small things and their health ends up going downhill because of it.

Mr. Henderson: Certainly, we – I know when home care come in and assess they do provide information on a number of private

services that are out there. I know – whether it could be Meals on Wheels is an example. It can be just individuals that are in the area that provide, like there is an organization, We Care, and some of those organizations that will come in. They do provide that information. I guess at this point in time it's not a service that we've added to our suite of services to provide, but I guess anything is possible at some point.

Chair: Just going back to the numbers, if you're talking 180 or whatever the number is a day, and Dr. Critchley's point, there's probably – and I think you made it, too, minister – there's probably a happy medium between 180 and zero, which would probably involve paying for some of that to – if your option is: I could probably take care of myself if I had a little bit of help around home, or I can go to a $180 a-day-bed, which would you prefer? I'd probably rather pay something between zero and the $180 than $180.

Mr. Henderson: Like I mentioned before though, this is a partnership. It's a partnership between our department; it's a partnership between government and other departments, as well as the families. Families have somewhat of an obligation to do what they can to help.

Chair: Yeah.

Mr. Henderson: It's what we can do to try to provide them with the supports to care for their loved one, I guess. We are doing our best to try to enhance services to seniors. I'm sure you're going to see these services continue to evolve, but I think we have to get it right when it comes to how we are actually assessing people to be eligible for some of these services.

We have to make sure that there's no impediments to the system in the way we bill and charge and allow people to – if it's an asset issue once you're in long-term care if you could go back to community care, should assets become part of the package again?

These are questions that we have to try to get a better handle on and determining where those locations of services are needed and to try to develop some priorities. That's what part of this whole strategy with Mr. Corman will be, to take what information we have now and to try to get it advanced a little bit further and have a more coordinated approach that we have consistency in our services across the province.

Chair: I'm wondering, too, another issue I've run into quite consistently in my district is in relation to respite care and I'm going to call it qualifying criteria for it.

Mr. Henderson: Yeah.

Chair: I guess, when I say that, I'll give you a few examples, and perhaps just state them and then you guys can address it.

I have one lady, as an example, that has a fellow actually that is my age that was born with a severe developmental disability, spent a good chunk of his life at Hillsborough in his later years, and he got quite frustrated there. He ended up back with his mother.

She's a single mother. She actually worked two jobs when he was growing up to try and kind of keep care of him and keep food on the table and all that. Quite literally she's worked herself to the bone. She's got health-related issues related to having basically worked too hard for a lot of her life. She struggles to keep her own health up now basically and take care of this young fellow.

I've got another individual that's got – she's got two children, but one son with severe autism. She does have access to great programming, but at the end of the day this young fellow is very severe and would be a significant responsibility, I guess, I might say to others.

Another situation where I have a lady that would be, what I'm going to call middle aged to be polite, with two very senior parents. One of whom has, I guess both of them at this point in time, would have dementia. One of them significant dementia, and actually he was just recently admitted and the mother, as well.

Basically, she's struggling to try and take care of the two of them, and she does get a bit of respite care here and there, but you kind of wonder like how – and my understanding is if you have respite care you look at more the – you have a person and this is the amount of respite care allotted to

that person; but if you only have one person versus, say a couple of spouses that are taking care of a child, or if you have one child taking care of two parents, it's not really the same thing.

I don't think, to my knowledge, our criteria factors in those differences in the family setting. I'm just wondering if you have any thoughts on that and whether that's –

Mr. Henderson: I think, a few things; it depends on if you're talking sometimes individuals with physical or mental disabilities, that would be a different department. That would be family and human services. The support services of respite and things of that nature would be through them.

If you're referring more to a family that they have a couple of seniors that are requiring respite care, then that's where we – but Andrew had a few points that I think he'd like to add in that –

Andrew MacDougall: Yeah, we do have –

Mr. Henderson: – we do have respite services.

Andrew MacDougall: It comes down to the nature of each case. In the health system, for example, we do have some respite services for younger people that have intellectual disabilities, for example. It's a limited capacity, but there are some respite services provided there.

I know on the social services side there's some – there's different places in the province, actually, where there's housing accommodations that are available for people to go on a temporary basis. It's to give relief to their primary caregivers.

In the health system there is – in terms of the criteria, like the amount of hours that could be allocated to someone – there are some benchmarks around that, but it's not necessarily always ruled with an iron fist. It's something that, all things being equal, if there are two people who are looking for a respite bed, then that might be the factor that you look at, like who's actually over that threshold, or who's had more?

If there is capacity there, if beds are available and someone may have used more than their allotment, that's not something that we would turn away from just because they got past this arbitrary date if the service was available.

