January 14, 2016

Dear [Redacted]

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: HCS/068/2015]

On December 14th, 2015, the Department of Health and Community Services (the Department) received your request for access to the following records/information:

“All briefing materials prepared for and/or provided to Minister John Haggie upon assuming the role of minister of health and community services. Where possible, electronic copies of all records are preferable to print copies.”

The Department has reviewed your request in the context of the Access to Information and Protection of Privacy Act (the Act) and Beverley Clarke, Deputy Minister, made a decision and is pleased to inform you that access to these records has been granted, in part. In accordance with your request for a copy of the records, the appropriate copies have been enclosed. Some information has been refused in accordance with the following exceptions to disclosure, as specified in the Act:

- s. 27(1)(e), 27(1)(i) Cabinet Confidences
- s. 29 (1)(a) Policy advice or recommendations
- s. 30(1)(a) Legal advice
- s. 34(1)(a)(i), 34(2)(b) Disclosure harmful to intergovernmental relations or negotiations
- s. 35(1)(d), 35(1)(f), 35(1)(g) Disclosure harmful to the financial or economic interests of a public body
- s. 38(1)(a), 38(1)(b)(i), Disclosure harmful to labour relations interests of public body as employer
- s. 40(a) Disclosure harmful to personal privacy

Pages 95-96 withheld in entirety pursuant to s.29(1)(a); 104-105 withheld in entirety pursuant to s.29(1)(a), 35(1)(a); 124-127 withheld in entirety pursuant to s.29(1)(a), 24(1)(a)(i); page 160 withheld in entirety pursuant to s.29(1)(a), 34(1)(a)(i); page 208 withheld in entirety pursuant to
s.35(1)(d); pages 209-211 withheld in entirety pursuant to s.29(1)(a), 25(1)(d); page 219 withheld in entirety pursuant to s.29(1)(a) and page 266 withheld in entirety pursuant to s.29(1)(a).

As required by 8(2) of the Act, we have severed information that is unable to be disclosed and have provided you with as much information as possible.

Please be advised that you may appeal this decision and ask the Information and Privacy Commissioner to review the decision to provide partial access to the requested information, as set out in section 42 of the Act (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner. Your appeal should identify your concerns with the request and why you are submitting the appeal.

The appeal may be addressed to the Information and Privacy Commissioner as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John's, NL A1B 3V8

Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act (a copy of this section of the Act has been enclosed for your reference).

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Office of Public Engagement's website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please contact the undersigned by telephone at 709-729-7007 or by email at angelapower@gov.nl.ca.

Sincerely,

[Signature]
Angela Power
ATIPP Coordinator
Book 1: Departmental Overview

1. About the Department
   a. Presentation - Departmental Overview

2. Descriptions of Branches and Divisions
   a. Organization Charts
   b. Key Contacts/Phone Numbers

3. Health and Community Services Programs and Services

4. Ministerial Authority

5. Legislation and Regulation-Making Authority

6. Financial Overview
   a. Financial Overview 2015-16 Presentation
   b. Estimates

7. Relationship between RHAs and the Department of Health and Community Services
   a. Profile: Central Health
   b. Profile: Eastern Health
   c. Profile: Labrador-Grenfell Health
   d. Profile: Western Health
   e. RHA Board of Trustees

8. Intergovernmental Agenda

9. Strategic Issues and Directions

10. Overview of Major Health and Community Services Strategies

11. Capital Spending Overview

12. Stakeholders

13. Commitments Roll-Up

14. Potential Legislation for Spring Session for House of Assembly

15. Ministerial Presentations - Key Presentations
   a. Health Care Sustainability
   b. Mental Health and Addictions
   c. Primary Health Care Framework
   d. TW - Long Term Care Procurement Update
   e. Long-Term Care and Community Supports Services Strategy
   f. Physician Assisted Dying
   g. E-Health
   h. Shared Services
   i. Infrastructure Projects

16. Briefing Notes: Hot Topics
   a. Shared Services Organization
   b. FPT Health Agenda
   c. Ambulance Negotiations
   d. Physician Assisted Dying
   e. All Party Committee
   f. Physician Recruitment
   g. Air Ambulance
   h. Syrian Refugees
   i. Midwifery
17. Central Health Hot Topics
   a. Budget
   b. Recruitment
   c. ALC-Capacity-Client Flow
18. Eastern Health Hot Topics
   a. Mental Health and Addictions Program
   b. Sustainability
   c. Rural Laboratory – X-Ray
19. Labrador-Grenfell Health Hot Topics
   a. List of Hot Topics
   b. Access to Primary Care
   c. Budget Pressures 2015-16
20. Western Health Hot Topics
   a. Access to Primary Health Care
   b. Over Capacity
   c. New Facility Planning

Book 2: References
1. Strategic Plan 2014-17
3. A Provincial Cancer Control Policy Framework for NL 2010
4. A Strategy for Long Term Care and Community Support Services
5. A Policy Framework for Chronic Disease Prevention and Management in NL
7. A Strategy to Reduce Emergency Department Wait Times in NL 2012
8. Healthy People, Healthy Families, Health Communities – A Primary Health Care Framework
9. Mental Health and Addictions Policy Framework
10. Strategic Health Workforce Plan
About the Department

The Department of Health and Community Services is responsible for setting the overall strategic directions and priorities for the health and community services system throughout Newfoundland and Labrador. The Department works with stakeholders to develop and enhance policies, legislation, provincial standards and strategies to support individuals, families and communities to achieve optimal health and well-being. The Department is also responsible for identifying key areas for strategic investments to support the health and community services system in providing the best quality health care to the people of the province. As well, the Department is responsible for monitoring and reporting on the performance of various aspects of the health care system.

The Department of Health and Community Services has a total budget of approximately $3.0 billion for 2015-16. As of March 2015, there were approximately 216 positions situated at three locations across the province.

- Grand-Falls Windsor (30 employees)
- Stephenville (11 employees)
- St. John’s (175 employees at Confederation Building and Major’s Path).

Mandate:
The following mandate describes the responsibilities of the Department of Health and Community Services. This mandate was revised in 2012-13.

1. To provide leadership, coordination, monitoring and support to the regional health authorities (RHAs) and other entities who deliver programs and services ensuring quality, efficiency and effectiveness in the following areas:
   - Preservation and promotion of health;
   - Prevention and control of disease;
   - Public health and the enforcement of public health standards;
   - Access and clinical efficiency;
   - Administration of health care facilities;
   - Programs for seniors, persons with disabilities and persons with mental health and addictions issues as well as long term care and community support services;
   - Health professional education and training programs; and
   - Control, possession, handling, keeping and sale of food and drugs.

2. To effectively administer and provide funding for the following:
   - Insured medical and hospital services;
   - Dental and pharmaceutical services for eligible individuals;
   - Grants to select community agencies in support of the Department’s mandate; an
   - The purchase of seats and bursary programs for students in select professional or technical fields connected with health and community services.
Departmental Structure

- As of March 2015, there were approximately 216 positions situated at three locations across the province.

  - Grand-Falls Windsor – 30
  - Stephenville – 11
  - St. John’s - 175 employees at Confederation Building and Major’s Path
HCS Mandate

- To provide leadership, coordination, monitoring and support to the regional health authorities and other entities who deliver programs and services ensuring quality, efficiency and effectiveness in areas such as (for complete mandate, please see attached handout):
  - The prevention and control of disease
  - The administration of health care facilities
  - Access and clinical efficiency

- To effectively administer and provide funding for the following:
  - Insured medical and hospital services
  - Dental and pharmaceutical services for eligible individuals
  - Seat purchase and bursary programs for students in select professional or technical fields connected with health and community services
## Legislative Mandate

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<tr>
<td>Centre for Health Information Act</td>
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<td>Chiropractors Act, 2009</td>
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<td>Communicable Diseases Act</td>
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<td>Dental Act, 2008</td>
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<td>Dieticians Act</td>
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<td>Dispensing Opticians Act, 2005</td>
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<td>Emergency Medical Aid Act</td>
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<td>Health and Community Services Act</td>
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<td>Health Care Association Act</td>
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<td>Health Professions Act</td>
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<td>Health Research Ethics Authority Act</td>
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<td>Hearing Aid Practitioners Act</td>
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<td>Hospital Insurance Agreement Act</td>
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<td>Human Tissue Act</td>
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<td>Licensed Practical Nurses Act, 2005</td>
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<td>Medical Act, 2011</td>
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<td>Medical Care Insurance Act, 1999</td>
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<td>Mental Health Care and Treatment Act</td>
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<td>Occupational Therapists Act, 2005</td>
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<td>Optometry Act, 2012</td>
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<td>Pharmaceutical Services Act</td>
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## Legislative Mandate (Continued)

### Legislative Mandate Continued

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<th>Pharmacy Act, 2012</th>
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<td>Regional Health Authorities Act</td>
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<td>Registered Nurses Act, 2008</td>
<td>Self-Managed Home Support Services Act</td>
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<td>Social Workers Act</td>
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### Legislation Required to Undergo Review After Five Years

<table>
<thead>
<tr>
<th>Mental Health Care and Treatment Act</th>
<th>Personal Health Information Act</th>
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<tr>
<td>• First review completed and legislation amended in 2014</td>
<td>• Review currently being undertaken</td>
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| Pharmaceutical Services Act | |
|-----------------------------||
| • Review ongoing | |
Department Branches and Divisions

- Professional Services Branch:
  - Dental Services Division
  - Emergency Management
  - Health Workforce Planning
  - Pharmaceutical Services

- Medical Consultant
  - Pathology and Laboratory Services
  - Physician Services

- Regional Services Branch:
  - Acute Health Services and Nursing Policy Division
  - Infrastructure Management Division
  - Long-Term Care and Community Support Services Division
Department Branches and Divisions

- Population Health Branch:
  - Public Health/Chief Medical Officer of Health
  - Communicable Disease Control
  - Environmental Public Health Division
  - Mental Health And Addictions
  - Primary Health Care

- Policy, Planning and Performance Monitoring Branch:
  - Health System Transformation and Policy
  - Planning, Performance Monitoring and Evaluation

- Corporate Services Branch:
  - Audit and Claims Integrity Division
  - Financial Services Division
  - Information Management Division
Entities Reporting to the Minister of HCS

- Four Regional Health Authorities:
  - Eastern Health
  - Central Health
  - Labrador-Grenfell Health
  - Western Health
- Newfoundland and Labrador Centre for Health Information
- Provincial Advisory Council on Mental Health and Addictions
- Cancer Control Advisory Committee
- Medical Consultants Committee
- Mental Health Care and Treatment Review Board
- Health Research ethics Authority
Descriptions of Branches and Divisions

The Department is made up of six branches and 20 divisions. The Department experienced major organizational change in November 2011 and, again, in March 2013 due to budget reductions and most recently October 2015. 291.5 full time equivalent positions have been reduced to 216 full time equivalent positions. This information represents the current organizational structure.

Executive Branch: The Executive Branch is comprised of the Minister and Deputy Minister’s office, and the Communications Division. The Department also has five Assistant Deputy Ministers and a Medical Consultant.

- Communications Division: This Division provides strategic communications planning and advice to the Minister and senior executive on communicating ministerial and Departmental priorities, policy development, issues management and program planning and implementation, as well as the coordination, production and distribution of speeches, news releases, publications and multimedia materials. This Division also manages the Departments’ advertising, publishing, marketing, media relations activities and event participation.

Professional Services Branch: The Professional Services Branch provides strategic and operational advice on matters pertaining to the development and maintenance of policies, programs and standards governing the Province’s health professionals.

- The Dental Services Division: This Division is responsible for the administration of the Provincial Dental Health Plan and the Surgical Dental Program. The Division directs and administers all matters relating to dentistry, including the Dental Bursary Program, in accordance with established Departmental policies.

- Emergency Management: This Division includes the following two programs:
  
  - Health Emergency Management Program: The main focus of the Health Emergency Management (HEM) program is to ensure that the provincial health system maintains a state of readiness to respond to and recover from an operational disruption or disaster event. The HEM program supports the Regional Health Authorities and facilitates the coordination of the support activities of other levels of government, departments, agencies and organizations at the provincial level during an event.

  - Provincial Road and Air Ambulance Program: The Road Ambulance Program is a critical component of the health care system and is often the first point of contact for individuals in an emergency situation. These road ambulance providers deliver pre-
hospital medical services to the public. The Department of Health and Community Services is responsible for policies, procedures, standards and negotiations with the private and community operators. The four Regional Health Authorities are responsible for the day-to-day operational issues related to the road ambulance program.

The Provincial Air Ambulance program performs medical evacuations, known as medivacs, to individuals requiring emergency care as well as non-emergency patients when a road ambulance or commercial flight is unsuitable due to a patient's condition, duration and distance of patient transport and geographic location. Patient transports normally take place within the province, however, out-of-province patient transports may occur if the required medical services are not available in this province and the patient is unable to travel by commercial flight.

- **Health Workforce Planning Division:** The Health Workforce Planning Division's goal is to ensure a sustainable health workforce through building a database and conducting research upon which projections and key human resource policy decisions can be made. The Division supports evidence-based decision making for health workforce issues by disseminating research and evaluation data, strategic planning, advising stakeholders on policy and program development, and facilitating provincial health workforce planning activities. It also administers incentives for health professionals including bursaries, signing bonuses and market adjustments.

- **Pharmaceutical Services Division:** This Division is responsible for the provision of strategic advice with respect to, and the administration and management of:
  - the Newfoundland and Labrador Prescription Drug Program (NLPDP);
  - the Tamper Resistant Prescription Drug Pad Program (TRPP) - intended to reduce prescription drug abuse and diversion by reducing the likelihood for prescription forgeries and/or alterations; and
  - the Newfoundland and Labrador Interchangeable Drug Products Formulary - applies to all residents of the province and is intended to assist the people of the Province to obtain prescription drugs of acceptable quality at reasonable prices.

**Medical Consultant** – The Medical Consultant position was created to ensure physician representation at the executive table and is involved in clinical decision making across the department. The Medical Consultant is responsible for the following divisions:

- **Pathology and Laboratory Services Division:** This Division develops provincial policies and procedures related to pathology and laboratory services in consultation with the RHAs. It also facilitates the RHAs’ preparation for lab accreditation; coordinates educational opportunities; and, disseminates information to pathologists and laboratory staff throughout the province. This division is also responsible for the
development of a strategic plan for provincial recruitment and retention of pathologists and laboratory medicine technologists.

- **Physician Services Division**: This Division is responsible for the development, maintenance and monitoring of insured medical service programs to beneficiaries. The Division develops and implements guidelines and procedures for salaried, fee-for-service and alternate funded physicians, and is involved in negotiations with the Newfoundland and Labrador Medical Association (NLMA). It is also responsible for the development and implementation of policies on the recruitment and retention of physicians; and medical student and resident bursary programs. This Division works in collaboration with Memorial University’s Faculty of Medicine regarding the ongoing and future supply of physicians for the province.

**Regional Services Branch**: The Regional Services Branch provides operational and strategic advice on matters pertaining to the four RHAs, infrastructure management; acute health services, and nursing policy; and long-term care and community support services.

- **Acute Health Services and Nursing Policy Division**: This Division is responsible for providing advisory and consulting support to the RHAs to enable them to deliver quality health care to the residents of Newfoundland and Labrador within available resources. Acute health facilities, the Provincial Blood Coordinating Program, and Provincial Chief Nurse role falls within this Division’s mandate. The Division monitors the operations of the RHAs, in collaboration with the Financial Services Division, to ensure that the health and community services system is responsive to the needs of the population through quality programs and services for residents throughout the province. This Division also includes the Office of Adverse Health Events which provides leadership, strategic advice and expertise to the Department in the areas of quality, patient safety and adverse health event management. It oversees the development, and implementation of the Provincial Adverse Health Event Management Framework and the provincial electronic occurrence reporting system. The Office works in collaboration with other divisions of the Department, the RHAs and other key stakeholders on an array of issues and initiatives affecting quality and patient safety.

- **Infrastructure Management Division**: This Division provides planning and consulting services related to the construction and redevelopment of health care facilities including acute care facilities, long-term care facilities, and community health clinics. The Division also works with the RHAs in identifying priority repairs and renovations, as well as equipment needs in health care facilities, and allocates financial resources on an annual basis.

- **Long-Term Care and Community Support Services Division**: This Division is responsible for providing leadership, policy, program development and monitoring for the long-term care
and community support services system. This system encompasses services provided by the RHAs in an individual's home, long-term care facilities, personal care homes and residences for adults with disabilities.

**Population Health Branch:** The Population Health Branch provides operational and strategic advice on matters pertaining to the development and maintenance of policies, programs and standards governing the province's population health.

- **Public Health/Chief Medical Officer of Health Division:** This Division is responsible for overseeing infection prevention and control, immunization, disease control, drinking water safety, food safety, environmental health, and pandemic planning and preparedness.

- **Communicable Disease Control Division:** This Division facilitates the prevention, intervention and timely investigation and control of infectious diseases. Surveillance activities identify trends, patterns, risk factors, and emerging disease events. This information is communicated to public health partners to facilitate an appropriate response and to continually evaluate public health programs. This Division also develops vaccine program policy and protocols for those diseases that are vaccine-preventable. The infection prevention and control program provides guidance to ensure optimum prevention methods in health care facilities and in the community.

- **Environmental Public Health Division:** The Environmental Public Health Division, through legislation, regulations, standards, awareness and other interventions is committed to protecting the health of the public and enhancing quality of life by assessing, correcting, controlling, and preventing those factors in the environment that can adversely affect human health.

- **Mental Health and Addictions Division:** The Mental Health and Addictions Division is responsible for providing leadership in the planning, development, implementation and evaluation of provincial policies and programs related to mental health and addictions in Newfoundland and Labrador. The Division works in partnership with the RHAs, various community groups, the Provincial Mental Health and Addictions Advisory Council as well as other stakeholders in the province.

- **Primary Health Care:** This division will lead the transformation of primary health care services in Newfoundland and Labrador. It will support the development and implementation of Primary Health Care policy and practice framework involving Government, Newfoundland and Labrador Medical Association and Canada's Strategy for Patient Oriented Research (SPOR). It will lead internal and external stakeholder engagement including RHAs, Government Departments, the research community and
professional associations. It will be responsible for best practice tracking and outcome monitoring and evaluation. This Division will also continue leadership in chronic disease management.

**Policy, Planning and Performance Monitoring Branch:** The Policy, Planning and Performance Monitoring Branch is responsible for advancing the Department’s cabinet agenda, providing support to the Department for policy development and overseeing the Department’s participation in horizontal, government-wide initiatives. This Branch also provides strategic and operational advice on all matters pertaining to corporate strategic planning and evaluation develops the Department’s legislative agenda and supports the deputy minister and minister in federal/provincial relations pertaining to health. The Branch also includes the work of the Legislative Consultant.

- **Health System Transformation and Policy:** This Division has three main functions: 1) legislative and regulatory affairs, 2) government relations and 3) policy development. The Division provides support for the development of strategic plans of the Department and the RHAs in delivering quality health and community services. This is achieved through researching, analyzing and disseminating current evidence and best practices which inform the development and implementation of policies, programs and legislation. The Division works with staff in the Department, other departments, research and health information organizations and key stakeholders to ensure that the most up-to-date and accurate information is available to support decision making. The Division provides administrative and advisory support services to the Department in matters pertaining to legislation, regulations and by-laws and legal affairs generally, and has the primary responsibility of working with self-regulated health professions with respect to interpretation, evaluation, and development/amendment of their legislation. The division also manages relations at the Minister and Deputy Minister level, and provides strategic advice on complex and diverse policy and program areas, incorporating government’s broad policy objectives. The Division liaises with other provincial/territorial governments to develop common positions and strategies on issues of mutual interest. In October 2015 this Division changed from the Policy Development and Legislative Affairs Division to the Health System Transformation and Policy Division to reflect the clinical efficiency and location of service mandate approved in Budget 2015 and to provide policy support, coordination and project management expertise to the matrix project leadership.

- **Planning, Performance Monitoring and Evaluation Division:** The Planning and Evaluation Division was renamed in October 2015 to Planning, Performance Monitoring and Evaluation to develop a cohesive and focused health analytics strategy/framework, to improve knowledge translation, develop scorecards and metrics for regular Department and public reporting and optimize stakeholder alignment with provincial priorities. This Division also coordinates Departmental activities related to a range of planning activities and supports monitoring and evaluation in accordance with Government’s Corporate Evaluation
Policy that contributes to improved policy and program development thereby cultivating a culture of quality. The Division also coordinates Departmental planning and accountability measures under the Transparency and Accountability Act through the development of strategic, operational and work plans, annual performance reports, and performance contracts. It supports formal monitoring and reporting activities within the Department and by entities that report to the Minister.

**Corporate Services Branch:** The Corporate Services Branch provides strategic and operational advice on all matters pertaining to financial management, audit and claims integrity, and information management. The Corporate Services Branch is also responsible for Department services that are delivered by the Division of Strategic Human Resources, even though direct line reporting rests with Human Resource Secretariat. This Division also includes Client Inquiries.

- **Audit and Claims Integrity Division:** The Audit and Claims Integrity Division ensures that public health care funds are distributed appropriately to healthcare providers for services provided to beneficiaries of the Medical Care Plan (MCP) and the Newfoundland and Labrador Prescription Drug Program (NLPDP), as well as to patients under the Medical Transportation Assistance Program (MTAP). This Division manages and/or administers: eligibility and registration services for MCP; the Dental Health Plan; the Inter-Provincial Reciprocal Billing Agreement and the Eligibility and Portability Agreement related to Newfoundland and Labrador residents accessing health services in other provinces, and other Canadian residents accessing health services in Newfoundland and Labrador; and, the identification of medical and hospital expenses incurred by residents due to negligence of a third party.

  The units which provide these services include: Insured Services; Medical Audit and Compliance; Programs Audit; Medical Care Plan (MCP) Public Service and Administration; Medical Affairs and Training; Claims Assessing; and Claims Processing.

- **Financial Services Division:** The Financial Services Division manages the internal and external financial affairs of the Department including providing financial management consulting, advisory and information services to the Department’s management team and other stakeholders within government; preparing the Department’s annual budget; determining the annual budget allocations for the RHAs and related agencies in consultation with Regional Services Staff; managing the Department’s budget monitoring program for health and community services organizations; and coordinating the office management and administrative support services related to the Department’s day-to-day operations.
The units which provide these services include: Financial Services, Accounting Services, Budget and Monitoring, Financial Information, Board Financial Services, and, Office Management Services.

*Information Management Division*: This Division provides internal support to the Department including: offering information management consulting, and advisory services to the Department's management team and other stakeholders within government and RHAs; managing the Department's paper and electronic records and information repositories; monitoring and providing advice to the Department on e-Health related projects; providing support and advice regarding the privacy of personal health information to public and private sector custodians, as well as to the general public; coordinating access-to-information requests including requests from the Child Youth Advocate, Office of Information and Privacy Commissioner, and Office of the Citizen Representative; and, liaising with the Office of the Chief Information Officer, and the RHAs in the use of information technology services and assets.
Department of Health and Community Services

Organization Charts

September 2015
Department of Health & Community Services
Chart 5 – Corporate Services (Audit and Claims Integrity)
September 2015
### Key Contacts - Department of Health and Community Services

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Office</th>
<th>Cell</th>
<th>Home</th>
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<tbody>
<tr>
<td>Colleen Power</td>
<td>Secretary to the Minister</td>
<td>3124</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Beverley Clarke</td>
<td>Deputy Minister</td>
<td>3125</td>
<td>631-8120</td>
<td></td>
</tr>
<tr>
<td>Elaine Power</td>
<td>Secretary to the Deputy</td>
<td>3125</td>
<td>690-9234</td>
<td></td>
</tr>
<tr>
<td>Larry Alteen</td>
<td>Medical Consultant</td>
<td>1716</td>
<td>699-7838</td>
<td></td>
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<tr>
<td>Tina Williams</td>
<td>Director of Communications</td>
<td>1377</td>
<td>728-2837</td>
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<tr>
<td>Michelle Jewer</td>
<td>ADM, Corporate Services</td>
<td>0620</td>
<td>682-4720</td>
<td></td>
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<tr>
<td>Denise Tubrett</td>
<td>ADM, Regional Services</td>
<td>0620</td>
<td>697-1734</td>
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<tr>
<td>Heather Hanrahan</td>
<td>ADM, Professional Services</td>
<td>3773</td>
<td>699-5263 BB</td>
<td></td>
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<tr>
<td>Karen Stone</td>
<td>ADM, Population Health</td>
<td>3103</td>
<td>697-5767</td>
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<tr>
<td>Michael Harvey</td>
<td>ADM, Policy, Planning &amp; Performance Monitoring</td>
<td>5295</td>
<td>693-8570</td>
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<tr>
<td>Angie Batstone</td>
<td>Executive Director, Acute Care and Long Term Care &amp; Community Support Services</td>
<td>7686</td>
<td>699-2446</td>
<td></td>
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<tr>
<td>Bev Griffiths</td>
<td>Director, Acute Health Services, Emergency Management &amp; Nursing Policy</td>
<td>0717</td>
<td>728-4526</td>
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<tr>
<td>Colleen Simms</td>
<td>Director, Mental Health and Addictions Services</td>
<td>3659</td>
<td>690-6833</td>
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<tr>
<td>David Allison</td>
<td>Chief Medical Officer of Health</td>
<td>3431</td>
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### Other Departments

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<tbody>
<tr>
<td>Julia Mullaley</td>
<td>Clerk, Executive Council</td>
<td>2853</td>
<td>693-5014</td>
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<tr>
<td>Paula Burt</td>
<td>Deputy Clerk, Executive Council</td>
<td>2844</td>
<td>697-5795</td>
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<tr>
<td>Tim Murphy</td>
<td>Deputy Chief of Staff, Premier’s Office</td>
<td>6487</td>
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<tr>
<td>Nancy O’Connor</td>
<td>Director of Communications, Premier’s Office</td>
<td>3960</td>
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### Regional Health Authorities

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<tr>
<th>Name</th>
<th>Title</th>
<th>Office</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Diamond</td>
<td>CEO, Eastern Health</td>
<td>777-1301</td>
<td>725-7195</td>
</tr>
<tr>
<td>Lynette Oats</td>
<td>VP Communications</td>
<td>777-3792</td>
<td>689-7059</td>
</tr>
<tr>
<td>Susan Gillam</td>
<td>CEO, Western Health</td>
<td>637-5000 Ext. 5245</td>
<td>639-3802</td>
</tr>
<tr>
<td>Rosemarie Goodyear</td>
<td>CEO, Central Health</td>
<td>292-2138</td>
<td>424-1941</td>
</tr>
<tr>
<td>Tony Wakeham</td>
<td>CEO, Labrador-Grenfell Health</td>
<td>897-2349</td>
<td>899-1728</td>
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Dec. 14, 2015
Health and Community Services Programs and Services

The Department provides strategic direction to four regional health authorities (RHAs): Eastern Health, Central Health, Western Health and Labrador-Grenfell Health. Each RHA is responsible for delivering direct care to individuals in hospitals, long term care facilities and community-based offices and clinics, as well as through public health and community support services. However, some programs and services are offered directly by the Department and are described below.

Corporate Services Branch

Medical Care Plan (MCP):
The Newfoundland and Labrador Medical Care Plan is a comprehensive plan of medical care insurance designed to cover the cost of physician services for residents of the province, including international workers and students.

Medical Transportation Assistance Program (MTAP):
MTAP provides financial assistance to beneficiaries of the MCP who incur substantial out-of-pocket travel costs to access specialized insured medical services which are not available in their immediate area of residence and/or within the Province. Claimable expenses include airfare, accommodations purchased from a registered accommodations provider, such as a hostel, hotel, motel and/or registered apartment, scheduled busing services, and taxis when used in conjunction with commercial air travel. When a patient/family is out of pocket for the cost of registered accommodations, there is a provision for claiming a meal allowance for each night of medically required purchased accommodations. Accommodations and/or meals provided by family/friends are not claimable expenses under the Program.

Professional Services Branch

Newfoundland Hospital Insurance Plan:
The Newfoundland Hospital Insurance Plan covers insured hospital services received within the province when recommended by a medical practitioner. All beneficiaries of MCP are automatically entitled to coverage under the Hospital Insurance Plan.

Insured hospital services provided to beneficiaries of the Newfoundland Hospital Insurance Plan, who are temporarily absent from the province, or who are medically referred outside the province for insured treatment, are eligible for coverage under the plan.

Newfoundland and Labrador Prescription Drug Program (NLPDP):
The NLPDP provides financial assistance for the purchase of eligible prescription medications. There are five main plans under the program:

*The Foundation Plan*: 100 per cent coverage of eligible prescription drugs for those in receipt of income support and select services in RHAs
The 65Plus Plan: coverage of eligible prescription drugs to residents 65 years of age and older who receive Old Age Security benefits and the Guaranteed Income Supplement (GIS). Beneficiaries pay a maximum $6.00 co-payment per prescription.

The Access Plan: This plan offers individuals and families with low incomes access to eligible prescription medications, and has a beneficiary co-payment requirement of 20% - 70% of the prescription cost, with the co-payment rate determined by net income level. Eligibility is determined by net income level and family status. The program is available to: families with children, including single parents, with net annual incomes of $42,870 or less; couples without children with net annual incomes of $30,009 or less; and single individuals with net annual incomes of $27,151 or less.

The Assurance Plan: This plan offers protection for individuals and families against the financial burden of eligible high drug costs, whether from the cost of one extremely expensive drug or the combined cost of different drugs. Depending on their income level, individuals and families will be assured that their annual out-of-pocket eligible drug costs will be capped at 5, 7.5 or 10 per cent of their net family income. Beneficiaries will have a co-payment of 0% - 100%, with the co-payment rate based upon their net income and anticipated drug costs.

- Those with net incomes up to $39,999 will pay a maximum of 5 per cent of their net income through a co-payment for eligible drugs.
- Those with net incomes of $40,000 up to $74,999 will pay a maximum of 7.5 per cent of their net income through a co-payment for eligible drugs.
- Those earning $75,000 up to $149,999 will pay a maximum of 10 per cent of their net income through a co-payment for eligible drugs.

The Select Needs Plan: This plan provides 100 per cent coverage for disease specific medications and supplies for residents with Cystic Fibrosis and Growth Hormone Deficiency.

Note: The NLPDP is payer of last resort. This means, that if a beneficiary has third party drug coverage, the NLPDP will pay prescription costs for which a person is eligible only after factoring in any payments for the prescription from the third party insurer.

Dental Health Plan:
The Children’s Dental Health Program provides universal access for eligible dental services received within the province for children age 12 years and under. Limited coverage is available for youth age 13 to 17 years whose families are in receipt of income support benefits or families eligible under the Low Income Access Program. Proof of eligibility is required.

The Department has developed a new Adult Dental Health Care Program that will significantly increase access to basic dental services for people living in low income, regardless of age. There is also a denture component. The Adult Dental Program was implemented January 1, 2012, and made diagnostic and therapeutic dental services available once every three years and denture services available once every eight years to adults aged 18 or over who are enrolled in the Foundation, Access or 65+ Plan of the NLPDP. Confirmation of enrollment or an application can be
requested by calling 1-888-859-3535. Confirmation of enrollment is required by the dental provider at the time of presentation for treatment. Currently, a Prior Approval is required for some services. In addition, an annual cap is in place toward basic services and also for dentures. It is recommended that beneficiaries eligible under the Adult Dental Program discuss treatment options with their dentist prior to commencement of treatment.

Health Emergency Management (HEM) Program:
The HEM program mandate is to enhance the capabilities of the Newfoundland and Labrador health system to effectively prevent, mitigate, prepare for, respond to, and recover from emergencies and/or service delivery disruptions. The program works extensively with the Regional Health Authorities (RHAs) and other key stakeholders at the Federal, Provincial, Municipal and Non-Governmental levels on emergency planning and preparedness initiatives. A key function of the program is to maintain situational awareness by engaging with emergency management partners and providing notifications/support for immediate and emerging threats that have the potential of impacting the health and safety of the citizens of Newfoundland and Labrador.

In the event of an emergency, the HEM program provides coordination and support for the provincial health response, including:
- The resumption of the Department of Health and Community Services critical programs, operations and services within a specified timeframe following a disruption or disaster;
- The provision of provincial direction and support to the RHAs as required;
- The coordination of an inter-regional, provincial response by the health sector;
- The coordination of the provincial health emergency management response within the provincial emergency response structure; and
- The coordination with Federal / Provincial / Territorial ministries of health.

Bursaries/Incentives:

Physician Bursary Program (annual investment: $1,287,500): The Provincial Physician Bursary Program is designed to attract undergraduate medical students and medical residents to commence practice in designated areas of need in Newfoundland and Labrador upon obtaining full licensure in this province. The Provincial Physician Bursary Program consists of two incentives: the Undergraduate Medical Student Bursary Program and the Medical Resident Bursary Program.

The Undergraduate Medical Student Bursary Program provides bursaries to full-time students enrolled in the 4th academic year of the Undergraduate Medical Education Program at Memorial University in exchange for a 12 month provincial service agreement. Students enrolled in medical schools in other educational institutions are not eligible for these bursaries. The amount of each bursary is $7,500 per student. These will be awarded on a first-come, first-serve basis up to a maximum of 30 undergraduate medical student bursaries per fiscal year.

The Medical Resident Bursary Program provides bursaries to medical residents who agree to provide service in a specific community in Newfoundland and Labrador upon obtaining full-licensure. Bursaries are available to medical residents who meet the following criteria:
- Are medical school undergraduates from Memorial University completing the final two years of their post-graduate medical education in Newfoundland and Labrador or in other Canadian programs; or
- Are medical school undergraduates from other Canadian jurisdictions completing the final two years of their post-graduate medical education in Newfoundland and Labrador.

Recipients are eligible for only one medical resident bursary that may be awarded in either of the last two years of training. The service requirement for one medical resident bursary is 36 months. The amount ranges from $25,000 to $90,000 based on community level of rural and remoteness.

**Traveling Fellowship Program (annual investment: $350,000):** Funding is available for physicians to undertake training in specialty and sub-specialty programs that are not offered by Memorial University. A recipient's salary (including cost of benefits) will be paid at the pay scale of the University offering the fellowship position. In return for this funding, it is required that the recipient return service within an RHA for each year funding is received. Candidates must first seek to obtain regular funded positions in the out-of-province programs and possess qualifications at least equivalent to that expected for the funded positions.

**Health Professional Bursaries excluding RNs (annual investment: $310,200):** The purpose of Health Professional Bursaries is to provide financial assistance to students enrolled in certain health related education programs who accept employment in a difficult-to-fill position. Preference will be given to applicants who are residents of Newfoundland and Labrador. Students must be studying for one of the eligible occupations. RHA employees who are currently upgrading and are studying for one of the below occupations may also be eligible. Not all occupations or positions will have bursaries available at all times; availability of bursaries varies each year by location and vacancy rate. A bursary is a maximum of $10,000 with a required service obligation of two years. A maximum of $5,000 with a one year service obligation is also available. There are some circumstances where longer service obligations may be required. An enhanced bursary program is available for clinical psychologists that provides bursaries of up to $20,000 for a four year service commitment.

**Health Professional Signing Bonus including RNs (annual investment: $730,100):** A signing bonus is a bonus intended to improve recruitment by providing potential employees with an incentive to join an organization. Signing bonuses are available for 24 selected health occupations, targeting difficult-to-fill positions, and tiered to address geographic considerations. Signing bonuses range from $3,000 to $8,000 per year up to a maximum of $16,000 with a two year service agreement. A maximum of two signing bonuses may be provided to an individual with a required service obligation of two years. Single-year signing bonuses are permitted with a service obligation of one year. An enhanced signing bonus program is available for clinical psychologists that provides a signing bonus for up to four years with a four year service commitment.

**Dental Bursary Program (annual investment $250,000):** This program has two components, the Rural Dental Bursary Program and the Specialist Bursary Program. Recipients of the Rural Dental Bursary are required to fulfill their practice commitment in a rural area determined by the province.
For the Specialist Bursary Program, applicants are required to work in an in-need area upon graduation.

Bursaries are provided to students enrolled in an accredited dental education program recognized by the Newfoundland and Labrador Dental Board, in the amount of $25,000 per year for up to three years per program (maximum of $75,000 per program). Students must apply annually for the bursaries. For each annual $25,000 bursary received, the student agrees to take up full time clinical practice of dentistry in the chosen location no later than six months after being eligible for licensure in Newfoundland and Labrador and to continue the full time clinical practice for one year. The number of dental bursaries available annually is limited. Recipients are determined through a competitive application process and while the program is open to Canadian citizens, preference is given to students from Newfoundland and Labrador.

**Nurse Practitioner Bursary Program (annual investment: $60,000)**
The Nurse Practitioner Grant Program provides applicants who are residents of Newfoundland and Labrador and who are enrolled in an accredited Nurse Practitioner Program in Canada with a $5,000 grant. The Recipient will be required to commit to a 1950 hour service obligation, as a nurse practitioner or registered nurse, in Newfoundland and Labrador upon completion of the Nurse Practitioner Program.

**Rural Nursing Student Incentive Program (annual investment: $90,000)**
This program offers payments of up to $1,500 to 4th year Bachelor of Nursing students for travel and accommodations to carry out their clinical practicum in rural communities.

**Bachelor of Nursing Bursary (annual investment: $504,000)**
Bachelor of Nursing Bursaries provide financial assistance to students of the Bachelor of Nursing (Collaborative) Program. A $2,500 bursary is available per each academic year as indicated above, to a maximum of $5,000. Students may receive a maximum of $2,500 in their first eligible year. If the student does not receive funding in the first eligible year, the full $5,000 may be received in the second year. Each bursary of $2,500 per academic year has a one year (1950 hours) service agreement with a regional health authority. Students eligible are enrolled in either year three or year four of the Bachelor of Nursing (Collaborative) Program or in year one or year two of the Fast Track option of the Bachelor of Nursing (Collaborative) Program.

**Bachelor of Nursing Practice Course Grant (annual investment: $270,000)**
This grant provides financial assistance in the amount of $750 per course for tuition and practice related expenses for two clinical courses, NURS 3523 Extended Practice III and NURS 4516 Consolidated Practicum.
**Occupational Therapy and Physiotherapy (annual investment: $216,800)**

Ten physiotherapy and eight occupational therapy seats are reserved at Dalhousie University for residents of Newfoundland and Labrador. When a student applies to Dalhousie University in the Physiotherapy or Occupational Therapy programs, s/he will be advised by Dalhousie University of these seats. Students are encouraged, during their training program at Dalhousie University, to seek employment with one of the RHAs in Newfoundland and Labrador and take advantage of available incentives.

**Radiation Therapy Student Support Program (annual investment: $30,000)**

Eastern Health has partnered with the Michener Institute for Applied Health Sciences in Toronto Ontario, to place qualifying students from Newfoundland and Labrador in the Radiation Therapy Program. Funding support for tuition, books and bursaries may be available if a student is willing to sign a service commitment agreement to work in Eastern Health upon graduation.

**Population Health Branch**

*Environmental Health Program:* Environmental Health is a component of the public health system and is committed to protecting the health of the public and enhancing their quality of life by assessing, correcting, controlling, and preventing those factors in the environment that can adversely affect human health. The prevention of injury, disease and death that may result from interactions of people with their environment is the goal of current environmental health policy. Environmental health policy areas that are within the scope of responsibility of Health and Community Services (HCS) include food safety, drinking water quality, food and waterborne illness investigations, public swimming pool water quality and safety, health and safety in schools, child care centres and personal care homes, private sewage disposal, health hazard investigations and personal services establishments (e.g., tanning facilities). Service NL (SNL) delivers the environmental health program in the province and is responsible for fulfilling the program standards established by HCS. The program is delivered at the field level by SNL’s 37 Environmental Health Officers. The protection of the public is achieved through a number of interventions including the enforcement of legislation and regulations, routine inspection and monitoring, and education and health promotion.

*The Provincial Chronic Disease Self-Management Program:* HCS holds a three year licence to deliver the Stanford Chronic Disease Self-Management Program in NL. Launched in December 2011, “Improving Health: My Way” is a peer-led program, coordinated by HCS and offered in each of the four RHAs to adults living with a chronic condition.

**Regional Services Branch**

**Healthline (811):**

The Department is responsible for the 24/7 811 Newfoundland and Labrador Healthline, which provides telephone access to nurse triage and health information from anywhere in the province. Fonemed North America Inc. is the current service provider for HealthLine. HCS is currently in year five of a five year contract with Fonemed. HealthLine operates out of three locations within the
province: St. Anthony (base site), Stephenville and Corner Brook (satellite sites). The budget for this service is approximately $3 million annually. An RFP to determine the next service closed on November 27, 2015 and a process has been implemented to oversee evaluation of the new service provider.

**Blood Coordinating Program:**

The Department established a Provincial Blood Coordinating Program that contributes to ensuring that blood and blood related products are utilized in a safe and efficient manner. The Provincial Blood Coordinating Program was created in December 2005 to provide leadership and collaboration with the RHAs and Canadian Blood Services to ensure blood products are managed safely and effectively in accordance with established standards for all health care recipients.