Chair: Is there – like am I right in saying that it's no different for, say, a couple with a child than it would be for a single parent? The respite is based on the individual with the health need, not the family situation?

Andrew MacDougall: Yeah, it's based on the individual.

Chair: Is there any thought to changing that to take more – I guess the way I would conceptualize it, would be respite is really for the people taking care of the person with the problem. It should be based on the needs of the people taking care of the person with the problem, not on the problem alone.

I heard all these situations and I'm thinking to myself: Wow, that seems a little strange that it would be confined to whatever the max is you get, you know, for –

Mr. Henderson: I think the point is, in our – we're going to really look – if 47.3% of our available respite beds aren't utilized, we have to ask that question, why? What are the impediments?

I don't know personally what they are, but, at the end of the day we have to get a better handle on that. That's one of the issues and challenges that we have within our department. It's great to have the services, but if they're not being utilized, why?

Jamie MacDonald: Can I make a comment, as well, on that? Just in terms of the respite beds. We have started to look at them because what else happens is in those three examples you provided what happens is the families are so exhausted or so frustrated they come to emergency.

Chair: Yeah.

Jamie MacDonald: They say: We cannot do this anymore, we need a break. They really do need a break. Is emergency the right place for them? Likely not, or then they get moved to the in-patient bed and is

that the most appropriate location? Probably not.

So in some instances lately we have said: I think this person is going to be moved somewhere else, perhaps we can provide some respite to that patient or family until they find a more appropriate location.

In those ways we do work with family and human services to try to provide some type of support and appropriate services, but you're right. We could utilize them better and we're starting to look at that now; better ways to do that.

Andrew MacDougall: We do see opportunity.

Jamie MacDonald: Yeah.

Andrew MacDougall: I heard the comment before; it's geared towards providing respite to the caregiver.

Jamie MacDonald: Yeah.

Andrew MacDougall: We see opportunity to provide value-added service to the person, to the actual client themselves. Right now, they come in, it's usually for a week or two at a time and it's – they're not really participating in a specific suite of services. We'd be interested in taking a look at what that could look at in terms of a value-added approach.

We talk about some people that are in the community that are teetering. Maybe if they came in for a tune-up, for lack of a –

Jamie MacDonald: Early intervention.

Andrew MacDougall: – lack of a better word. A mini-restorative type of program to get them moving, to get them ambulated and help them with some skills, too. In terms of helping them dress and helping them bathe and brush – some of those basic things that you'd mentioned earlier that sometimes can be the tipping point. There's definitely opportunity there.

Chair: Great. Excellent. Anybody else have any questions before we go?

Thank you very much, folks. It's been a great, very comprehensive presentation. I appreciate all of the time all of you have taken out of your busy days to come and fill us in. Hopefully, this enables the public to get some more information on the different services that are there, and the work that you guys are doing to make them fit the needs of the public.

Mr. Henderson: On behalf of our department and the staff that are here, and all of the staff that are out in the province, we certainly appreciate your interest in the topic, and look forward to some of your committee's recommendations as you compile that information and present it to the Legislature.

Thank you.

Unidentified Voices: (Indistinct)

Chair: I (Indistinct) your cord for this for next week. Your cord for –

Unidentified Voices: (Indistinct)

Chair: – motion to adjourn. Thanks, Bush.

Mr. Aylward: New business, isn't there?

Chair: Oh yeah. We'll just let them (Indistinct)

Clerk Assistant (Doiron): We can have them recess for five minutes.

Unidentified Voices: (Indistinct)

[Recess]

Chair: Folks, our meeting's not over yet, so if we could get members back to the table and –

Mr. R. Brown: Okay there, boss.

Chair: Things get a lot noisier with you here, today.

Mr. R. Brown: Yes. It's going to get noisier over the next couple of months. You think you had problems with them?

Mr. Aylward: You be careful or he'll start bullying you.

Mr. R. Brown: Can you believe that? (Indistinct) Steve Myers.

Mr. Dumville: (Indistinct) read it in *The Guardian*, it must be true.

Mr. R. Brown: Bullying Steve Myers.

Mr. Dumville: Can you imagine?

Mr. R. Brown: (Indistinct) ring in front of it.

Chair: You signed the letter, too. I don't know whether you're in trouble, too or what?

Mr. Aylward: You bullied me into it.

Chair: I guess, yeah, fair enough.

Okay, new business before we –

Mr. Aylward: Chair?

Chair: – go onto other things. Yes.

Mr. Aylward: I had written a letter back on February 28th to the committee, just with regards to another issue that's come up. You haven't seen it, or –

Chair: Read it.