**Office of Adverse Health Events:**

The Department has implemented a Provincial wide Clinical Safety Reporting System (CSRS) and leads oversight for day to day operations of the RHAs related to reporting. The Office of Adverse events staff provide policy and support to the RHAs in the areas of quality and patient safety and adverse event management in accordance with provincial framework and policies and works with legislative consultant in the development of Patient Safety Legislation.

**Community Grants:**

1. **Community Addictions Prevention and Mental Health Promotion Fund** - $140,000: Open to individuals, not-for-profit community groups and organizations to support projects which increase awareness and understanding or problematic substance abuse, work to reduce alcohol-related harms, develop supportive communities and/or promote positive mental health in the community.

2. **Minister's Discretionary Community Grant Funding** – $40,000 - Agencies may receive one-time funding amounts as a contribution or donation to a specific event or project. This funding is approved at the Minister’s discretion.

3. **Chronic Disease** – $60,000 - The Department provides grant funding to support projects with community agencies to implement Chronic Disease awareness initiatives.

4. **Cancer Care Strategy** - $246,400 - The Department provides grant funding to assist community agencies and not-for profit community groups with cancer awareness initiatives.
Ministerial Authority

This section outlines the legal authority of the Minister and the context of relationships with external entities including advisory committees, crown corporations and regulatory bodies.

Powers of the Minister: As outlined in the Regional Health Authorities Act, the Minister may determine:
- objectives and priorities for the provision of health and community services in the province or in areas of the province;
- health and community services provided by a Regional Health Authority (RHA); and
- standards for the provision of health and community services.

Where the Minister determines a health and community service or a standard, the RHA must comply with the Minister’s determination.

Ministerial Directions: As outlined in the Regional Health Authorities Act, ministerial direction can be given for the following purposes:
- achieving objectives and priorities;
- providing guidelines for the RHA to follow in carrying out its duties and responsibilities; and
- coordinating the work of the RHA with the programs, policies, and work of the Government, agencies of Government, and other RHAs and other persons in the provision of health and community services in the province.

These are meant to enhance RHA accountability to the Minister who is ultimately responsible for the province’s health and community services system.

There are no restrictions on the subject matter about which the Minister can issue a directive. The Act specifically states that once the Minister gives direction, the RHA must comply with the direction.

The Act came into force on April 1, 2008. To date, the Minister has issued two formal written directives (see letters following this note). Both directives are about information sharing and reflect the importance of providing patients and/or their families with information about the health care provided by the RHA.

Officials Shall Respond: As outlined in the Health and Community Services Act, for any matter affecting public health or the provision of services to families, children or youth, every official of a public institution, medical health officer, clerk or secretary of a municipal authority, chairperson or secretary of a school board, medical practitioner, nurse, social worker, dentist, dental surgeon, optometrist and pharmacist must:
• answer all communications from the department promptly; (e.g., When an issue or complaint is brought to the attention of the department, officials of the department will contact the appropriate member of the RHA senior executive. It is expected that the request will be made a priority.)
• collect and tabulate facts and statistics according to instructions given by the department; and
• supply accurate information.

Legislation: The Department is responsible for the 33 pieces of legislation, listed below:
Centre for Health Information Act
Chiropractors Act, 2009
Communicable Diseases Act
Dental Act, 2008
Denturists Act, 2005
Dietitians Act
Dispensing Opticians Act, 2005
Emergency Medical Aid Act
Food Premises Act
Health and Community Services Act
Health Care Association Act
Health Professions Act
Health Research Ethics Authority Act
Hearing Aid Practitioners Act
Hospital Insurance Agreement Act
Human Tissue Act
Licensed Practical Nurses Act, 2005
Massage Therapy Act, 2005
Medical Act, 2011
Medical Care Insurance Act, 1999
Mental Health Care and Treatment Act
Occupational Therapists Act, 2005
Optometry Act, 2012
Personal Health Information Act
Personal Services Act
Pharmaceutical Services Act
Pharmacy Act, 2012
Physiotherapy Act, 2006
Psychologists Act, 2005
Regional Health Authorities Act
Registered Nurses Act, 2008
Self-Managed Home Support Services Act
Social Workers Act
HCS Advisory Committees to the Minister
There are several committees reporting to the Minister. Under the Transparency and Accountability Act, these entities are provided with the Strategic Directions of the Provincial Government and also prepare plans and annual reports in keeping with their categorization under that Act. These are as follows:

1. **Provincial Mental Health and Addictions Advisory Council**: Established in 2010, the Council reports directly to the Minister and advises on key mental health and addictions matters needed in order to enhance services for and improve the lives of those living with mental health and addictions issues.

   **Membership**: The Council is a 22-member group representing persons/families affected by mental illness/addictions; service representation within regional health authorities and non-government organizations; and community agencies. Membership is voluntary and appointments are made by the Minister of Health and Community Services. The Chairperson of the Provincial Mental Health and Addictions Advisory Council is Mr. Sheldon Pollett.

2. **Cancer Control Advisory Committee**: Established in 2011, the Committee advises the Minister of Health and Community Services on actions to advance and improve cancer control in Newfoundland and Labrador. Secretariat services are provided by the Department of Health and Community Services through the Primary Health Care Division.

   **Membership**: The Committee is led by an independent chair, appointed by the Minister of Health and Community Services. The Committee has a membership of 13 people. The membership consists of a diverse cross-section of individuals who are familiar with cancer control issues, and includes representatives from the regional health authorities, community organizations, Memorial University, and cancer survivors. The Chairperson of the Cancer Control Advisory Committee is Ms. Sharon Smith.

3. **Government Entities**: There are a number of additional entities for which the department provides funding, support, priority direction and guidance. Under the Transparency and Accountability Act, these entities are also provided with Government’s Strategic Directions. The entities prepare plans and annual reports in keeping with their categorization under that Act:

   1. Eastern Regional Health Authority
   2. Central Regional Health Authority
   3. Western Regional Health Authority
   4. Labrador - Grenfell Regional Health Authority
5. Newfoundland and Labrador Centre for Health Information (NLCHI): NLCHI provides information to health professionals, the public, researchers and health system decision-makers; supports the development of data and technical standards; maintains key health databases; and carries out applied health research and evaluations. NLCHI's mandate also includes the development and implementation of the provincial electronic health record. The Chairperson of the Board of Directors for NLCHI is Mr. Ray Dillon.

6. Medical Consultants' Committee: The Committee reviews the patterns of practice and billing procedures of physicians who submit claims to the Medical Care Plan as well as the utilization of services by beneficiaries. The Committee can recommend recovery of funds billed in error and other corrective actions that serve to deter misbilling by all fee-for-service physicians. The Committee makes recommendations to the Minister of Health and Community Services with regard to cases of physician and beneficiary over-utilization, inappropriate billing and/or abuse. The Chairperson of the Committee is Dr. Blair Fleming.

7. Mental Health Care and Treatment Review Board: The Board reviews applications made by patients who have been certified or are subject to a community treatment order under the Mental Health Care and Treatment Act. The board can decertify a patient, rescind a community treatment order and make recommendations where a patient's rights have been violated. The Chairperson of the Mental Health Care and Treatment Review Board is Ms. Sandra Burke.

8. Health Research Ethics Authority: The Research Ethics Authority oversees ethics review of all health research conducted in the province in accordance with the Health Research Ethics Authority Act. It is also responsible for facilitating health research in the province and for providing public awareness and education on ethics issues related to human health research. The Chairperson of the Health Research Ethics Authority is Ms. Jeannie House.

9. Primary Health Care Advisory Committee: While not captured under the Transparency and Accountability Act, the Primary Health Care Advisory Committee was established in June 2014 to provide advice to the Minister of Health and Community Services on the development and implementation of a new Primary Health Care Framework and related action plans. The Committee consists of representatives from health professions, educational institutions, regional health authorities, regulatory bodies, the general public, government departments and is chaired by a representative of the Department of Health and Community Services. Since February of 2015, the Committee has worked with the Department of Health and Community services to develop PHC reform goals and objectives informed by current evidence and public consultation.
Regulatory Bodies:
The Department of Health and Community Services is responsible for seventeen statutes that regulate a number of health professions in the province. Sixteen of those statutes establish stand alone board, councils and/or colleges that have responsibilities for regulating a specific health profession. For example the College of Physicians and Surgeons, pursuant to the Medical Act, 2011, regulates the practice of medicine in the province.

Regulatory bodies, such as the Council of the College of Physicians and Surgeons or the Health Professions Council, are charged with the responsibility of ensuring that persons working in the specific health profession or professions have the appropriate academic credentials and competencies for entry to practice. Continuing education and competency development are regulated requirements to ensure that practitioners maintain and enhance their skills in providing services. The regulatory body also provides an avenue for responding to allegations of professional misconduct on the part of practitioners or the professional corporations that may exist for some health professions. The professional regulatory bodies are as follows:

- Newfoundland and Labrador Chiropractic Board
- Newfoundland and Labrador Dental Board
- Newfoundland and Labrador Denturists Board
- Newfoundland and Labrador College of Dietitians
- Dispensing Opticians Board
- Newfoundland and Labrador Council of Health Professionals
- Hearing Aid Practitioners Board
- College for Licensed Practical Nurses of Newfoundland and Labrador Board
- College of Massage Therapists of Newfoundland and Labrador Board
- Council of the College of Physicians and Surgeons of Newfoundland and Labrador
- Newfoundland and Labrador Occupational Therapy Board
- Newfoundland and Labrador College of Optometrists
- Newfoundland and Labrador Pharmacy Board
- Council of the Newfoundland and Labrador College of Physiotherapists
- Newfoundland and Labrador Psychology Board
- Council of the Association of Registered Nurses of Newfoundland and Labrador
- Newfoundland and Labrador Association of Social Workers Board

Ministerial Committees
The Minister may be required to represent the Department on various Cabinet committees for horizontal initiatives at the direction of the Premier (e.g. Aging and Seniors, Poverty Reduction Strategy, Violence Prevention Initiative).
Legislation and Regulation-Making Authority

The following outlines all 33 pieces of legislation which are currently the responsibility of the department. This includes a brief description as well as the authority of the Minister and others to make regulations under the various acts.

1. Centre for Health Information Act: Establishes the Newfoundland and Labrador Centre for Health Information as a statutory corporation responsible to the minister through a board of directors. The object of the centre is to assist individuals, communities, health service providers and policy makers in making informed decisions to enhance health and well-being by providing a comprehensive province-wide information system.
   - Act authorizes Lieutenant-Governor in Council to make regulations.
   - There are currently no regulations in force.

2. Chiropractors Act, 2009: Governs the practice of chiropractors in the province.
   - Authorizes Chiropractic Board to make regulations, subject to ministerial approval.
   - Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where Board fails to do so.
   - Chiropractors Regulations, made under the previous Act, are still in force.

3. Communicable Diseases Act: Contains reporting requirements for specified diseases, grants inspection, investigation and order powers.
   - Administered jointly with Service Newfoundland and Labrador.
   - Authorizes Minister to make general and immunization regulations.
   - Authorizes Minister to make, subject to the approval of the Lieutenant-Governor in Council, quarantine regulations.
   - No regulations have been made under the Act.

4. Dental Act, 2008: Governs the practice of dentists in the province.
   - Authorizes Dental Board to make regulations, subject to ministerial approval.
   - Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where Board fails to do so.
   - Dental Auxiliaries' Regulations, 2012, made under this Act, are currently in force.
   - Dental Regulations, and Professional Dental Corporations Regulations, made under the previous Act, are still in force.

   - Authorizes Denturists Board to make regulations, subject to ministerial approval.
   - Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where Board fails to do so.
   - Denturists Regulations, made under the previous Act, are still in force.
6. **Dietitians Act**: Governs the practice of dietitians in the province.
   - Authorizes the College of Dietitians to make regulations, subject to the approval of the Minister.
   - Minister may make regulations to prescribe time limits for events in the disciplinary process where College fails to do so.
   - No regulations have been made under this Act.

7. **Dispensing Opticians Act, 2005**: Governs the practice of dispensing opticians in the province.
   - Authorizes Dispensing Opticians Board to make regulations, subject to ministerial approval.
   - Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where Board fails to do so.
   - **Dispensing Opticians Regulations**, made under the previous Act, are still in force.

8. **Emergency Medical Aid Act**: Provides liability protection for persons who provide voluntary medical care at the scene of an accident or emergency.
   - Does not contain regulation-making authority.

9. **Food Premises Act**: Governs storage, commercial preparation and sale of food.
   - Replaced the previous **Food and Drug Act** as of December 10, 2013.
   - Administered jointly with Service Newfoundland and Labrador.
   - Authorizes Minister to make regulations.
   - **Food Premises Regulations**, made under the previous Act, are currently in force.

10. **Health and Community Services Act**: Governs appeal mechanism for benefits arising from **Employability Assistance Agreement for Persons with Disabilities**, allows minister to declare buildings unfit for human habitation, contains inspection powers and rules regarding sewage facilities.
    - Administered jointly with Service Newfoundland and Labrador.
    - Authorizes Minister to make regulations.
    - **Diagnostic and Public Health Laboratories Regulations, Personal Care Home Regulations, Public Pools Regulations and Sanitation Regulations**, made under this Act, are currently in force.

11. **Health Care Association Act**: Establishes mandate for the Newfoundland and Labrador Health Care Association, most recently known as the Newfoundland and Labrador Health Boards Association.
    - Authorizes the Newfoundland and Labrador Health Care Association to make regulations regarding pensions and benefits for certain groups.
    - No regulations have been made under this Act.
    - Health Boards Association was abolished in Spring 2013.
    - The **Health Care Association Act Repeal Act** repealing the **Health Care Association Act** received Royal Assent on December 10, 2013.
• The Repeal Act is not yet in force.

   • Authorizes Lieutenant Governor in Council, the Minister and the Council of Health Professionals, subject to ministerial approval, to make specified regulations.
   • Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Council fails to do so.
   • Acupuncturists Regulations, Audiologists and Speech-Language Pathologists Regulations, Dental Hygienists Regulations, Medical Laboratory Technologists Regulations and Respiratory Therapists Regulations, made under this Act, are currently in force.
   • The Act is not yet in force for midwives or medical radiation technologists.

13. Health Research Ethics Authority Act: Requires all human health research conducted in the province to receive ethics review and authorizes appointment of the Health Research Ethics Authority, Review Board and Constituent Committee.
   • Authorizes Minister to make regulations.
   • Health Research Ethics Authority Regulations, made under this Act, are currently in force.

   • Authorizes Hearing Aid Practitioners Board to make regulations, subject to ministerial approval.
   • Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where Board fails to do so
   • Hearing Aid Dealers Regulations, made under the previous Act, are still in force.

15. Hospital Insurance Agreement Act: Authorizes the province to enter into an agreement with the Federal Government providing for financial contributions for hospital insurance.
   • Authorizes Minister to make regulations with retroactive effect.
   • Hospital Insurance Regulations are currently in force.

   • No regulation making authority.

17. Licensed Practical Nurses Act, 2005: Governs the practice of licensed practical nurse in the province.
   • Authorizes the College of Licensed Practical Nurses to make regulations, subject to ministerial approval.
   • Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where College fails to do so.
   • Licensed Practical Nurses Regulations, 2011, made under this Act, are currently in force.
18. **Massage Therapy Act, 2005**: Governs the practice of massage therapists in the province.  
- Authorizes the College of Massage Therapists to make regulations, subject to ministerial approval.  
- Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where College fails to do so.  
- *Massage Therapy Board Regulations, 2005* made under the previous Act are still in force.

19. **Medical Act, 2011**: Governs the practice of physicians in the province.  
- Authorizes the Council of the College of Physicians and Surgeons to make regulations, subject to ministerial approval.  
- Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Council fails to do so.  
- The Peer Assessment Regulations made under the previous Act is still in force. The Medical Regulations came into force on July 1, 2015.

20. **Medical Care Insurance Act, 1999**: Governs the administration of the Medical Care Insurance Plan (MCP) in the province.  
- Authorizes the Lieutenant-Governor in Council and Minister to make specified regulations.  
- *Medical Care Insurance Beneficiaries and Inquiries Regulations, Medical Care Insurance Insured Services Regulations* and the *Medical Care Insurance Release of Information Order* made under the previous Act are still in force.  
- *Physicians and Fee Regulations* are currently in force.

21. **Mental Health Care and Treatment Act**: Governs the detention and treatment of involuntary patients, sets out the rights of involuntary patients and creates the Mental Health Care and Treatment Review Board.  
- Authorizes Lieutenant-Governor in Council to make regulations.  
- *Mental Health Care and Treatment Regulations* are currently in force.

22. **Occupational Therapists Act, 2005**: Governs the practice of occupational therapists in the province.  
- Authorizes Occupational Therapy Board to make regulations, subject to ministerial approval.  
- Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Board fails to do so.  
- *Occupational Therapists Regulations* made under the previous Act are still in force.

23. **Optometry Act, 2012**: Governs the practice of optometrists in the province.  
- Authorizes the Council of the College of Optometrists to make regulations, subject to ministerial approval.  
- Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Board fails to do so.

24. Personal Health Information Act: Establishes rules for the collection, use and disclosure of personal health information.
   • Authorizes Lieutenant-Governor in Council to make regulations.
   • Personal Health Information Regulations and Pharmacy Network Regulations are currently in force.

25. Personal Services Act: Protects the public and prevents the transmission of disease in the personal service industry (tattooing, body piercing and indoor tanning facilities) by imposing standards and permitting inspections of such facilities.
   • Act came into force on January 31, 2014.
   • The Personal Services Regulations, made under the Act, are in force.

26. Pharmaceutical Services Act: Governs the administration of the Newfoundland and Labrador Prescription Drug Program (NLPDP), the provincial interchangeable drug formulary, and the Tamper Resistant Prescription Drug Pad Program.
   • Authorizes the Lieutenant-Governor in Council to make specified regulations and the Minister to make specified regulations.
   • Interchangeable Drug Products Formulary Regulations, 2012, Pharmaceutical Services Administration Regulations and Pharmaceutical Services Regulations, made under this Act, are currently in force.

27. Pharmacy Act, 2012: Governs the practice of pharmacists in the province.
   • Authorizes the Pharmacy Board to make regulations, subject to ministerial approval.
   • Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Board fails to do so.
   • The Regulations that are in force are: the Administration of Drug Therapy by Inhalation or Injection Regulations, the Authorization to Prescribe Regulations and the Pharmacy Regulations, 2014.

   • Authorizes the Council of the College of Physiotherapists to make regulations, subject to ministerial approval.
   • Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Council fails to do so.
   • Physiotherapy Regulations made under this Act are currently in force.

29. Psychologists Act, 2005: Governs the practice of psychologists in the province.
   • Authorizes the Psychology Board to make regulations, subject to ministerial approval.
• Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Board fails to do so.
• Psychology Regulations, made under previous Act, are still in force.

30. Regional Health Authorities Act: Creates the four Regional Health Authorities and sets out governance procedures, powers and accountabilities. Act provides Minister with authority to direct the RHAs and requires RHAs to comply with ministerial direction.
• Authorizes Lieutenant-Governor in Council to make regulations.
• Regional Health Authorities Regulations, made under this Act, are currently in force.

31. Registered Nurses Act, 2008: Governs the practice of nurses in the province.
• Authorizes the Council of the Association of Registered Nurses, to make regulations, subject to ministerial approval.
• Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Council fails to do so.
• Registered Nurses Regulations, made under this Act, are currently in force.

32. Self-Managed Home Support Services Act: Establishes that a recipient of home support services is considered to be the employer of the person who provides the home support services.
• Does not contain regulation-making authority.

33. Social Workers Act: Governs the practice of social workers in the province.
• Authorizes the Board of the Association of Social Workers to make regulations, subject to ministerial approval.
• Authorizes Minister to make regulations to prescribe time limits for events in the disciplinary process where the Association fails to do so.
• No regulations have been made under this Act.

October 9, 2015
Financial overview for
Department of Health and Community Services (HCS) for 2015-16.

General:
- The total 2015-16 budget for HCS is approximately $3.0 billion. This represents 40% of the total provincial budget.

- Since 2007-08 HCS’s budget has increased by approximately $800 million.

Regional Health Authorities:
- Approximately $2.1 billion of HCS’s $3.0 billion is used to fund the four RHAs, Newfoundland and Labrador Centre for Health Information, repairs and renovations for the RHAs, vaccines, and other agencies.

Updated: October 9, 2015
Financial Overview – Budget 2015-16
Total Budget $2,924,916,600

- Regional Health Authorities and Related Services - $2,124,549,600 – 73%
- Provincial Drug Program - $149,322,400 – 5%
- Other - $45,690,600 – 2%
- Capital - $120,640,700 – 4%
- MCP Physician Services and Dental - $484,713,300 – 17%
## Department of Health and Community Services – Financial Overview

### Budget 2015-16

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Expenditure</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Operating Salaries</td>
<td>14,617,500</td>
<td>15,347,100</td>
<td>729,600</td>
<td>4.8%</td>
<td>161,000</td>
<td>(834,600)</td>
<td>170,000</td>
<td>347,600</td>
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<td>General Operating</td>
<td>3,350,000</td>
<td>3,484,000</td>
<td>94,000</td>
<td>2.7%</td>
<td>(204,600)</td>
<td>(223,600)</td>
<td>(110,600)</td>
<td>0</td>
<td>2,945,200</td>
<td>-13.1%</td>
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<td>Professional Services</td>
<td>8,041,300</td>
<td>8,111,300</td>
<td>70,000</td>
<td>0.9%</td>
<td>(819,100)</td>
<td>(70,000)</td>
<td>(170,000)</td>
<td>0</td>
<td>7,052,200</td>
<td>-12.3%</td>
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<td>Grants &amp; Subsidies</td>
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<td>1,269,600</td>
<td>1,269,600</td>
<td>100.0%</td>
<td>42,000</td>
<td>(1,311,600)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
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<td>MCP - Physician’s Services</td>
<td>486,087,000</td>
<td>492,087,000</td>
<td>6,000,000</td>
<td>1.2%</td>
<td>(1,877,800)</td>
<td>0</td>
<td>(5,495,900)</td>
<td>0</td>
<td>484,713,300</td>
<td>-0.3%</td>
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<tr>
<td>Support to Community Agencies</td>
<td>0</td>
<td>6,771,900</td>
<td>6,771,900</td>
<td>100.0%</td>
<td>0</td>
<td>(6,771,900)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Provincial Drug Program</td>
<td>147,427,000</td>
<td>148,992,700</td>
<td>1,565,700</td>
<td>1.1%</td>
<td>0</td>
<td>0</td>
<td>(1,402,000)</td>
<td>0</td>
<td>147,590,700</td>
<td>0.1%</td>
</tr>
<tr>
<td>MUN Faculty of Medicine</td>
<td>57,871,000</td>
<td>59,259,400</td>
<td>1,388,400</td>
<td>2.3%</td>
<td>0</td>
<td>0</td>
<td>(1,672,100)</td>
<td>0</td>
<td>57,587,300</td>
<td>-0.5%</td>
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<tr>
<td>Regional Health Authorities</td>
<td>2,082,164,300</td>
<td>2,091,703,300</td>
<td>9,539,000</td>
<td>0.5%</td>
<td>(818,000)</td>
<td>165,300</td>
<td>(2,033,000)</td>
<td>35,532,000</td>
<td>2,124,549,600</td>
<td>2.0%</td>
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<tr>
<td><strong>Total Current Expenditure</strong></td>
<td>2,799,598,100</td>
<td>2,827,026,300</td>
<td>27,428,200</td>
<td>1.0%</td>
<td>(3,516,500)</td>
<td>(9,046,400)</td>
<td>(10,713,600)</td>
<td>35,879,600</td>
<td>2,839,629,400</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Related Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Provincial Revenue</td>
<td>(31,316,000)</td>
<td>(31,166,000)</td>
<td>150,000</td>
<td>-0.5%</td>
<td>(1,100,000)</td>
<td>0</td>
<td>(250,000)</td>
<td>0</td>
<td>(32,516,000)</td>
<td>3.8%</td>
</tr>
<tr>
<td>Federal Revenue</td>
<td>(3,390,300)</td>
<td>(3,163,500)</td>
<td>226,800</td>
<td>-7.2%</td>
<td>708,000</td>
<td>100,000</td>
<td>(482,000)</td>
<td>0</td>
<td>(2,837,500)</td>
<td>-16.3%</td>
</tr>
<tr>
<td><strong>Total Related Revenue</strong></td>
<td>(34,706,300)</td>
<td>(34,329,500)</td>
<td>376,800</td>
<td>-1.1%</td>
<td>(392,000)</td>
<td>100,000</td>
<td>(732,000)</td>
<td>0</td>
<td>(35,353,500)</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Net Current Expenditure</strong></td>
<td>2,764,891,800</td>
<td>2,792,696,800</td>
<td>27,805,000</td>
<td>-5.0%</td>
<td>(3,908,500)</td>
<td>(8,946,400)</td>
<td>(11,445,600)</td>
<td>35,879,600</td>
<td>2,804,275,900</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Capital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furnishings and Equipment (AS49)</td>
<td>61,432,500</td>
<td>54,950,000</td>
<td>(6,482,500)</td>
<td>-11.8%</td>
<td>0</td>
<td>0</td>
<td>(8,017,500)</td>
<td>0</td>
<td>46,932,500</td>
<td>-23.6%</td>
</tr>
<tr>
<td>Health Care Facilities (AS51)</td>
<td>117,660,200</td>
<td>173,514,300</td>
<td>55,854,100</td>
<td>32.2%</td>
<td>0</td>
<td>0</td>
<td>(99,805,100)</td>
<td>0</td>
<td>73,708,200</td>
<td>-37.4%</td>
</tr>
<tr>
<td><strong>Total Capital Expenditure</strong></td>
<td>179,092,700</td>
<td>228,464,300</td>
<td>49,371,600</td>
<td>21.6%</td>
<td>0</td>
<td>0</td>
<td>(107,823,600)</td>
<td>0</td>
<td>120,640,700</td>
<td>-32.6%</td>
</tr>
<tr>
<td><strong>Total Net Expenditure</strong></td>
<td>2,943,984,500</td>
<td>3,021,161,100</td>
<td>77,176,600</td>
<td>2.6%</td>
<td>(3,908,500)</td>
<td>(8,946,400)</td>
<td>(119,269,200)</td>
<td>35,879,600</td>
<td>2,924,916,600</td>
<td>-0.6%</td>
</tr>
</tbody>
</table>
The Department of Health and Community Services is responsible for the overall direction of the Province’s health and community services system which provides services and programs aimed at the prevention of disease and the restoration and maintenance of health and well-being.

These goals are supported by the various programs of the Department which include funding for the operation of hospitals, health care centres and long term care facilities and the provision of medical care, public health and other community services.

**PROGRAM FUNDING SUMMARY**

**FISCAL YEAR 2015-16**

*(Gross Expenditure)*

<table>
<thead>
<tr>
<th>Program</th>
<th>Current</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive and Support Services</td>
<td>20,956,800</td>
<td>-</td>
<td>20,956,800</td>
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<tr>
<td>Professional Services and Support</td>
<td>694,123,000</td>
<td>-</td>
<td>694,123,000</td>
</tr>
<tr>
<td>Health and Community Service Delivery</td>
<td>2,124,549,600</td>
<td>120,640,700</td>
<td>2,245,190,300</td>
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<td><strong>TOTAL: PROGRAM ESTIMATES</strong></td>
<td><strong>2,838,629,400</strong></td>
<td><strong>120,640,700</strong></td>
<td><strong>2,960,270,100</strong></td>
</tr>
</tbody>
</table>

**SUMMARY OF EXPENDITURE AND RELATED REVENUE**

**FISCAL YEAR 2015-16**

Gross Expenditure

Amount Voted

$2,960,270,100

Less: Related Revenue

Current

(35,353,500)

**NET EXPENDITURE (Current and Capital)**

$2,924,916,600
HEALTH AND COMMUNITY SERVICES

EXECUTIVE AND SUPPORT SERVICES

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>MINISTER’S OFFICE</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>CURRENT</strong></td>
<td></td>
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<tr>
<td>1.1.01. MINISTER’S OFFICE</td>
<td></td>
<td></td>
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<tr>
<td>Appropriations provide for the operating costs of the Minister’s Office.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>01. Salaries</td>
<td>412,000</td>
<td>405,100</td>
<td>405,100</td>
</tr>
<tr>
<td>Operating Accounts:</td>
<td></td>
<td></td>
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<tr>
<td>Transportation and Communications</td>
<td>71,400</td>
<td>48,000</td>
<td>71,400</td>
</tr>
<tr>
<td>Supplies</td>
<td>3,000</td>
<td>1,500</td>
<td>5,900</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>1,500</td>
<td>100</td>
<td>2,700</td>
</tr>
<tr>
<td>02. Operating Accounts</td>
<td>75,900</td>
<td>49,800</td>
<td>80,000</td>
</tr>
<tr>
<td>Amount to be Voted</td>
<td>487,900</td>
<td>454,700</td>
<td>485,100</td>
</tr>
<tr>
<td>Total: Minister’s Office</td>
<td>487,900</td>
<td>454,700</td>
<td>485,100</td>
</tr>
<tr>
<td><strong>TOTAL: MINISTER’S OFFICE</strong></td>
<td>487,900</td>
<td>454,700</td>
<td>485,100</td>
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**GENERAL ADMINISTRATION**

**CURRENT**

<table>
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<tbody>
<tr>
<td>1.2.01. EXECUTIVE SUPPORT</td>
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<td></td>
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</tr>
<tr>
<td>Appropriations provide for the senior planning and direction of the Department, including the establishment and evaluation of policies and objectives.</td>
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</tr>
<tr>
<td>01. Salaries</td>
<td>1,731,100</td>
<td>1,667,400</td>
<td>1,590,400</td>
</tr>
<tr>
<td>Operating Accounts:</td>
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<tr>
<td>Employee Benefits</td>
<td>4,500</td>
<td>500</td>
<td>4,500</td>
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<tr>
<td>Transportation and Communications</td>
<td>38,400</td>
<td>41,000</td>
<td>38,400</td>
</tr>
<tr>
<td>Supplies</td>
<td>9,500</td>
<td>8,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Professional Services</td>
<td>-</td>
<td>-</td>
<td>15,000</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>22,500</td>
<td>3,500</td>
<td>22,500</td>
</tr>
<tr>
<td>02. Operating Accounts</td>
<td>74,900</td>
<td>53,000</td>
<td>93,400</td>
</tr>
<tr>
<td>Amount to be Voted</td>
<td>1,806,000</td>
<td>1,720,400</td>
<td>1,683,800</td>
</tr>
<tr>
<td>Total: Executive Support</td>
<td>1,806,000</td>
<td>1,720,400</td>
<td>1,683,800</td>
</tr>
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HEALTH AND COMMUNITY SERVICES

EXECUTIVE AND SUPPORT SERVICES

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<tr>
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<tr>
<td>GENERAL ADMINISTRATION (Cont'd)</td>
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<tr>
<td>1.2.02. CORPORATE SERVICES</td>
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<tr>
<td>Appropriations provide for the management of the financial and operational activities of the Department, audit of programs and expenditures, the registration of eligible beneficiaries of the MCP and NLPDP programs as well as claims processing, and information management functions of the Department.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01. Salaries</td>
<td>5,032,300</td>
<td>4,850,100</td>
<td>4,797,700</td>
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<td>Operating Accounts:</td>
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<tr>
<td>Employee Benefits</td>
<td>329,500</td>
<td>266,600</td>
<td>329,500</td>
</tr>
<tr>
<td>Transportation and Communications</td>
<td>635,100</td>
<td>635,100</td>
<td>635,100</td>
</tr>
<tr>
<td>Supplies</td>
<td>150,000</td>
<td>84,600</td>
<td>195,800</td>
</tr>
<tr>
<td>Professional Services</td>
<td>361,000</td>
<td>79,800</td>
<td>1,111,000</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>982,200</td>
<td>726,600</td>
<td>1,316,400</td>
</tr>
<tr>
<td>Property, Furnishings and Equipment</td>
<td>50,000</td>
<td>40,000</td>
<td>100,000</td>
</tr>
<tr>
<td>02. Operating Accounts</td>
<td>2,507,800</td>
<td>1,832,700</td>
<td>3,687,800</td>
</tr>
<tr>
<td>Amount to be Voted</td>
<td>7,540,100</td>
<td>6,682,800</td>
<td>8,485,500</td>
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<tr>
<td>01. Revenue - Federal</td>
<td>(250,000)</td>
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<td>(1,000,000)</td>
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<tr>
<td>02. Revenue - Provincial</td>
<td>(350,000)</td>
<td>(300,000)</td>
<td>(350,000)</td>
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<tr>
<td>Total: Corporate Services</td>
<td>6,940,100</td>
<td>6,382,800</td>
<td>7,135,500</td>
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</table>

1.2.03. PROFESSIONAL SERVICES

Appropriations provide for the development and maintenance of policies, programs and standards governing the Province's health professionals, the management of physician and dental services, the provincial drug program, laboratory and pathology services, health workforce planning and nursing.

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### EXECUTIVE AND SUPPORT SERVICES

**GENERAL ADMINISTRATION (Cont'd)**

#### CURRENT

**1.2.04. REGIONAL SERVICES**

Appropriations provide for the development and maintenance of policies, programs and standards governing access and clinical efficiency, long-term care and community support services, emergency management, as well as for direction and support to the four Regional Health Authorities, including support for infrastructure projects.

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**1.2.05. POPULATION HEALTH**

Appropriations provide for the development and maintenance of policies, programs and standards governing population health in the Province, and the prevention of illness and disease for the residents of the Province.

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## HEALTH AND COMMUNITY SERVICES

### EXECUTIVE AND SUPPORT SERVICES

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<tr>
<td>1.2.06. POLICY AND PLANNING</td>
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<tr>
<td>Appropriations provide for the development of policies and legislation, corporate strategic planning, evaluation, and support to the Deputy Minister and Minister in Federal/Provincial/Territorial relations and initiatives related to health.</td>
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<td>(100,000)</td>
<td>(150,000)</td>
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<td>Total: Policy and Planning</td>
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<td>1,836,200</td>
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<td>17,100,700</td>
<td>19,832,000</td>
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# HEALTH AND COMMUNITY SERVICES

## PROFESSIONAL SERVICES AND SUPPORT

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<th>2014-15</th>
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<td>Revised $</td>
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<td>MEMORIAL UNIVERSITY FACULTY OF MEDICINE</td>
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<td><strong>CURRENT</strong></td>
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<tr>
<td>2.1.01. MEMORIAL UNIVERSITY FACULTY OF MEDICINE</td>
<td></td>
<td></td>
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<tr>
<td>Appropriations provide for the operating costs of the Memorial University Faculty of Medicine.</td>
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<tr>
<td>10. Grants and Subsidies</td>
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<td>57,477,500</td>
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<tr>
<td>Amount to be Voted</td>
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<td>57,477,500</td>
</tr>
<tr>
<td>Total: Memorial University Faculty of Medicine</td>
<td>57,587,300</td>
<td>57,477,500</td>
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<td><strong>TOTAL: MEMORIAL UNIVERSITY FACULTY OF MEDICINE</strong></td>
<td>57,587,300</td>
<td>57,477,500</td>
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</table>

## DRUG SUBSIDIZATION

**CURRENT**

### 2.2.01. PROVINCIAL DRUG PROGRAMS

Appropriations provide for the subsidization of prescription drug costs and the provision of pharmaceutical services for persons who are deemed eligible, and other programs.

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<tr>
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</thead>
<tbody>
<tr>
<td><em>Professional Services</em></td>
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<td>4,231,700</td>
<td>4,231,700</td>
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<td>02. Operating Accounts</td>
<td>4,231,700</td>
<td>4,231,700</td>
<td>4,231,700</td>
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<tr>
<td>09. Allowances and Assistance</td>
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<td>137,927,000</td>
<td>147,427,000</td>
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<td>Amount to be Voted</td>
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<td>142,158,700</td>
<td>151,668,700</td>
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<td>02. Revenue - Provincial</td>
<td>(2,500,000)</td>
<td>(100,000)</td>
<td>(2,250,000)</td>
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<td>Total: Provincial Drug Programs</td>
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<td>142,068,700</td>
<td>149,408,700</td>
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</tbody>
</table>

**TOTAL: DRUG SUBSIDIZATION** | 149,322,400 | 142,068,700 | 149,408,700 |
HEALTH AND COMMUNITY SERVICES

PROFESSIONAL SERVICES AND SUPPORT

<table>
<thead>
<tr>
<th></th>
<th>2015-16 Estimates</th>
<th>2014-15 Revised</th>
<th>Budget</th>
</tr>
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<tbody>
<tr>
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</table>

MEDICAL CARE PLAN

CURRENT

2.3.01. PHYSICIANS' SERVICES
Appropriations provide for the payment of insured physician services provided to residents both within and outside the Province.

Operating Accounts:

| Professional Services | 337,001,500 | 330,501,500 | 332,501,500 |
| 02. Operating Accounts | 337,001,500 | 330,501,500 | 332,501,500 |
| 09. Allowances and Assistance | 10,072,800 | 9,572,800 | 11,072,800 |
| 10. Grants and Subsidies | 123,173,500 | 123,669,400 | 126,669,400 |
| Amount to be Voted | 470,247,800 | 463,743,700 | 470,243,700 |
| 02. Revenue - Provincial | (3,000,000) | (3,000,000) | (3,000,000) |
| Total: Physicians' Services | 467,247,800 | 460,743,700 | 467,243,700 |

2.3.02. DENTAL SERVICES
Appropriations provide for the subsidization of dental services for children and other persons who are deemed eligible.

Operating Accounts:

| Professional Services | 13,765,500 | 11,643,300 | 15,143,300 |
| 02. Operating Accounts | 13,765,500 | 11,643,300 | 15,143,300 |
| 09. Allowances and Assistance | 700,000 | 700,000 | 700,000 |
| Amount to be Voted | 14,465,500 | 12,343,300 | 15,843,300 |
| Total: Dental Services | 14,465,500 | 12,343,300 | 15,843,300 |

TOTAL: MEDICAL CARE PLAN | 481,713,300 | 473,087,000 | 483,087,000 |
TOTAL: PROFESSIONAL SERVICES AND SUPPORT | 688,623,000 | 672,623,200 | 690,366,700 |
HEALTH AND COMMUNITY SERVICES

HEALTH AND COMMUNITY SERVICE DELIVERY

<table>
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</table>

REGIONAL HEALTH AUTHORITIES AND RELATED SERVICES

CURRENT

3.1.01. REGIONAL HEALTH AUTHORITIES AND RELATED SERVICES

Appropriations provide for the delivery of acute care, long term care and community based programs in the Province through the four Regional Health Authorities, funding lease payments for health centres being acquired under lease-purchase arrangements, insured hospital services received by residents outside the Province, the Province’s share of operating costs of the Canadian Blood Services, repairs and renovations to health facilities, non-emergency medical transportation assistance and other related programs and services.

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<tr>
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<td>09. Allowances and Assistance</td>
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<td>7,853,600</td>
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<td>10. Grants and Subsidies</td>
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<td>(26,566,000)</td>
<td>(25,566,000)</td>
<td>(25,566,000)</td>
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Total: Regional Health Authorities and Related Services | 2,095,396,100 | 2,073,826,700 | 2,055,090,600 |

TOTAL: REGIONAL HEALTH AUTHORITIES AND RELATED SERVICES | 2,095,396,100 | 2,073,826,700 | 2,055,090,600 |
HEALTH AND COMMUNITY SERVICES

HEALTH AND COMMUNITY SERVICE DELIVERY

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<td>AND EQUIPMENT</td>
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<td>61,432,500</td>
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<tr>
<td>TOTAL: HEALTH AND</td>
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<td>2,197,318,500</td>
<td>2,234,183,300</td>
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<td>DELIVERY</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,924,916,600</td>
<td>2,887,497,100</td>
<td>2,944,857,100</td>
</tr>
<tr>
<td>TOTAL: DEPARTMENT</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Relationship between Regional Health Authorities (RHAs) and the Department of Health and Community Services

This note describes the relationship between the department and the RHAs. The Department provides strategic direction to four regional health authorities: Eastern Health, Central Health, Western Health and Labrador-Grenfell Health. Each RHA is responsible for delivering direct care to individuals in hospitals, long term care facilities and community-based offices and clinics, as well as through public health and community support services. There are more than 19,000 employees throughout the RHAs in Newfoundland and Labrador.

The Department provides leadership, coordination, monitoring, support, and funding to the RHAs. RHAs provide the delivery and administration of health and community services, the direct care, in their respective health regions.

HCS Regular Working Interactions with RHAs:

- **Budget Management and Monitoring**: The department provides ongoing management and support to the RHAs in relation to their budgets. The Department meets quarterly with each RHA to review and monitor their budgets.

- **Policy Development**: The department will liaise and consult with the RHAs to identify policies for consideration or revision by the Department related to the reform of the institutional and community health system, and to provide direction regarding the implementation and monitoring of these polices.

- **Program and Service Monitoring and Evaluation**: The Department liaises with the RHAs, who monitor compliance with the operational standards related to the delivery of the institutional and community based programs and services. Data collection and analysis is on-going and is used to assist senior executive of the department and RHAs in decision making to provide efficient and affordable delivery of health care related programs and services.