Mr. Aylward: Okay.

"Dear Chair;

"The recent agreement on health funding between the Governments of Canada and Prince Edward Island will contain specific funding earmarked towards the improvement of mental health services.

"As is widely known, mental health services in the province would benefit from new resources to address current gaps and bottlenecks in the system accessing the proper supports in a timely fashion.

"One particular area where gaps and bottlenecks currently seem to exist is mental health services for women and youth. Over the last number of months a group of Island women have built an online support network where stories have been shared about challenges in accessing quality health care.

"With that in mind I would like to invite representatives of Island Mothers Helping Mothers (Sarah Stewart-Clark et al) to appear before Committee at the earliest opportunity. Information from and discussion with this group will be valuable in putting together the recommendations of our committee to the House. It is essential that the new targeted funding for mental health services achieves the maximum benefit for Islanders."

Sincerely,
James Aylward, MLA
Stratford-Kinlock

I'll just give you a little background on that.

I was contacted, probably about a week and a half ago now, by one of these mothers. Her 20-year-old son was in the ER. He had attempted suicide. He was in the ER for, at that time, six days awaiting a bed in Unit 9.

I'm meeting shortly with another mother of a 16-year-old girl that attempted suicide. Her 16-year-old daughter has now been in the ER for 13 days waiting for an adolescent bed in Unit 9. The mother was told two days ago: The daughter, well, we're probably going to be releasing her. They're discharging her, which I don't think is a very good solution currently right now – if you have a 16-year-old girl that attempted suicide, to house her in the ER for roughly 13 days and she's not getting those services and the supports that obviously she requires.

Anyway, at one point, a week and a half ago, there were 18 individuals in the ER waiting for a bed in Unit 9. There was one young man, I believe, who was 19, he tried to light himself on fire. He was in the ER for three days. They were going to discharge him until his mother blew a gasket. To the best of my knowledge he's still there.

I called the minister, who was here today, and gave him a quick briefing. I said: I don't know if you're aware of what's happening out there right now, but we have a crisis in that unit of the ER. He calls Dr. Michael Mayne, the CEO, but it's still – it's deplorable what's happening out there.

This Sarah Stewart-Clark had a meeting as well with the minister and I think he basically just said: Well, occasionally we have spikes. But I mean, I'm hearing these stories over and over again.

Mr. R. Brown: Same here.

Mr. Aylward: The issue, too, is we're hearing more and more about these online support groups that are popping up out of necessity and need because they're not getting the services or the support there so they're having to help themselves.

We're hearing it from grandmothers raising grandchildren and great grandchildren. We're hearing it from H.O.P.E in Summerside: Helping Other Parents Educate. It's continual.

I think we should be asking this individual. She's actually a doctor. She's a professor over at Dalhousie University, but she's originally from Prince Edward Island and she's very engaged. She started this support group so she would be very interested in coming in.

Mr. R. Brown: I agree with my colleague and you know, I think we need an action plan on this mental health issue. We have a strategy, but we need an action plan to see how we're going to implement this strategy because I'm hearing the same things, that the lack of –

Mr. Aylward: But, Rich, even the strategy that was just released – they even admitted that day that there's no new money tagged to it –

Mr. R. Brown: But there's new federal money coming –

Mr. Aylward: Well, yeah, but I mean –

Mr. R. Brown: Yeah, we should allocate that.

Mr. Aylward: That's still to be questioned, how much and where we're going with that.

Chair: One thing at a time. (Indistinct)

Unidentified Voice: (Indistinct) Chair –

Chair: We have a request here to bring in Sarah Stewart-Clark?

Mr. Aylward: Sarah Stewart-Clark.

Chair: And the Island Mothers Helping Mothers −

Mr. Aylward: Correct.

Chair: − for a presentation here at the committee meeting. So why don't we, unless there's any contrary-minded, get her in. We can evaluate whether we need anybody else and I'm not sure – do you know –

Mr. Aylward: There's two primary facilitators of this Facebook support group and Emily, I'm sorry that for some reason that this –

Chair: Actually, I should apologize for that, too.

Mr. Aylward: − letter didn't get to you.

Chair: I just assumed it was cc'd to the committee clerk. I had seen it so I –

Mr. Aylward: Okay.

Chair: My apologies for that.

Mr. R. Brown: That's a good point. We should – if you're going to write the clerk, the Chairman better cc the clerk.

Mr. Aylward: Yeah.

Chair: That's my oversight.

Clerk Assistant: Do you have a copy of the letter there?

Mr. Aylward: I do. It's not a great copy, but I mean I can certainly give you – you can keep that. I can get you another one.

Clerk Assistant: Okay, and I'll circulate to the committee −

Mr. Aylward: Okay, perfect.

Clerk Assistant: − so you'll have it for your reference.

Mr. Aylward: I'll get a new electronic version sent to you, Emily.

Clerk Assistant: Perfect.

Chair: Is there any – just knowing two things: March break and –

Mr. Aylward: Yeah.

Chair: − we're getting pretty close to sitting time. Is there an urgency that it happen before (Indistinct)

Mr. Aylward: I think it's imperative that we get going on this right away.

Chair: You would have her contact (Indistinct) −

Mr. Aylward: Yes.

Chair: − (Indistinct) to Emily.

Mr. Aylward: Yes.

Chair: Okay. Let's see what we can set up then, and we can head off from there.

Mr. Aylward: Thank you, Chair, and just while I still have it under new business – I want to go back under old business, actually.

Just curious; I had raised several issues back four months ago. I'm sad to say it's been that long since this committee's met, but I had asked about facilitated communication and we had − I think, Chair, you had said we would send a letter to the Minister of Family and Human Services and Minister of Health and Wellness to get an update on what's happening with facilitated communications. I haven't seen anything on it. I don't know if they've responded.

Chair: (Indistinct)

Unidentified Voice: (Indistinct)

Mr. Aylward: Yes.

Clerk Assistant: (Indistinct) sent to the committee, but I can –

Chair: Yeah, we got the responses back, I think, from both ministers of health and family and human services –

Mr. Aylward: I don't recall seeing anything on that.

Chair: − which were circulated to committee members.

Mr. Aylward: Okay. Could you reissue that, please, Emily?

Clerk Assistant: Yes, of course.

Mr. Aylward: Thank you.

Then I also had down that I would like to see an update from – well, at that time it was chief – yeah, the CEO of Health PEI, Dr. Michael Mayne, with regards to wait times for surgeries, particularly orthopedic surgeons. Not only wait times for surgeries, but the wait times for referrals from the GPs to the orthos.

Clerk Assistant: There has been no response to that letter. It was issued – it was reissued to the recipient.

Mr. Aylward: It was reissued to the recipient?

Clerk Assistant: Yes, in the fall after our last meeting, I believe.

Mr. Aylward: Okay.

An Hon. Member: (Indistinct)

Clerk Assistant: Would the committee like me to send that correspondence again?

Mr. Aylward: Yes, please.

Some Hon. Members: (Indistinct)

Mr. R. Brown: Remind them. Yeah, let's remind them. Genius.

Mr. Aylward: That's your word, not mine.

Chair, the very last thing that I have sort of pertains to the first one that I brought up around the issue with mental health and addictions right now.

Ms. Compton: (Indistinct)

Mr. Aylward: I'm starting to hear from people that the province is no longer funding off-Island treatment at Portage or Homewood and I would certainly like to get an update on that because as we know, the great reputation of both of those facilities – Portage, of course, in New Brunswick, which treats addictions for youth, I believe between the ages of 14 to 21, in that range; and Homewood, which is in Ontario which focuses more on mental health issues but some with addictions as well, but mostly mental health issues.

I'm just fearful that the department or the government right now might be just trying to send everybody up to the strength program in Summerside to –

Chair: All right. We'll send a letter off to the minister of health and –

Mr. Aylward: Okay.

Chair: − see what the kind of policy is in relation to funding. What do you want to call it? Out-of-province –

Mr. Aylward: Out-of-province treatment −

Chair: For –

Mr. Aylward: − for mental health and addictions.

Chair: − mental health and addictions.

Mr. Aylward: Yes.

Chair: Do you want to confine it to those two specific locations or just say general?

Mr. Aylward: Um –

Chair: Or we could say for example.

Mr. Aylward: For example, thank you. Yes. I would love to have asked Rhonda Matters, but apparently she's not around anymore which is probably just as well – and I'm on record saying that, too.

Clerk Assistant: Is the committee looking for a written response?

Some Hon. Members: (Indistinct)

Chair: Yes.

Clerk Assistant: Okay.

Mr. Aylward: What's that?

Mr. Dumville: You didn't like that one-page report?

Mr. Aylward: Did you?

Mr. Dumville: Not really.

Mr. Aylward: That was – if I had of been her, I would have been embarrassed.

Chair: Members here, be quiet for a second.

Okay, any other matters under new business? I'm going to bully the committee here to be quiet. Nothing? If I could get a motion for adjournment?

Some Hon. Members: (Indistinct)

Chair: Thank you.

Some Hon. Members: (Indistinct)

The Committee adjourned