- **Issue Analysis and Preparation of Briefing Notes/Correspondence**: The department consults directly with the RHAs related to issues and correspondence that is directed to the Department but related to health and community services delivered by the RHAs.

- **Committees/Working Groups**: Representatives from the department and the RHAs (as well as other stakeholders as required) often work together as part of committees or working groups initiated for the purposes of developing or improving policies, programs or services.

- **HCS Deputy Minister and RHA CEOs** meet monthly to discuss issues of mutual concern.

Responsible/Role of RHAs:

An RHA is responsible for the delivery and administration of health and community services in its health region in accordance with the *Regional Health Authorities Act*. An authority may provide health and community services designated by the minister on an inter-regional or province-wide basis when authorized to do so by the minister.
RHA Responsibilities:
- promote and protect the health and well-being of its region and develop and implement measures for the prevention of disease and injury and the advancement of health and well-being;
- assess health and community services needs in its region on an ongoing basis;
- develop objectives and priorities for the provision of health and community services which meet the needs of its region and which are consistent with provincial objectives and priorities;
- manage and allocate resources, including funds provided by the government for health and community services, in accordance with the Regional Health Authorities Act;
- ensure that services are provided in a manner that coordinates and integrates health and community services;
- collaborate with other persons and organizations, including federal, provincial and municipal governments and agencies and other regional health authorities, to coordinate health and community services in the province and to achieve provincial objectives and priorities;
- collect and analyze health and community services information for use in the development and implementation of health and community services policies and programs for its region;
- provide information to the residents of the region respecting the services provided by the authority, how they may gain access to those services, and how they may communicate with the authority respecting the provision of those services by the authority;
- monitor and evaluate the delivery of health and community services and compliance with prescribed standards and provincial objectives and in accordance with guidelines that the minister may establish for the authority; and comply with directions the minister may give.

The RHAs supervise, direct and control the delivery of health and community services in the areas of:
- health protection and promotion;
- continuing and long term care;
- community health;
- mental health;
- addiction services;
- community supports and home care;
- treatment of illness and injury;
- hospital care;
- evaluation, research, and quality assurance;
- health screening;
- neglected adults; and
- road ambulance services.
Central Regional Health Authority
Regional Profile
December 2015

Board Chair: Mr. John George

Chief Executive Officer and Executive Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosemarie Goodyear</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Dr. Jeff Cole</td>
<td>Vice President – Medical Services</td>
</tr>
<tr>
<td>Terry Ings</td>
<td>Vice-President – Human Resources and Support Services</td>
</tr>
<tr>
<td>Trudy Stuckless</td>
<td>Vice-President – Population Health and Chief Nursing Officer</td>
</tr>
<tr>
<td>Heather Brown</td>
<td>Vice-President – Long Term Care, Community Supports, and Rural Health</td>
</tr>
<tr>
<td>Sean Tulk</td>
<td>Vice-President – Diagnostics and Information Management and Chief Operating Officer – Central Newfoundland Regional Health Centre in GP-W</td>
</tr>
<tr>
<td>Sherry Freake</td>
<td>Vice-President – Acute Care and Chief Operating Officer – James Paton Memorial Regional Health Centre in Gander</td>
</tr>
<tr>
<td>John Kattenbusch</td>
<td>Vice President – Finance &amp; Infrastructure</td>
</tr>
<tr>
<td>Ms. Gail Huang (A)</td>
<td>Director of Communications</td>
</tr>
</tbody>
</table>

Catchment Area
The Central Regional Health Authority extends from Charlottetown (inclusive) in the east, Fogo Island in the northeast, Harbour Breton/Connagaire Peninsula in the south to the Baie Verte Peninsula in the west. The geographical area serviced by Central health includes 177 communities and encompasses more than half the total landmass of the island. As per January 2014 population projections, there are 93,114 residents in the Central region (Department of Finance, Research and Statistics Division, January, 2015).

Overview
Central Health currently has 787 beds operational and staffed in facilities throughout the region - 268 acute care beds (including 13 palliative and 5 restorative care beds), 513 long term care beds, and 6 respite beds. The number of beds may fluctuate from year to year depending on the impact of major renovations and capital infrastructure at any given site. Central Health has approximately 3200 employees (2300 FTEs). There are also 115 fee-for-service physicians practicing within the region, and the organization is supported by 900 volunteers and two foundations. The Central Northeast Health Foundation and the South and Central Health Foundation operate under the direction of two volunteer Boards of Directors.

Regional Institutional Based Services
Central Health has 13 facilities – 2 acute care regional referral centres (located in Gander and Grand Falls-Windsor), 8 health centres (located in Springdale, Buchans, New-Wes-Valley, Fogo Island, Twillingate, Harbour Breton, Baie Verte, and Botwood) and 3 long-term care facilities (located in Lewisporte, Gander, and Grand Falls-Windsor), as well as a 12 bed protective care residence in Lewisporte.

Regional Community Based Services
Central Health is committed to a Primary Health Care model of service delivery. Regional primary health care and community based services in the Central region include Primary Care Physician Services, Population and Public Health, Health Protection, Community Supports, Mental Health and Addictions Services, Long Term Care and Residential Services, and Early Learning and Child Development. These services are offered by physicians, social workers, nurses, and other allied health professionals.

Community based services are provided from clinics/offices located in the following 29 communities: Baie Verte, Belleoram, Botwood, Brookfield, Buchans, Carmanville, Centreville, Change Island, Eastport, Fogo, Gambo, Gander, Gander Bay, Glovertown, Grand Falls-Windsor, Harbour Breton, LaScie, Lewisporte, St. Alban’s, Musgrave Harbour, New World Island, Robert’s Arm, Springdale, St. Brendan’s, Twillingate, Hare Bay, Gaultous, McCallum, Rencontre (there are services in Conne River however they are provided by Conne River Health and Social Services, not Central Health).
Central Financial Position

2014-15
- Central Health had a 2014-15 original Provincial Plan Revenue budget of $297,134,300.
- Central Health had an annual operating surplus of $955,900 as per the Statement of Operations at March 31, 2015.
- Central Health has an accumulated operating deficit to March 31, 2015 of $10.3 million.

2015-16
- Central Health has a 2015-16 original Provincial Plan Revenue budget of $312,968,800.
- Based on second quarter operating results the health authority is projecting an annual operating deficit of $4.5 million to March 31, 2016.

Capital Infrastructure (Central Health)
- From 2003-04 to 2015-16, over $276 million has been allocated for health care infrastructure which includes new construction, capital equipment and repairs and renovations to health facilities in Central Health.
## Central Regional Health Authority
### Facilities Profile (as of Dec 1, 2015 as reported by Central Health)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Paton Memorial Health Centre</td>
<td>Gander</td>
<td>85</td>
<td><strong>Acute</strong></td>
</tr>
<tr>
<td>Central Newfoundland Regional Health Centre</td>
<td>Grand Falls-Windsor</td>
<td>117</td>
<td><strong>Long Term Care</strong></td>
</tr>
<tr>
<td><strong>Community Health Centres</strong></td>
<td></td>
<td></td>
<td><strong>Holding/Observation</strong></td>
</tr>
<tr>
<td>A.M. Guy Memorial Health Centre</td>
<td>Buchans</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Brookfield Bonnies Health Care Centre</td>
<td>Brookfield and Badger’s Quay</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>Fogo Island Health Centre</td>
<td>Fogo</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Notre Dame Bay Memorial Health Centre</td>
<td>Twillingate</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Connaigre Peninsula Health Centre</td>
<td>Harbour Breton</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Baie Verte Peninsula Health Centre</td>
<td>Baie Verte</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Green Bay Health Centre/Valley Vista Senior Citizens Home*</td>
<td>Springdale</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers</td>
<td>Services Provided</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------</td>
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<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Dr. Hugh Twomey Health Centre</td>
<td>Botwood</td>
<td>2</td>
<td>76</td>
</tr>
<tr>
<td><strong>Long Term Care Homes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeside Homes</td>
<td>Gander</td>
<td>0</td>
<td>101</td>
</tr>
<tr>
<td>Carmelite House</td>
<td>Grand Falls-Windsor</td>
<td>1</td>
<td>64</td>
</tr>
<tr>
<td>North Haven Manor (Lewisporte Health Centre)</td>
<td>Lewisporte</td>
<td>1</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>268</strong></td>
<td><strong>513</strong></td>
</tr>
</tbody>
</table>

Prepared by: Lesley Rogers/Derek Penney/Rosemarie Goodyear CEO
Approved by: Bev Griffiths
Date: December 09, 2015
Board Chair: Mr. Michael J. O'Keefe

Chief Executive Officer and Executive Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Diamond</td>
<td>President and Chief Executive Officer</td>
</tr>
<tr>
<td>Katherine Chubbs</td>
<td>Vice President (Cancer Care, Chief Nursing Officer, Clinical Efficiency and Ambulatory Clinics, Medicine, Research &amp; Knowledge Transfer, Surgery)</td>
</tr>
<tr>
<td>Alice Kennedy</td>
<td>Vice President (Cardiac/Critical Care, Centre for Nursing Studies, Community Supportive Services, Health Promotion, Home and Community Care, Long Term Care, Public Health, Rehabilitation/Palliative Care)</td>
</tr>
<tr>
<td>Collette Smith</td>
<td>Interim Vice President (Children &amp; Women’s Health, Emergency Services, Mental Health &amp; Addictions, Paramedicine, Pastoral Care and Ethics, Professional Practice)</td>
</tr>
<tr>
<td>George Butt</td>
<td>Vice President (Accounting, Treasury and Internal Control (Financial Services), Budgeting, Environmental Services, Food Services, Infrastructure Support, Legal Services, Materiels Support, Medical Device Reprocessing Services, Redevelopment)</td>
</tr>
<tr>
<td>Debbie Molloy</td>
<td>Interim Vice President (Access to Information and Privacy, Employee Relations, HR Client Services, Infection Prevention &amp; Control, Occupational Health &amp; Safety and Rehabilitation, Protection Services, Quality/Patient Safety and Risk Management, Regional Policy)</td>
</tr>
<tr>
<td>Lynette Oates</td>
<td>Vice President (Acting) (Corporate Communications and Government Relations)</td>
</tr>
<tr>
<td>Dr. Oscar Howell</td>
<td>Vice President (Diagnostic Imaging, Laboratory Services, Medical Services, Perioperative, Pharmacy)</td>
</tr>
<tr>
<td>Ron Johnston</td>
<td>Interim Chief Performance Officer (Decision Support, Health Information Services and Infomatics, Health Technology and Data Management)</td>
</tr>
</tbody>
</table>

Catchment Area

- Eastern Health includes the Avalon Peninsula, west to Port Blandford (inclusive) and includes the Burin and Bonavista Peninsulas. There are 317,340 residents in the Eastern region (Department of Finance, Economic Research and Analysis Division, January 2015) which represents 60.3% of the provinces total population.

- Eastern Health provides comprehensive community and institutional based services, as well as cancer and rehabilitative care, to the population of the Region. It also provides tertiary institutional services and many outreach programs, e.g., cancer clinics, to other areas of the Province. The corporate headquarters are located in St. John’s.
Regional Institutional Based Services
- Eastern Health provides acute care, long term care, rehabilitative services and cancer care to provincial residents. There are 29 health facilities – 8 hospitals including the Miller Centre, 7 community health centres, 13 long term care homes, and the Dr. H. Bliss Murphy Cancer Centre.

Regional Community Based Services
- Community based services include Health Promotion, Community Corrections, Health Protection, Mental Health, Intervention Services, Addictions Services, Community Support Programs, Residential Services, Community Health Nursing Services, Satellite Renal Dialysis Services, and Medical Clinics. Health promotion and prevention programs with an overall population health focus continue to be a priority for community staff. These services are offered primarily by social workers, nurses and other allied health professionals.

- Regional community based services are offered in 28 communities: Marystown, St. Bernard’s, Grand Bank, St. Lawrence, Bonavista, Trinity, Lethbridge, Clarenville, Come by Chance, Whitbourne, Heart’s Delight, Old Perlican, Harbour Grace, Bay Roberts, Holyrood, Mount Carmel, St. Mary’s, Placentia, St. Bride’s, Conception Bay South, Mount Pearl, St. John’s (3 sites: Major’s Path, Cordage Place, Charles R. Bell), Bell Island, Torbay, Portugal Cove, Witless Bay, Trepassey and Ferryland.

Eastern Financial Position
2014-15
- Eastern Health had a 2014-15 original Provincial Plan Revenue budget of $1,140,763,800.
- Eastern Health had a balanced budget as per the Statement of Operations at March 31, 2015.
- Eastern Health has an accumulated operating deficit to March 31, 2015 of $80.0 million.

2015-16
- Eastern Health has a 2015-16 original Provincial Plan Revenue budget of $1,193,132,100.
- Based on second quarter operating results the health authority is projecting an annual operating deficit of $41.6 million to March 31, 2016.

Capital Infrastructure
- From 2003-04 to 2014-15, over $700 million has been allocated for health care infrastructure which includes new construction, capital equipment and repairs and renovations to health facilities in Eastern Health.
## Eastern Regional Health Authority
### Facilities Profile

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers (as of December 1, 2015 as reported by EH)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janeway Children’s Health &amp; Rehabilitation Centre</td>
<td>St. John’s</td>
<td>79</td>
<td>Secondary and tertiary medical and surgical services including neonatal intensive care, an acute psychiatric unit and ambulatory care services</td>
</tr>
<tr>
<td>General Hospital, Health Sciences Centre</td>
<td>St. John’s</td>
<td>346</td>
<td>Secondary and tertiary medicine, surgery services, and critical care and sub-specialty services which include cardiac surgery, neurosurgery, plastic surgery, burn unit, obstetrics/gynecology (which includes 30 bassinets), and an acute psychiatric unit.</td>
</tr>
<tr>
<td>St. Clare’s Mercy Hospital</td>
<td>St. John’s</td>
<td>205</td>
<td>Secondary and tertiary medical and surgical services, and critical care, including general surgery, vascular surgery, thoracic surgery, ENT, orthopedics, internal medicine, and a full range of ambulatory services</td>
</tr>
<tr>
<td>Waterford Hospital</td>
<td>St. John’s</td>
<td>84</td>
<td>Acute adult mental health services, long term care, forensic maximum security unit, and developmentally disabled unit and short stay.</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (as of December 1, 2015 as reported by EH)</td>
<td>Services Provided</td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Carbonear General Hospital</td>
<td>Carbonear</td>
<td>72</td>
<td>0</td>
</tr>
<tr>
<td>Dr. G. B. Cross Memorial Hospital</td>
<td>Clarenville</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Burin Peninsula Health Care Centre</td>
<td>Burin</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Dr. Leonard A. Miller Centre - Acute Rehabilitation</td>
<td>St. John’s</td>
<td>62 rehab</td>
<td>10 palliative care</td>
</tr>
</tbody>
</table>

Provincial Cancer Centre
<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers (as of December 1, 2015 as reported by EH)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. H Bliss Murphy</td>
<td>St John’s</td>
<td>Acute: -</td>
<td>Outpatient clinics, chemotherapy, radiation therapy, pain and symptom management/palliative care, social work, prevention and screening initiatives, nutrition counseling, research and the cancer registries. Offers chemotherapy and visiting specialist services in other areas of province.</td>
</tr>
<tr>
<td>Cancer Centre</td>
<td></td>
<td>Long Term Care: -</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding/Observation: -</td>
<td></td>
</tr>
<tr>
<td>Community Health Centres</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Walter Templeman Health</td>
<td>Bell Island</td>
<td>Acute: 5</td>
<td>Primary health centre which includes emergency/outpatient services, diagnostic services including lab and x-ray and long term residential services for clients requiring 24-hour nursing care</td>
</tr>
<tr>
<td>Centre</td>
<td></td>
<td>Long Term Care: 16 (includes 1 respite bed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding/Observation: 0</td>
<td></td>
</tr>
<tr>
<td>US Memorial Health Centre</td>
<td>St. Lawrence</td>
<td>Acute: 0</td>
<td>Primary acute care, emergency/OPD services and limited diagnostic services, i.e., lab, x-ray and residential accommodations for long term care clients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long Term Care: 41 (includes 1 respite bed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding/Observation: 0</td>
<td></td>
</tr>
<tr>
<td>Dr. A.A. Wilkinson Memorial</td>
<td>Old Perlican</td>
<td>Acute: 4</td>
<td>Primary acute care, emergency, outpatients, basic laboratory and x-ray, mobile ultrasound</td>
</tr>
<tr>
<td>Health Centre</td>
<td></td>
<td>Long Term Care: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding/Observation: 0</td>
<td></td>
</tr>
<tr>
<td>Placentia Health Centre</td>
<td>Placentia</td>
<td>Acute: 10</td>
<td>Primary acute care; long term care, emergency/outpatients, basic laboratory and x-ray, mobile ultrasound</td>
</tr>
<tr>
<td>Lions Manor</td>
<td></td>
<td>Long Term Care: 77 (includes 2 respite beds)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding/Observation: 0</td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (as of December 1, 2015 as reported by EH)</td>
<td>Services Provided</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dr. William H. Newhook Community Health Centre</td>
<td>Whitbourne</td>
<td>Acute: 0, Long Term Care: 0, Holding/Observation: 3</td>
<td>24 hour emergency services, including overnight observation; basic laboratory and x-ray, mobile ultrasound. Affiliated with MUN’s Medical School.</td>
</tr>
<tr>
<td>Bonavista Peninsula Health Centre</td>
<td>Bonavista</td>
<td>Acute: 10, Long Term Care: 2 respite beds, Holding/Observation: 0</td>
<td>Primary acute care, emergency/OPD services and limited diagnostic services, i.e. Lab, x-ray and residential accommodations for long term care clients.</td>
</tr>
<tr>
<td>Grand Bank Community Health Centre</td>
<td>Grand Bank</td>
<td>Acute: 0, Long Term Care: 0, Holding/Observation: 0</td>
<td>Emergency/OPD services and limited diagnostic services, i.e., lab, x-ray.</td>
</tr>
<tr>
<td>Treatment Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuckermore Youth Treatment Centre</td>
<td>Paradise</td>
<td>Acute: 12, Long Term Care: 18</td>
<td>Inpatient treatment services to youth and adolescents from ages 12 to 18 offering six to twelve month program for clients for complex mental health needs.</td>
</tr>
</tbody>
</table>
| Harbour Grace Adult Addictions Treatment Centre | Harbour Grace    | Acute: 18, Long Term Care: 18                         | Provincial adult addictions centre offering short stay adult addictions rehabilitation.  
**Scheduled to open in 2016.**                                                                                           |
<p>| Long Term Care Homes                        |                      |                                                        |                                                                                                                                                                                                               |
| The Salvation Army Glenbrook Lodge           | St. John’s           | Acute: 0, Long Term Care: 104, Holding/Observation: 0  | Long term residential accommodations for the frail elderly with high care needs.                                                                                                                                |
| St. Patrick’s Mercy Home                     | St. John’s           | Acute: 0, Long Term Care: 210, Holding/Observation: 0  | Long term residential accommodations for the frail elderly with high care needs.                                                                                                                                |
| Saint Luke’s Homes                           | St. John’s           | Acute: 0, Long Term Care: 117, Holding/Observation: 0  | Long term residential accommodations for the frail elderly with high care needs and a day care program for seniors.                                                                                           |</p>
<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers (as of December 1, 2015 as reported by EH)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Agnes Pratt Home</td>
<td>St. John’s</td>
<td>Acute: 0    Long Term Care: 134    Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs.</td>
</tr>
<tr>
<td>Masonic Park Nursing Home</td>
<td>St. John’s</td>
<td>Acute: 0    Long Term Care: 40    Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs.</td>
</tr>
<tr>
<td>St. John’s LTC</td>
<td>St. John’s</td>
<td>Acute: 0    Long Term Care: 457   Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs and for younger adults with physical and developmental disabilities.</td>
</tr>
<tr>
<td>Chancellor Park (Contracted service)</td>
<td>St. Johns</td>
<td>Acute: 0    Long Term Care: 120   Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs and persons with dementia.</td>
</tr>
<tr>
<td>Harbour Lodge Nursing Home</td>
<td>Carbonear</td>
<td>Acute: 0    Long Term Care: 83    Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs and persons with dementia.</td>
</tr>
<tr>
<td>Interfaith Citizens Home</td>
<td>Carbonear</td>
<td>Acute: 0    Long Term Care: 53    Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs and younger adults with physical and developmental disabilities.</td>
</tr>
<tr>
<td>Pentecostal Senior Citizens Home</td>
<td>Clarke’s Beach</td>
<td>Acute: 0    Long Term Care: 69    Holding/Observation: 0</td>
<td>24 cottage units on-site. It provides Level I, II, and III care to residents of the catchment area and persons of the Pentecostal faith throughout the Province. It is administered by a Board of Directors of the Pentecostal Assemblies Benevolent Association.</td>
</tr>
<tr>
<td>Golden Heights Manor</td>
<td>Bonavista</td>
<td>Acute: 0    Long Term Care: 70    Holding/Observation: 0</td>
<td>Long term residential accommodations for the frail elderly with high care needs and persons with dementia.</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (as of December 1, 2015 as reported by EH)</td>
<td>Services Provided</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------</td>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bonavista Protective Community Residence</td>
<td>Bonavista</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Blue Crest Nursing Home</td>
<td>Grand Bank</td>
<td>0</td>
<td>61</td>
</tr>
<tr>
<td>Dr. Albert O’Mahoney</td>
<td>Clarenville</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>999</strong></td>
<td><strong>1,816</strong></td>
</tr>
</tbody>
</table>

Prepared by: Karen Nolan  
Approved by: Bev Griffiths  
Date: December 2, 2015
Labrador-Grenfell Regional Health Authority
Regional Profile
December 2015

Board Chair: Mr. Raymond Norman
Chief Executive Officer and Executive Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tony Wakeham</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Norma Forsey</td>
<td>VP, Quality Management</td>
</tr>
<tr>
<td>Barbara Molgaard Blake</td>
<td>VP, People and Information Management and</td>
</tr>
<tr>
<td></td>
<td>Chief Operating Officer (South)</td>
</tr>
<tr>
<td>Donnie Sampson</td>
<td>VP, Nursing and Chief Nurse</td>
</tr>
<tr>
<td>Ozette Simpson</td>
<td>Chief Operating Officer (Labrador West)</td>
</tr>
<tr>
<td>Delia Connell</td>
<td>VP, Community and Aboriginal Affairs and</td>
</tr>
<tr>
<td></td>
<td>Chief Operating Officer (Labrador East)</td>
</tr>
<tr>
<td>Roger Snow</td>
<td>Chief Financial Officer (A)</td>
</tr>
<tr>
<td>Dr. Michael Jong</td>
<td>VP, Medical Services</td>
</tr>
<tr>
<td>Allan Bock</td>
<td>Regional Director of Communications</td>
</tr>
</tbody>
</table>

Catchment Area

- Labrador-Grenfell Health (LGH) includes the area north of Bartlett’s Harbour to Harbour Deep on the Northern Peninsula and all of Labrador. The corporate headquarters are located in Happy Valley-Goose Bay.
- The region has a population of 37,959 residents (Department of Finance, Economic Research and Analysis Division, January 2015). This represents 7.2 percent of the total provincial population.

Overview

- LGH provides acute care, community and long-term care services to clients who are geographically dispersed throughout the region. The majority of these services are offered from three main regional referral sites; Happy Valley-Goose Bay, St. Anthony and Labrador City, as well as permanent or traveling services offered in communities or local geographic areas. Select specialty services are available on a visiting-consultant basis. Tertiary Care is provided outside of the LGH region.
- In providing services to meet the needs of its clients, LGH collaborates with a number of partners and stakeholders, including Aboriginal health organizations. Thirty-three per cent of the residents of the LGH region identified themselves as Aboriginal. LGH ensures health services are provided to these clients in a culturally appropriate manner.
Regional Community Based Services
- Community Based Services in LGH include; Primary Care Services, Population Health Services, Mental Health and Addiction Services, Dental Services and Therapeutic Intervention, Family Rehabilitation and Other Rehabilitation Services.
- In LGH, services are provided in 21 communities from clinics and offices located in the following areas: Nain, Natuashish, Hopedale, Postville, Makkovik, Rigolet, Cartwright, Black Tickle, Charlottetown, Port Hope Simpson, St. Lewis, Mary’s Harbour, Forteau, Happy Valley-Goose Bay, North West River, Sheshatshiu, Labrador City, Churchill Falls, as well as St. Anthony, Roddickton and Flower’s Cove on the Northern Peninsula.

Regional Institutional Based Services
- LGH provides Acute Care, Diagnostic and Clinical Support Services (in selected locations), Long-Term Care Services and Residential Services.
- There are 22 facilities including 3 hospitals, 3 community health centres, 14 community clinics, and 2 long term care facilities.
- There are 217 beds in the region – 89 acute, 122 long term care, and 6 holding/observation beds. Community clinics do not have staffed beds. The extension to the Long Term Care Facility in Happy Valley-Goose Bay, scheduled to be completed in early 2016, will see an additional 20 long-term care beds in the region.

Labrador-Grenfell Health - Financial Position
2014-15
- Labrador-Grenfell Health had a 2014-15 original Provincial Plan Revenue budget of $123,668,500.
- Labrador-Grenfell Health had a balanced budget to March 31, 2015.
- Labrador-Grenfell Health has an accumulated operating deficit to March 31, 2015 of $19.1 million.

2015-16
- Labrador-Grenfell Health has a 2015-16 original Provincial Plan Revenue budget of $132,487,400.
- Based on second quarter operating results the health authority is projecting an annual operating deficit of $6.8 million to March 31, 2016.

Labrador- Grenfell Health - Capital Infrastructure
- From 2003-04 to 2014-15, over $195 million has been allocated for health care infrastructure which includes new construction, capital equipment and repairs and renovations to health facilities in Labrador-Grenfell Health.
## Facilities Profile

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers (Dec 2015)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Labrador Health Centre</td>
<td>Happy Valley-Goose Bay</td>
<td>25</td>
<td>0</td>
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<tr>
<td>Labrador West Health Centre</td>
<td>Labrador City</td>
<td>14</td>
<td>13</td>
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<tr>
<td>The Charles S. Curtis</td>
<td>St. Anthony</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

## Health Centres

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Acute</th>
<th>Long Term Care</th>
<th>Holding</th>
<th>Primary acute and emergency care, basic laboratory and x-ray services, on site physician and dental services. One holding bed is dedicated to palliative care as needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Bay Central Health</td>
<td>Roddickton</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (Dec 2015)</td>
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<tr>
<td>--------------------------------</td>
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<td>-----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
<td>Holding/Observation</td>
<td></td>
</tr>
<tr>
<td>Strait of Belle Isle Health</td>
<td>Flower’s Cove</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>Community health, mental health and addictions and family rehabilitative services on site.</td>
</tr>
<tr>
<td>Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labrador South Health Centre</td>
<td>Forteau</td>
<td>0</td>
<td>13</td>
<td>4</td>
<td>Primary acute and emergency care, basic laboratory and x-ray services, on site physician and dental services. Community health, mental health and addictions and family rehabilitative services on site.</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paddon Memorial Home (New LTC</td>
<td>Happy Valley-Goose Bay</td>
<td>0</td>
<td>49</td>
<td>0</td>
<td>Long term residential accommodations for the elderly with high care needs and persons with dementia. Includes one respite care bed.</td>
</tr>
<tr>
<td>Facility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John M. Gray Health Centre</td>
<td>St. Anthony</td>
<td>0</td>
<td>47</td>
<td>0</td>
<td>Long term residential accommodations for the elderly with high care needs and persons with dementia. Includes one respite care bed.</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (Dec 2015)</td>
<td>Services Provided</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
<td>Holding/Observation</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Charlottetown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Primary health care, community health and emergency services by regional nurses.</td>
</tr>
<tr>
<td>Community Clinic</td>
<td>St. Lewis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Mental health and addictions, family and rehabilitative and behaviour management services are provided throughout the coastal area.</td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Mary’s</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Visiting physician and select allied health services.</td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Port Hope Simpson</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Blood collection is completed at the Community Clinics for processing at regional referral centres. Emergency and elective consults both within and external to LGH provided.</td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Sheshatshiu</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Churchill</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Nain</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Natuashish</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Black Tickle</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Cartwright</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Makkovik</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Postville</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Rigolet</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Clinic</td>
<td>Hopedale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>89</strong></td>
<td><strong>122</strong></td>
<td><strong>12</strong></td>
<td></td>
</tr>
</tbody>
</table>
Board Chair: Dr. Anthony Genge

Chief Executive Officer and Executive Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Susan Gillam</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Cynthia Davis</td>
<td>VP Patient Services</td>
</tr>
<tr>
<td>Dr. Dennis Rashleigh</td>
<td>VP Medical Services</td>
</tr>
<tr>
<td>Michelle House</td>
<td>VP Population Health and Human Resources</td>
</tr>
<tr>
<td>Kelli O’Brien</td>
<td>VP Long Term Care and Rural Health</td>
</tr>
<tr>
<td>Lisa Hoddinott</td>
<td>VP Information and Quality</td>
</tr>
<tr>
<td>Devon Goulding</td>
<td>VP Financial and Support Services</td>
</tr>
<tr>
<td>Catherine McDonald</td>
<td>VP Health Protection and Professional Practice, Chief Nursing Officer</td>
</tr>
<tr>
<td>Tara Pye</td>
<td>Regional Director of Communications (Acting)</td>
</tr>
</tbody>
</table>

Catchment Area

- The Western Regional Health Authority extends from Port aux Basques on the southwest coast east to Francois, northwest to Bartlett’s Harbour and on the eastern boundary north to Jackson’s Arm. There are 77,816 residents in the Western region (Dept. of Finance, Economic Research and Analysis Division, January 2015) which represents a total population of 14.8% of the province.
- The corporate headquarters for Western Health is located in Corner Brook.

Regional Institutional Based Services

Western Health provides acute and long term care services in 10 health facilities – 2 hospitals, 4 rural health centres, 2 long term care homes, 1 addictions treatment facility and protective community residences that provide housing and support for 40 individuals with mild to moderate dementia in a residential homelike setting.

Primary Care Services

Western Health provides services by physicians, and/or nurse practitioners in 26 medical clinics throughout the region.
Regional Community Based Services
Community based services in the western region include Health Promotion and Primary Health Care, Community Health (Public Health, Chronic Disease Prevention and Management, Diabetes, and Community Rehabilitative Services), Mental Health and Addictions Services, Community Support (Home Support, Acute Home Nursing, Continuing Care, Adult Protection, Special Assistance), Health Protection, Communicable Disease Control, Environmental Health, and Cervical Screening Initiative. These services are offered primarily by social workers, nurses and other allied health professionals.

Nursing Undergraduate Education
Western Regional School of Nursing (WRSON) offers Memorial University’s Bachelor of Nursing Program including the 4 Year Option and the 2 Year Fast Track Option. The School is one of three partner schools in Newfoundland in a consortium arrangement offering university level education. There are currently 232 full-time students enrolled at the school. WRSON is an accredited and approved School of Nursing through the Canadian Association of Schools of Nursing (CASN) and the Association of Registered Nurses of Newfoundland and Labrador (ARNNL), respectively.

Western Health - Financial Position
2014-15
- Western Health had a 2014-15 original Provincial Plan Revenue budget of $282,570,200.
- Western Health had a balanced budget as per the Statement of Operations at March 31, 2015.
- Western Health has an accumulated operating deficit to March 31, 2015 of $11.4 million.

2015-16
- Western Health has a 2015-16 original Provincial Plan Revenue budget of $303,012,400.
- Based on second quarter operating results the health authority is projecting an annual operating deficit of $1.6 million to March 31, 2016.

Western Health - Capital Infrastructure
- From 2003-04 to 2014-15, over $215 million has been allocated for health care infrastructure which includes new construction, capital equipment and repairs and renovations in Western Health.
### Western Regional Health Authority
#### Facilities Profile

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers (March 31, 2015)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Memorial Regional Hospital</td>
<td>Corner Brook</td>
<td>217</td>
<td>Primary and secondary services to the residents of the region. Services include: General Surgery, Ophthalmology, Orthopedics, Urology, Psychiatry, Cardiology, Internal Medicine, Obstetrics and Gynecology, Mental Health, Palliative Care, Neurology, Pediatrics, ENT, Nephrology, Dermatology, Gastroenterology, Anesthesiology, Otolaryngology, Colposcopy, Vascular and Dental surgery, Cardiopulmonary services, Endoscopy, Psychiatry, Diagnostic and Laboratory services, Nutritional services. Bed numbers include 166 acute care, 35 Alternate Level of Care, 8 rehabilitation and 8 palliative care beds.</td>
</tr>
<tr>
<td>Sir Thomas Roddick Hospital</td>
<td>Stephenville</td>
<td>44</td>
<td>Primary and limited secondary services in General Surgery, Medicine, and Ophthalmology. Bed numbers includes 44 medical surgery beds.</td>
</tr>
<tr>
<td><strong>Health Centres</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Charles L. LeGrow Health Centre</td>
<td>Port aux Basques</td>
<td>14, 30, 0</td>
<td>Primary care, acute inpatient care, long term care, emergency and outpatient clinics, basic laboratory and x-ray services and outpatient dialysis. LTC includes 30 long stay beds. The facility also offers a seniors day</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (March 31, 2015)</td>
<td>Services Provided</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------</td>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Calder Health Centre</td>
<td>Burgeo</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Bonne Bay Health Centre</td>
<td>Norris Point</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Rufus Guinehard Health Centre</td>
<td>Port Saunders</td>
<td>7</td>
<td>22</td>
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</table>

**Long Term Care Homes**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Community</th>
<th>Bed Numbers</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corner Brook Long Term Care Home</td>
<td>Corner Brook</td>
<td>14 Rest. Care</td>
<td>236</td>
</tr>
<tr>
<td>Protective Community Residences</td>
<td>Corner Brook</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Bay St. George Long Term Care Centre</td>
<td>Stephenville Crossing</td>
<td>0</td>
<td>114</td>
</tr>
<tr>
<td>Facility</td>
<td>Community</td>
<td>Bed Numbers (March 31, 2015)</td>
<td>Services Provided</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------</td>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Addictions Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humberwood Treatment Centre</td>
<td>Corner Brook</td>
<td>10</td>
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</tr>
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</table>

Total |            317 | 474 | 0 | 791 |
<table>
<thead>
<tr>
<th>Position</th>
<th>Appointee / Represents</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Mr. Michael J. O'Keefe</td>
<td>Board of Trustees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c/o Eastern Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Executive Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1 - Room 1345</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Sciences Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prince Philip Drive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>St. John's, NL A1B 3V6</td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Frank Ryan</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Robert Andrews</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Leslie O'Reilly</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Bill McCann</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Barbara Cribb</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. William Abbott</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Cynthia Goff</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Shirley Rose</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Sister Sheila O'Dea</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Sharon Forsey</td>
<td>St. John's</td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Maurice J. Tuff</td>
<td>Mount Pearl</td>
</tr>
<tr>
<td>Trustee</td>
<td>Dr. Peter Ford</td>
<td>Moncton, NB</td>
</tr>
<tr>
<td>Position</td>
<td>Appointee / Represents</td>
<td>Address</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Chair</td>
<td>Mr. John George</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Rick LeDrew</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Gerard O'Brien</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Marjorie Gaulton</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Rhonda Byrne</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. David Dove</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Derm Flynn</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Ms. Valerie Hoskins</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Donald Sturge</td>
<td></td>
</tr>
<tr>
<td>Trustee</td>
<td>Mr. Dave Brown</td>
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<td>Trustee</td>
<td>Mr. Bill O'Reilly</td>
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<tr>
<td>Trustee</td>
<td>Ms. Yvonne Bradbury</td>
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<tr>
<td>Trustee</td>
<td>Mr. Samuel Saunders</td>
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</table>
## Western Regional Health Authority
### Board of Trustees Listing

<table>
<thead>
<tr>
<th>Position</th>
<th>Appointee / Represents</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Mr. Anthony Genge</td>
<td></td>
</tr>
<tr>
<td>Vice Chair</td>
<td>Mr. Tom O'Brien</td>
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<tr>
<td>Trustee</td>
<td>Mr. Don Fudge</td>
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<td>Trustee</td>
<td>Mr. David Kennedy</td>
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<td>Trustee</td>
<td>Ms. Regina Warren</td>
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<td>Trustee</td>
<td>Ms. Sonia Lovell</td>
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<td>Trustee</td>
<td>Mr. Richard Parsons</td>
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<td>Trustee</td>
<td>Mr. Ralph Rice</td>
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<td>Trustee</td>
<td>Mr. Colin Short</td>
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<tr>
<td>Trustee</td>
<td>Dr. Tom Daniels</td>
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<tr>
<td>Trustee</td>
<td>Mr. Brian Hudson</td>
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<tr>
<td>Trustee</td>
<td>Mr. Sheldon Peddle</td>
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<tr>
<td>Position</td>
<td>Appointee / Represents</td>
<td>Address</td>
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<tr>
<td>Chair</td>
<td>Mr. Raymond Norman</td>
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<tr>
<td>Trustee</td>
<td>Ms. Trudy Baikie</td>
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<tr>
<td>Trustee</td>
<td>Mr. Andrew Robertson</td>
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<tr>
<td>Trustee</td>
<td>Ms. Iris Decker</td>
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<td>Trustee</td>
<td>Ms. Gloria Toope</td>
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<td>Trustee</td>
<td>Ms. Mary Abbass</td>
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<td>Trustee</td>
<td>Mr. Rick Pelley</td>
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<td>Trustee</td>
<td>Mr. Todd Hedderson</td>
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<tr>
<td>Trustee</td>
<td>Mr. Hedley Ryland</td>
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<tr>
<td>Trustee</td>
<td>Ms. Lori O'Brien</td>
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s. 40(1)
Overview

• Upcoming Intergovernmental Calendar
  – PT / FPT DM Meetings
  – PT / FPT Health Ministers’ Meeting Jan 19-21 Vancouver
  – Potential Atlantic Ministers’ Meeting?

• Atlantic Regional Cooperation
Ministers/Deputy Ministers of Health Forum

- Ongoing work also direction from Premiers through the Council of the Federation (COF) and Health Care Innovation Working Group (HCIWG).

- BC currently chairs the PT forum and co-chairs the FPT forum with Health Canada. SK assumes the lead province role in January 2016.

- PT DMs hold monthly conference calls.

- PT/FPT DMs meet twice a year usually in June and December. Most recent meeting - December 8 & 9, 2015 in Toronto, ON.

- PT/FPT Ministers meet on an ad hoc basis via conference call and have annual meetings. Next meeting scheduled for January 19-21, 2016 in Vancouver, BC. Next meeting likely in fall in SK.
Council of the Federation (COF)

- Established in 2003.
- Comprised of Canada’s 13 provincial and territorial Premiers.
- Its objectives are to:
  - Promote interprovincial-territorial cooperation and closer ties between Premiers;
  - Foster meaningful relations between governments;
  - Show leadership on issues important to all Canadians;
  - Enables Premiers to work collaboratively by fostering a constructive relationship among the provinces and territories, and with the federal government; and
  - Supported by a small Secretariat located in Ottawa.
- Meet at least annually and additionally as required.
- In July 2015, NL (Municipal and Intergovernmental Affairs) assumed the lead province role; role rotates annually.
Health Care Innovation Working Group (HCiWG)

- Established in 2012 as a key intergovernmental mechanism for provinces and territories to advance health care innovation.
- Currently co-chaired by the Premiers of ON and YK and includes all PT Health Ministers.
- At the July 2013 COF meeting, Premiers extended the mandate of the HCiWG to 2016 and directed focus on: pharmaceuticals, appropriateness of care and seniors care.

s.29(1)(a), s.34(1)(a)
Aboriginal Health

- Prominent agenda item for Health Ministers meeting in January 2016.
- PTs interested in federal government’s vision for Aboriginal Health.
- Government responses to recommendations and findings of Truth and Reconciliation Commission.
- In NL this will involve collaborating with regional, community and Aboriginal partners to advance the process of reconciliation.
- Federal Minister of Indigenous and Northern Affairs lead on a number of matters related to indigenous health.
- Pending approval, FPT Working Group to develop a background paper outlining the current “lay of the land”, including:
  - structures currently in place in each province and territory; and
  - key issues in each province and territory, related to indigenous health.
- The Working Group will also examine:
  - supporting better transitions/transition points - data and surveillance, cultural safety practices; and better coordination of services; and
  - mental health.
Atlantic Regional Collaboration

Atlantic Health Sector

- NS current Atlantic lead (as of July 2015).
- Atlantic Health Ministers last met August 2015.
- No regular meeting schedule.
- Project Management virtual office established.

Council of Atlantic Premiers (CAP)

- Established in May 2000. Comprised of the four Atlantic Premiers.
- Promotes collaboration among the four Atlantic provinces.
- Meets annually and additionally as required.
- Last CAP meeting - June 2015. Next meeting Dec 16th.
Other Key Files

**Physician Assisted Dying (PAD)**

- Supreme Court decision striking down the prohibition effective February 2016. Federal government has recently requested a 6-month extension.

- Federal External Panel announced in July 2015
  - FPT working group established to link Federal Panel with PTs.

- PT Expert Advisory Group (EAG)
  - Led by Ontario
  - Final Report received.
  - Discussions ongoing about public release.
  - PT ADM Working Group established to keep PTs informed.

- Separate presentation to Ministers of SWSD, JPS and HCS.
Other Key Files cont’d

**Federal Advisory Panel on Health Care Innovation**

- Established June 24, 2014. Dr. David Naylor Chair.

- Mandate: “identify the five most promising areas of innovation that have the potential to sustainably reduce growth in health spending while improving quality and accessibility of care, and recommend the five ways the federal government can support innovation in the areas identified above.”

- Final report - “Unleashing Innovation: Excellent Healthcare for Canada,” was released on July 17, 2015.
Other Key Files cont’d

- CAP Directed Atlantic Ministers of Health to enhance efforts for increased collaboration on:
  - joint procurement of medical equipment and pharmaceuticals, including generic drugs;
  - rural health care delivery;
  - adolescent mental health; and
  - drugs - to explore ways to help those without medical insurance have access to the medication they require.

- Atlantic DMs established a Project Management Office (1/2 FTE allocated in each Atlantic jurisdiction) to focus on short-term priority areas, including:
  - Procurement;
  - Physician fee codes;
  - Canadian Medical Protective Association (CMPA);
  - Pharmaceuticals; and
  - Opioid Monitoring.
Thank you
Strategic Issues and Directions

This note outlines the strategic issues and directions as published in the Department of Health and Community Services Strategic Plan 2014-2017. The Strategic Plan can be found in Binder 2.

Strategic Issues
These three strategic issues form the primary focus of the Department’s three-year Strategic Plan. They identify the areas that will be of particular focus for the health and community services system over the next three years. This plan was tabled in the House of Assembly on June 30, 2014.

Under the Transparency and Accountability Act, the Department’s strategic plan is tabled every three years and the Department must report annually on its performance in meeting the targets outlined in this plan. Any variances in performance must be explained publically.

1. Population Health:
The Department’s approach to population health reflects the belief that being free from illness is only one indicator of an individual’s overall health and well-being. By providing services and supports across the life course and across all areas of health care (from prevention and promotion to health protection, diagnosis, treatment and care) the Department aims to influence the social, economic, physical and environmental conditions that shape the health of the population and help individuals achieve optimal health and well-being.

2. Access to Priority Services:
Access to services is not only about increasing the number of services available but also improving existing services to ensure they are meeting the needs of patients and clients. It is about measuring existing programs, policies and services and taking action to ensure they are adequately servicing the people they were meant to serve.

3. Quality of Care and Efficiency:
Health care accounts for approximately 40% of the provincial budget and costs continue to rise with new equipment, new treatments, and new resources. Without a change in approach, health care will continue to consume a greater proportion of the provincial budget. While residents continue to receive top quality care, the Department must work to prepare the health and community services system to ensure it is sustainable for future generations. Quality of care and efficiency are inter-connected. Efficiency can mean more streamlined processes for improved patient care and also for cost-savings. All these actions are important measures for the Department to remain accountable to the people of Newfoundland and Labrador.
Strategic Directions
Strategic directions summarize the outcomes desired for the health sector. They normally require action by or involvement of, more than one government entity and have been communicated to entities that plan and report in collaboration with the Department.

Strategic Direction 1: Population Health
Outcome: Strengthened population health and healthy living

Population health refers not just to the health "status" of the population, but to the ability of people to adapt and respond to various aspects of life. Health is affected by many factors such as social, economic, physical and environmental conditions. A population health approach encompasses a range of services and supports that can help individuals, families and communities experience the best outcomes possible.

Initiatives that focus on social and emotional well-being, the prevention of illness and injury, as well as initiatives to support people in managing and maintaining their own health and lifestyle, form a solid foundation for addressing population health. The following focus areas target the key factors impacting population health in Newfoundland and Labrador: aboriginal health, cancer care, chronic disease management, healthy aging and healthy living.

Strategic Direction 2: Access
Outcome: Improved accessibility to programs and services meeting the current and future needs of individuals, families and communities, particularly those most vulnerable.

Making the appropriate services available at the appropriate place and time is the defining feature of accessible health and community services. Striking the right balance between fiscal abilities and planning for equitable access is the key challenge. Together with stakeholders, the Department engages in reviews and consultations to determine how and what services should be delivered to maximize access.

The following focus areas for the health and community services sector address priority needs in the province and also target primary and community services that can reduce the need for more intensive and costly acute care interventions for individuals: e-health, infrastructure, long term care and community supports, mental health and addictions, pharmacare initiatives-NLPDP plans, rural health and wait times.

Strategic Direction 3: An Accountable, Sustainable, Quality Health and Community Services System
Outcome: Improved performance and efficiency in the health and community services system to provide quality services that are affordable and sustainable.
Currently, approximately 40% of the provincial budget is spent on health care. The budget has almost doubled since 2003/04 to its current level of $3 billion. The growth in health care spending can be attributed to a number of factors including the aging of our population, geographical layout of the province, new and more expensive treatments, increased incidence in chronic disease and increased health provider costs. These demands and growth characteristics require the Department, in partnership with the Regional Health Authorities, to work together to address cost containment and sustainability through innovation and the adoption of consistent evidence informed service delivery approaches.

Through a renewed focus on collaboration, innovation and best practices, health and community services will become more efficient. Improved efficiency means sustainable costs over the long term and the delivery of quality services in a more effective manner to better meet the needs of individuals, families and communities. The focus areas of this strategic direction are: clinical efficiency review, evaluation of legislation, policies, programs and services, evidence informed research in health and other related areas, health emergency management, health workforce planning, operational improvement plans and quality and safety.
Overview of Major
Health and Community Services Strategies

The following describes and provides the status for the major strategies either released by the Department since 2005 or under development.

1. **Mental Health and Addictions Policy Framework: Working Together for Mental Health**
   **Status:** Released 2005

   This framework sets out a comprehensive strategy for the mental health and addictions system that encompasses all age groups and the full continuum of mental health and addictions services. Five policy directions have been endorsed by the partners in the system. These include: Enhancing prevention and early intervention; Involving consumers and significant others; Building bridges for better access; Providing quality mental health and addictions services; and, Demonstrating accountability. The current Mental Health and Addictions Strategy is undergoing revisions.

2. **Long-Term Care and Community Support Services Strategy**
   **Status:** Released June 2012

   The Long-Term Care and Community Support Services (LTC CSS) System provides services to seniors, adults and children with disabilities, and individuals requiring professional services while at home or following hospitalization. It includes services provided in the home, residential options, personal care homes and long-term care facilities. The LTC CSS system is challenged with societal and demographic changes compounded by an increase in the prevalence of chronic disease. The strategy focuses investments in areas that will keep people healthy; enhance home and community based services; and, delay or prevent institutional placement. It identifies five priority directions that will be focal points for transforming the LTC CSS system: Healthy Living and Wellness, Person-centered Service, Family and Informal Caregiving Support, Quality Services and Service Delivery and System Sustainability. Province-wide consultations were held to give input on the strategy in 2010.

3. **Hip and Knee Joint Replacement Surgery Wait Times**
   **Status:** Released 2012

   This 5-year strategy identifies five goals which will focus on: shortening the wait time and improving coordination of the initial orthopedic assessment (Wait 1) and the services required by patients before and after hip and knee joint replacement surgeries are performed; improving the efficiency of hospital services associated with providing joint replacement surgeries; reducing the backlog of patients waiting for joint replacement; improving the collection and use of wait time data for joint replacement; and, reducing the number of patients who require joint replacement in the longer term.
NL was recognized in a national Canadian Institute for Health Information (CIHI) report, *Wait Times for Priority Procedures*, released in March 2013. The report highlighted that NL was one of only two provinces to show improvements over three years (2010 to 2012) in meeting joint replacement benchmarks. A key driver of this improvement was noted to be the province’s hip and knee joint replacement wait time reduction strategy, and the increased funding to complete additional joint replacements.

A national report released by the Wait Time Alliance in June 2013, showed that Newfoundland and Labrador is the best in Canada for priority wait times. The report also acknowledged the strategy which resulted in this province being one of two provinces to receive an A grade for wait times for knee replacement.

4. **Strategy to Reduce Emergency Department Wait Times**
   **Status:** Released 2012
   This 5-year strategy identifies five goals which will focus on: improving the efficiency of high volume emergency departments; improving access to community-based health services that will support effective utilization of emergency departments; implementing a province-wide standard for patient triage and wait times to receive initial medical attention; improving the collection, reporting and use of emergency department wait time data; and, improving communication with patients and the public regarding emergency department wait times.

5. **Strategic Health Workforce Plan**
   **Status:** Released 2015
   Released on July 20, 2015, this 4-year strategy supports the provision of sustainable, high-quality health services for NL residents through stabilization of the health workforce. The plan focuses on the workforce of the four regional health authorities consisting of about 19,000 people. Labour costs are about 65 per cent of health expenditures, therefore about 24 cents of every dollar spent by the Provincial Government is health workforce-related. The plan includes five strategic directions, 15 goals and 38 potential actions.

   The Strategic Health Workforce Plan covers the period of 2015 to 2018 and was approved to be implemented using the existing budget of the Health Workforce Planning Division in the Department of Health and Community Services, with annual activities being prioritized by a Provincial Workforce Planning Steering Committee and approved by the Minister of Health and Community Services.

6. **Strategy for Primary Health Care**
   **Status:** Released 2015
   Released on October 27, 2015, the Primary Health Care Framework was driven by a need to address the lack of a standardized approach to primary health care (PHC) in NL, a lack of inter-disciplinary PHC teams, an aging population, poor population health and cost sustainability. Since 2002-03, health care spending has doubled from $1.5B to almost $3B in 2015-16. Also, NL spends approximately 30 per cent more per person on health care than the Canadian average. The Primary Health Care Framework covers the period of 2015-2025.
The Primary Health Care Framework was developed by the Department of Health and Community Services in collaboration with the Primary Health Care Advisory Committee which is comprised of two citizen representatives and representatives from various health professional associations, post-secondary institutions, all regional health authorities and other government departments/agencies. A jurisdictional scan reveals the new framework brings NL in line with other provinces and territories who have already taken measures to reform primary health care.
CAPITAL SPENDING OVERVIEW

Department of Health and Community Services

- The Department of Health and Community Services have essentially three "capital" funding sources:
  o Major Capital Projects
    - Funding for New Construction and Major Redevelopment projects
    - Costs generally in excess of $1M
    - Estimates Activity – 3.2.02 – Health Care Facilities
  o Repairs and Renovations
    - Funding for repair and renovations projects to existing facilities
    - Costs generally less than $1M
    - Estimates Activity – included in 3.1.01 – Regional Health Authorities and Related Services
  o Equipment
    - Funding for purchases of Health Care Equipment
    - No cost parameters
    - Estimates Activity – 3.2.01 – Furnishings and Equipment

- Major Capital Projects
  o Projects are managed by either Transportation and Works (TW), or the respective Regional Health Authority (RHA)
    - Although not exclusive, TW generally manages the larger new construction projects while the RHA’s manage the smaller construction and redevelopment projects

- Repairs and Renovations
  o Projects are managed by the RHA’s
  o During each Budget process, each of the RHA’s submit to the Department a listing of their top 30 most urgent/critical repair and renovation projects.
  o Once the Department is informed of its approved Repair and Renovation budget for the fiscal year, officials at the Department make tentative recommendations on funding allocations which are then reviewed/approved by the Minister.
  o The RHA’s are then informed of the approved projects and the funding is advanced to them on a quarterly basis.

- Furnishings and Equipment
  o Equipment purchases are managed by individual RHA.
  o During each Budget process, each of the RHA’s submit to the Department a listing of their top 60 most urgent/critical equipment requirements.
  o Once the Department is informed of its approved Furnishings and Equipment budget for the fiscal year, officials at the Department make tentative recommendations on funding allocations which are then reviewed/approved by the Minister.
  o The RHA’s are then informed of the approved equipment purchases and the funding is advanced to them on a quarterly basis.
CAPITAL SPENDING OVERVIEW

Department of Health and Community Services

Major Infrastructure Projects:

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<tr>
<th>Project Description</th>
<th>2015-16 Budget</th>
<th>Project Total</th>
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<tr>
<td>Carbongear Long Term Care Facility</td>
<td>$17,304,200</td>
<td>$107,223,200</td>
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<td>Molecular Imaging Facility</td>
<td>$16,631,300</td>
<td>$30,500,000</td>
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<td>Corner Brook Acute Care</td>
<td>$9,600,000</td>
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<td>HV-GB LTC Extension</td>
<td>$5,767,000</td>
<td>$8,787,000</td>
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<td>HSC Electrical Substation</td>
<td>$5,400,000</td>
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<td>HSC Emergency Generators</td>
<td>$4,600,000</td>
<td>$4,600,000</td>
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<td>CNHRC Redevelopment (GF-W)</td>
<td>$3,800,000</td>
<td>$11,655,000</td>
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<td>HSC MDR Redevelopment</td>
<td>$3,000,000</td>
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<td>Green Bay Health Centre (Springdale)</td>
<td>$2,300,000</td>
<td>$18,262,000</td>
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<td>Clarenville Dementia Bungalow</td>
<td>$1,270,800</td>
<td>$2,300,000</td>
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<td>CNHRIC Lab Redevelopment (GF-W)</td>
<td>$1,200,000</td>
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<td>Adult Addictions Centre (Hr. Grace)</td>
<td>$964,900</td>
<td>$6,775,000</td>
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<td>Integrated OR’s (HSC &amp;SCM)</td>
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<td>Labrador West Health Centre</td>
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<td>Burin Dementia Bungalow</td>
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<td>Flower’s Covt Health Centre</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$73,672,600</strong></td>
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Funding included in DTW Planning Block:

- St. John’s Acute Care Master Plan: $1,000,000
- St. Patrick’s Mercy Home Study: $250,000

**TOTAL**: $1,250,000

Repairs & Renovations: 2015-16 Allocation - $20,000,000

- Eastern - $8,385,000 (approved)
- Central - $7,206,000 (approved)
- Western - $490,000 (approved)
- Lab-Grenfell - $1,000,000 (approved)
- Faculty of Medicine - $782,700 (approved)
- Contingency - $2,136,300 (remaining)

Equipment: 2015-16 Allocation - $40,000,000

- Eastern - $19,098,400 (approved)
- Central - $4,395,100 (approved)
- Western - $3,194,400 (approved)
- Lab-Grenfell - $1,420,300 (approved)
- Faculty of Medicine - $250,000 (approved)
- NLCH - $200,000 (approved)
- Foundations - $650,000 ($495,000 spent, $155,000 remaining)
- PET Scanner / Cyclotron - $4,936,500 (approved)
- Contingency - $5,855,300 (remaining)
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<th>Organization</th>
<th>Rationale</th>
<th>Proposed Agenda Topics</th>
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<tr>
<td>Association of Registered Nurses of NL (ARNNL)</td>
<td>ARNNL is a key stakeholder in relation to the following issues: (1) Government has been working towards enhanced primary health care with increased utilization of Nurse Practitioners (NPs), ARNNL regulates NPs; (2) In January 2015, a new national registered nursing exam was introduced in Canada, NCLEX. There has been a higher failure across the country, including NL. ARNNL was involved in the national committee overseeing the implementation of the N-CLEX; and (3) The 2005 White Paper on Public-Post-Secondary Education recommending discussions toward implementing a model to see the administration of nursing education within Memorial University. This issue has recently been in the media.</td>
<td>• Nurse Practitioners                                                                                  • National Exam change to adopt NCLEX</td>
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<td>• Nursing School consolidation under MUN</td>
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<td>Canadian Union of Public Employees</td>
<td>CUPE has expressed concerns with the new Shared Services organization and the impact on staff.</td>
<td>• Shared Services Organization                                                                         • Collective agreement expires March 31, 2016</td>
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<td>College of Physicians and Surgeons of NL</td>
<td>An Agreement on Internal Trade (AIT) has been accepted by all provinces. This agreement has implications on the licensure of physicians and service delivery in NL. It provides properly licensed physicians portability/mobility across the country. The College has established requirements for the supervision and monitoring of provisionally licensed physicians</td>
<td>• Recruitment/Retention International medical graduates                                                  • Monitoring of provisionally licensed physicians</td>
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**Contact Information:**
- Lynn Power, Executive Director
  lpower@arnnl.ca
  753-6173

**Contact Information:**
- Wayne Lucas, President
  wlucas@nl.rogers.com
  753-0732

**Collective Agreement Expiration:**
- CUPE – March 31, 2016
- CUPE Group Home and Transition Houses - expires June 30 2016
<table>
<thead>
<tr>
<th>Organization</th>
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<th>Proposed Agenda Topics</th>
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| Community Coalition 4 Mental Health       | This organization will be very proactive in connecting with the Premier early in the mandate.                                                                                                             | • The Coalition’s mandate  
• Plans for the future  
• Provide an overview of the work they are doing overall |
| Faculty of Medicine                        | Training meeting the service needs of province both in primary care and specialist care.                                                                                                                 | • Training needs for NL                                                                                       |
| Newfoundland Association of Ambulance Services (NAAS) | Contract negotiations have broken off over an issue with the Return Transfer Policy contract language. The NAAS has asked for a revision to the Return Transfer Policy language that is in direct conflict with the Return Transfer Policy language that the Minister has signed for the NL Community Ambulance Operator Association (NLCAOA) and the NL Private Ambulance Operator Association (NLPAOA). | • Contract negotiations (Return Transfer Policy conflict)  
• New MOA                                                                                                     |
| Newfoundland and Labrador Association of Public and Private Employees | NAPE is campaigning against privatization in health care. NAPE has advocated on behalf of its paramedicine members regarding resource issues including concerns regarding the number of red alerts throughout the province. The other issues identified are labour relation issues which have been ongoing for some time. | • Privatization of health care  
• Attrition reductions  
• Negotiations  
• Trades Workers and contracting out  
• Shared Services  
• Paramedicine and Medical Transport  
• Causal employment versus permanent  
• Attendance Management |
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<tr>
<th>Organization</th>
<th>Rationale</th>
<th>Proposed Agenda Topics</th>
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| Newfoundland and Labrador Medical Association – Robert Thompson, Executive Director and President Jonathan Greenland | Key figures in medical practice issues. NLMA has been supportive of the movement towards the primary health care model. Government has been working towards enhanced primary health care with increased utilization of Nurse Practitioners (NPs) which included using NPs in areas where there were physician vacancies. The Clinical Stabilization Fund (CSF) is a jointly-controlled fund that was negotiated as part of the 2009 Memorandum of Agreement. This one-time funding is segmented across priority areas, including primary health care renewal. The CSF Management Committee recently had a call for proposals from members interested in undertaking projects or initiatives that will inform and advance primary health care renewal in the province and establish new patterns of practice. | - Implementation of the Primary Health Care Strategy  
- Electronic Medical Records  
- Planning for regional and provincial health services |
| Pharmacists’ Association of NL                  | They have been active in terms of meeting with the Minister of HCS regarding issues of scope of practice, compensation and market adjustments, health care efficiencies. Also, HCS issues with Memorial University entry-to-practice change to PharmD. Furthermore, our four year agreement with PANL expires in March 2016, and they have been pressing government to begin negotiations. | - Contract negotiations  
- Scope of Practice  
- Compensation and market adjustments  
- Health care efficiencies  
- Memorial University entry-to-practice change to PharmD |

**Contact Information:**

Jerry Earle, President  
jeearle@napec.ca  
754-0700

**Collective Agreement Expiration:**

NAPE-HP, NAPE-HS, NAPE-LX - March 31, 2016  
NAPE Group Homes – June 30, 2016

**Contact Information:**

Robert Thompson, Executive Director  
rthompson@nlma.nl.ca  
726-7424

**Contact Information:**

Glenda Power, Executive Director  
gpower@panl.net  
753-7881 (ext. 203)
<table>
<thead>
<tr>
<th>Organization</th>
<th>Rationale</th>
<th>Proposed Agenda Topics</th>
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</thead>
<tbody>
<tr>
<td>Provincial Advisory Council on Mental Health and Addictions</td>
<td>Mental health and addictions issues have been prevalent across the province and have gained a substantial amount of media attention in recent months. This organization represents multiple stakeholder groups and provides advice to government on mental health and addictions issues. Given the</td>
<td>• Various issues relating to mental health and addictions across the province</td>
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</table>
| Registered Nurses Union of Newfoundland and Labrador | A nursing Forum was held on October 30th and raised many issues and potential solutions. Some issues raised include:  
  • Attendance and relief  
  • Core staffing  
  • Quality of work life/workplace culture  
  • Stress/mental health of staff access to management/leadership  
  • Recruitment and retention  
  • Non-nursing duties | • Outcomes of October 30th Nursing Forum  
• Negotiations  
• Privatization of health care  
• Vacancies  
• Casual versus permanent employment  
• Primary healthcare  
• Violence Prevention  
• Absenteeism |
| Regional Health Authorities | Health care accounts for 40% of the provincial budget, a large portion of this budget goes to the Regional Health Authorities. It is important that the RHAs have a discussion with the Premier to gain of sense of his vision regarding the types of services and location of services within this province, given the current fiscal environment. | • Service delivery |

**Contact Information:**

Sheldon Pollett, Interim Chair  
spollett@choicesforyouth.ca  
754-3047

**Contact Information:**

Debbie Forward  
President  
dforward@rmunl.ca  
753-9961

**Collective Agreement Expiration:**  
RNUNL – June 30, 2016

**Contact Information:**

David Diamond, CEO, Eastern Health  
777-1301  
Rosemarie Goodyear, CEO, Central Health  
292-2138  
Susan Gillam, CEO, Western Health  
637-5000 Ext. 5245  
Tony Wakeham, CEO, Labrador-Grenfell Health  
897-2349
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<th>Department/Agency Responsible</th>
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<td>Reduce health care wait times through better prevention and management</td>
<td>27-Oct-15</td>
<td>Social Media Announcement</td>
<td>HCS</td>
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<td>Will not privatize any health care, including long-term care</td>
<td>28-Aug-15</td>
<td>Media Interview</td>
<td>HCS</td>
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<td>Replace the Waterford Hospital</td>
<td>21-Nov-15</td>
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<td>Initiate a Dementia Management Program to improve support and coordinate care for our citizens with dementia</td>
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<td>Implement regulated midwifery</td>
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<td>Develop and implement a mental health and addictions strategy to strengthen mental health and addictions care and raise awareness</td>
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<td>Construct a West Coast Regional Hospital</td>
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<td>Develop a comprehensive plan to expand health professionals scope of practice: conduct a thorough legislative review to identify ways to allow health care professionals to work to their full scope of practice</td>
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<td>Prevention and Management Program with RHAs and their primary health care</td>
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<td>Review current health outcomes and set measurable goals for future</td>
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<td>Provide support to NLCHI, in consultation with the NLMA, to complete the</td>
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<td>Review all mental health legislation to ensure the province is keeping</td>
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<td>Strengthen policies to demonstrate the importance placed on mental health</td>
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<td>Work in consultation with stakeholders to establish an adult inpatient</td>
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<td>Conduct Healthy Living Assessments for Seniors 70 and up</td>
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<td>Develop a home support system for seniors that is flexible and</td>
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<td>Improve transportation options for seniors and a more modern Medical</td>
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<td>Eliminate use of IQ+70 to determine service needs and provision of</td>
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<td>Ensure a more coordinated, integrated and responsive approach across departments and agencies when addressing mental health and addictions needs</td>
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<td>Regional Healthcare Delivery</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
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<tr>
<td>Work with community partners and schools to ensure coordinated and seamless approaches to mental health and addictions issues</td>
<td>21-Nov-15</td>
<td>Election Platform</td>
<td>HCS</td>
<td>Regional Healthcare Delivery</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
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<tr>
<td>Encourage and support employers to assist employees who are coping with mental health and addictions issues</td>
<td>21-Nov-15</td>
<td>Election Platform</td>
<td>HCS</td>
<td>Labour Relations</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
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<td>Develop a comprehensive autism strategy</td>
<td>21-Nov-15</td>
<td>Election Platform</td>
<td>HCS</td>
<td>Regional Healthcare Delivery</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
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<td>Establish regional adolescent health clinics that offer preventative care services, sexually transmitted infections testing, treatment for acute health issues, and counselling in such areas as bullying, sexual orientation, eating disorders, and unhealthy relationships</td>
<td>17-Nov-15</td>
<td>Election Platform</td>
<td>HCS</td>
<td>Healthy Living</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>$3.5M over four years</td>
<td>X</td>
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<td>HCSS is the Supporting Department</td>
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<tr>
<td>Promote health and healthy living and develop a health promotion and healthy living strategy</td>
<td>21-Nov-15</td>
<td>Election Platform</td>
<td>SWSD</td>
<td>Healthy Living</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
<td>X</td>
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<td>Chronic Disease Prevention and Management Program: promotion of healthy eating habits through a combination of awareness campaigns and community outreach</td>
<td>21-Nov-15</td>
<td>Election Platform</td>
<td>SWSD</td>
<td>Healthy Living</td>
<td>Longer Term (Greater than 120 Days)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Commitment</td>
<td>Date</td>
<td>Source of Commitment</td>
<td>Department/Agency Responsible</td>
<td>Supporting Department/Agency</td>
<td>Policy Area</td>
<td>Timeline</td>
<td>Funding Requirement Identified by Party</td>
<td>No Funding Required</td>
<td>Cost Savings Measure</td>
<td>Machinery of Gov't Change</td>
<td>Legislative Change</td>
<td>Recommended for Future Action</td>
<td>Consultations Recommended</td>
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<td>Implement an anti-smoking program including support for organizations that offer smoking cessation programs</td>
<td>17-Nov-15</td>
<td>Election Platform</td>
<td>SWSD</td>
<td>HCS</td>
<td>Healthy Living</td>
<td>Short Term (First 90-120 Days)</td>
<td>$1M over four years</td>
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Overview

• I. Where we are
  a. Poor health status
  b. An expensive health system

• II. How we got here
  a. Challenges shared by all Canadian jurisdictions
  b. Challenges unique to NL

• III. Where to go
  a. Initiatives to date
  b. Initiatives to come
I a. Health Status

- NL has among the lowest, or the lowest, health status indicators in Canada across a wide range of indicators.
- NL has high rates of chronic disease:
  - 63% of residents have at least one chronic disease
  - NL has the second highest rate of diabetes among those aged 12+ (9.5%)
  - NL has the highest rate of obesity (29.4%).
Health Status Indicators

- NL is near or at the bottom among Canadian provinces in a number of key health status indicators

Figure A presents Canadian and provincial results relative to the OECD average, measured in standard deviations. The shaded band represents the area between the top and bottom quarters (25th and 75th percentiles) of OECD.

- Brown dots are Canadian average; Green dots NL
- Numbers indicate NL rank among Canadian provinces

Source: Canadian Institute for Health Information; Data 2013 or most recent year
I b. An Expensive Health System

Per person (public and private), projected for 2015

Provincial/territorial government health spending as percentage of budget, projected for 2014

Includes:
- $5,181 p.c. GNL
- $1,643 p.c. private
- $213 p.c. other public

Source:
National Health Expenditure Database, Canadian Institute for Health Information.
Budget Overview

- HCS is about 40% of provincial budget
- HCS budget has almost doubled from $1.6 billion in 2004-05 to $3 billion in 2015-16
- Per capita provincial spending: $5,181 (2015)
- Spending increased steadily through 80’s and 90’s; accelerated 2006-2012; relatively steady 2013 – 2015.
Where does the money go?

Department of HCS – Budget 2015-16

- RHAs: 72%
- Dept of HCS: 1%
- MCP - Physicians: 16%
- MCP - Dentists: 0.5%
- Drug program (NLPDP): 5%
- Capital: 4%
- Faculty of Medicine: 2%
Health System in NL

- Health and community services are delivered by the 4 RHAs through:
  - 13 hospitals (11 with surgical capacity); plus 2 providing specialized services – Waterford and Miller Centre
  - 23 community health centres
  - 119 community health service offices
  - 23 long term care facilities

- Within a 30-minute drive:
  - 82% of NL residents can access a 24/7 ER
  - 98% of NL residents can access community clinic
Regional Health Authorities

Overview

- Approx 62.7% of RHA budget is spent on human resources (compensation/benefits)
- Workforce of the 4 RHAs = approx. 19,000
  - More than 12,000 front line workers
    - 5,200 RNs and 2,000 LPNs;
    - 1,400 personal care attendants
    - 1,500 allied health professionals
  - Approx 6,000 support services (e.g. dietary, housekeeping)
  - Approx 1,100 managers
- RHA deficits (projected 2015-16): $54.5M
- RHA Sick Leave a major issue:
  - For 2014-15 1.9M hours taken or more than 950 FTEs
  - Costs: $51.5M in leave taken, $25.1M relief at straight time, and $8.1M in relief at overtime sick rates for a total of $84.7M
    - RNs take an average of 16.5 days per FTE
II. How we got here

a. Canadian Trends / Cost Drivers
   - Health Workforce Costs Increasing
   - Increasing Costs of Pharmaceuticals

b. NL Specific Trends / Cost Drivers
   - Our history – settlement patterns
   - Our culture – unhealthy lifestyles
   - Our economy – aging population
II a. Health Spending in Canada

- National nominal expenditure growth similar to Canada (approx. doubled in past 12 years)
- Spending is driven by physician costs and pharmaceuticals.

**How much will we spend on health in 2015?**

- **$219 billion**
- 1.6% growth
- $6,105 per person
- 10.9% of GDP

*Figure is total p.c. expenditure; NL figure is $7,036*

Source:
National Health Expenditure Database, Canadian Institute for Health Information.
Physician Costs as Share of Total Expenditures (Canada)

Sources:
National Health Expenditure Database, CIHI; Statistics Canada.

© Canadian Institute for Health Information, 2015.
II b. NL Specific Cost Drivers

i. We are aging faster than the Canadian average

ii. Our small population is spread over an enormous territory

iii. Societal factors: our eating/drinking habits and approach to non-work physical activity
But NL’s population is aging faster than Canada’s.
NL Specific Factors: Non-medical determinants of health

- NL is at or near the bottom among Canadian provinces of key determinants of health

Source: Canadian Institute for Health Information; Data 2013 or most recent year
Poor Determinants Lead to Poor Outcomes

63% of NL residents over the age of 12 have at least one Chronic Disease

Percent of Adult Population Affected in NL

- Arthritis: 22.1%
- Chronic Pain: 21.2%
- Diabetes: 9.5%
- Heart Disease: 6.3%
- Cancer: 6.3%
- Lung Disease: 5.4%
- Effect of Stroke: 3.9%
- 1.0%

... and chronic diseases lead to poorer outcomes on indicators such as cancer mortality, stroke mortality, etc.
Geography and Health Spending

- NL annually spends more per capita on health than any other province
  - First per capita on hospitals, long-term care
  
  **BUT:**
  - Fifth per capita on physicians
  - Sixth per capita on capital expenditures
  - Fifth per capita on administration
  - Seventh per capita on public health and health promotion

- To turn this vicious circle into a virtuous circle, we must invest more in public health and health promotion
Locations of Hospitals, Health Centres, and Long Term Care Facilities

Newfoundland and Labrador

Source: Department of Health and Community Services. Compiled by the Newfoundland and Labrador Statistics Agency.
Select Health Professions in NL compared to Canada (2013 data)

- NL has more core health professionals than the Canadian average:
  - 46% more registered nurses (1,149 per 100,000)
  - 16% more family physicians (126 per 100,000 - 2012)
  - 8% more specialists (114 per 100,000 - 2012)

- We have fewer than average among certain allied health professionals:
  - 24% fewer respiratory therapists (25 per 100,000)
  - 20% fewer physiotherapists (46 per 100,000)
  - 17% fewer occupational therapists (35 per 100,000)
III. Where to go from here?

- **The objective** is the Triple Aim: better health, better care, better value
- **The challenge** is how to manage growth in demand for services while optimizing quality and operational efficiency of the system.
  - How to resolve the tension between expectations (access) and resources?
  - How to improve accountabilities and performance of the health care system?
- **We can transform** our health care system to make it sustainable and improve the health of the population. It will require:
  - Change in how, where and from whom services are provided in the province
  - Comprehensive engagement and collaboration from community level upwards: residents, patients, all health professionals
Transformation to date

• RHA Operational Improvement Process
  o Focus on non-clinical operations
  s.29(1)(a), s.38(1)(b)(i)
  o Benchmarking provided comparative data
  o Initiatives for performance improvement include measures aimed at:
    ▪ human resource practices
    ▪ administrative structures
    ▪ procurement practices
Transformation to date (cont’d)

s.29(1)(a), s.38(1)(b)(i)
Transformation to date (cont’d)

- Procurement reform
  - RHA group purchasing of goods and services and Government Strategic Procurement project
  - (annual savings $7–8M)
  - National group purchasing (HealthPro and Capsource)
    - Healthpro cost avoidance ($25.8M since 2010-11; $7.3M in 14-15)

- Generic drug pricing reform
  - Reduced max price in provincial drug formulary to 25% of brand-name cost
  - Positive financial impact on RHAs, NLPDP, and individuals purchasing generic drugs
  - Savings in 14-15 compared to baseline (2011-12): $43M
Transformation to date (cont’d)

- Wait times
  - Hip and knee replacements – substantial progress
  - Emergency departments – strategy being implemented
- Ongoing work in many areas (e.g. Mental Health and Addictions)
- Ambulance Review
  - Road ambulance review complete
  - Transition Contracts signed (with all 1 assn, 15 providers)
Where to go from here?

- Shared Services
- Continue Primary Health Care Reform
Operational Improvement and Clinical Efficiency

- Operational Improvement
  - Consultant has been re-engaged to re-do benchmarking to provide more information about performance.  
    s.29(1)(a), c.38(1)(b)
Laboratory Reforms

- A formulary will identify
  - which tests are available and where,
  - who may order tests, and
  - what clinical circumstances must be present
- Will help ensure that the correct tests avoid unnecessary or inappropriate tests.

- Annual savings of $6.7M has been removed from the Fiscal Framework
Shared Services

- NL Health Shared Services Organization Incorporated October 2015
- Will consolidate a range of back-office functions:
  - supply chain management,
  - finance and payroll,
  - human resources,
  - information technology and telecommunications (ITT),
  - marketing and communications
  - NL Centre for Health Information
- Annual savings ramping up to $22.0M by 2019-20 have already been removed from Fiscal Framework.
- Estimated up to 232 FTE reduction through attrition.
- Savings do not include $40M - $58M up-front investment on ITT.
Primary Health Care Reform

- Primary Health Care is typically a patient’s first point of contact with the health care system –
- Ideally community based and engaging a mix of appropriate health professionals working at full scope of practice.
- Good PHC will keep people healthier, keep them out of hospitals, and keep physician and hospital costs down.
- NL is behind Canadian jurisdictions on PHC.
- PHC Framework Released October 2015
- HCS and key partners (e.g. NLMA, associations representing other health profs) working to develop Action Plans
- PHC vision: the right service; at the right place; at the right time
- Separate Presentation provided on this topic
Home First

- *Home First* is a strategy based on the Home Is Best philosophy: clients can access the right care, at the right time, in the right place and from the right provider.
- It facilitates
  - early discharge from acute care and
  - prevents admission from emergency departments and
  - enables patients to recover and restore in their home environment with enhanced support and restorative services
- Implemented successfully in ON, BC and NS
- Proven positive impact on:
  - timely access to community based services,
  - Alternate Level of Care patient days,
  - number of transfers from acute care to nursing homes,
  - length of hospital stays,
  - emergency room visits,
  - surgery cancellations
Other Measures

- Cost avoidance and Service Improvement measures
  - Population health initiatives/strategies
    - Separate presentation on Mental Health and Addiction
    - Program delivery for SWSD Strategies
  - NL HealthLine
    - provides access to registered nurses;
    - may decrease hospital visits
    - improve access for remote patients
  - Telehealth
    - consultations can be provided remotely
    - Utilization grown from 402 consultations in 2006-07 to 14,122 in 2014-15
  - E – Health prevention and treatment initiatives
    - E.g. Bridge the Gap
Mental Health and Addictions
December 2015
Overview

- Mental Health: A Priority
- The Facts
- Selected Milestones: 2002-2015
- Budget
- The Mental Health and Addictions System
- Need for a New Strategy
- Provincial Leadership
Mental Health: A Priority

- In order to achieve optimal health and wellness, individuals need to maintain both physical and mental health.

- Mental well-being refers to finding meaning and purpose in life through:
  - Psychological well-being (how we think);
  - Emotional well-being (how we feel); and,
  - Social well-being (how we relate).

- With good mental health and wellness people can manage emotions and behaviours, handle stress, build relationships, and lead productive and fulfilling lives.
The Facts

• 1 in 5 (100,000+) Newfoundlanders and Labradorians will experience a mental illness or addiction in any given year.

• The chance of a person developing a mental illness during the lifespan is close to 50%.

• Over 70% of mental illnesses have their onset in childhood.

• Suicide is the leading cause of death among young people.

• 60% of people with mental health issues or mental illness will not seek help – largely due to stigma.

• Mental illness and addiction cost the Canadian economy approximately $51 billion a year.
The Facts

- 500,000 employees are absent from work each week in Canada due to mental illness and addiction.

- 5.9% of people in the province have a substance abuse (alcohol and/or drug) disorder.

- Over 1,200 clients are currently receiving methadone maintenance treatment in Newfoundland and Labrador.

- NL has some of the highest rates of binge drinking in Canada.

- The 2012 Student Drug Use Survey reported that:
  - In the previous 12 months, 47% of NL youth drank;
  - 31.4% reported binge drinking in the previous 30 days; and,
  - 30% of NL students had used cannabis.
Selected Milestones: 2002-2015

Luther Inquiry (2002)
- Report based on an inquiry regarding the shooting deaths of two people living with mental illness. The inquiry played a major role in developing a provincial mental health and addictions strategy.

- Collaborative, interdepartmental partnership to develop a strategy for the management of OxyContin and other related narcotics abuse.

Working Together for Mental Health (2005)
- First provincial policy framework for mental health and addictions services in Newfoundland and Labrador.

Mental Health Care and Treatment Act (2007)
- Provides for the rights-based protection and treatment of people with severe and persistent mental illness.
Selected Milestones: 2002-2015

Mental Health Commission of Canada (2007)
- Established in 2007 with a mandate from Health Canada to improve the mental health system and change attitudes and behaviours around mental health issues.

Community Coalition 4 Mental Health (2014)
- Local coalition of community and labour groups, students and individuals working together to end stigma and raise awareness of mental health issues.

All-Party Committee on Mental Health and Addictions (2015)
- Comprised of members of the House of Assembly with a mandate to conduct a full review of the provincial mental health and addictions system to identify gaps in services and areas for improvement.
Budget

Regional Health Authorities - $100 million
- Operational funding
- Funding for community partners for mental health and addictions programs and services

Provincial Division of Mental Health & Addictions - $4.7 million
- Salaries
- Out-of-province treatment
- E-health and anti-stigma initiatives
- Drug Treatment Funding Program
- Grant funding

Community Groups - $2 million
- Core operational funding and grants for programs and services
The Mental Health and Addictions System

Continuum of Services

The mental health and addictions system requires a broad approach that extends beyond the formal mental health and addictions services and reflects the social determinants of health including access to housing, adequate income, employment and community participation.

Continuum of Services

Promotion & Prevention  Early Intervention  Treatment  Aftercare
The Mental Health and Addictions System

**Stakeholders**
- Individuals and families
- Primary health care providers
- 4 Regional Health Authorities
- Community partners:
  - Choices for Youth
  - Stella’s Circle
  - Community Mental Health Initiative
  - U-Turn
  - CHANNAL
  - Eating Disorders Foundation of NL
  - Canadian Mental Health Association-NL
  - Schizophrenia Society NL
  - Turnings
The Mental Health and Addictions System

Referrals and Admissions

• 20,000 referrals yearly
• 12,000 crisis calls yearly to the crisis line
• 3,000 admissions to inpatient mental health and addictions services yearly:
  • 15% have both mental health and addictions conditions;
  • 15% were involuntary admissions under the Mental Health Care and Treatment Act; and,
  • On over 500 occasions last year someone in NL was detained for up to 72 hours under the Act.
The Mental Health and Addictions System

Promotion/Prevention/Self-Help/Peer Support

• **New E-Health Initiatives**
  • Bridge the gAPP website and apps for youth and adults;
  • Strongest Families program children 3-17 and their families; and,
  • The BreathingRoom (13-24 years).

• **Peer Support/Warm Line**
  • 4 peer support positions and a provincial warm line (a non-emergency telephone peer support and referral service) pilot project.

• **Community-Based Primary Mental Health Services**
  • 59 counselling offices located in various communities across the province.
The Mental Health and Addictions System

Emergency Services

• Eastern Health: A Psychiatric Assessment Unit located at the Waterford Hospital provides psychiatric assessment 24 hours a day, 7 days a week.

• Mobile Crisis Response Team (St. John’s region): A team comprised of psychiatric nurses, LPNs and social workers who assist/intervene with mental health-related crisis, directly in a person’s home or community.

• Emergency Departments: Located throughout the province with mental health nurses located in Western Memorial (Corner Brook), Central Newfoundland Regional Health Centre (Grand Falls-Windsor), the Health Sciences Centre and the Janeway (St. John’s).

• Mental Health Crisis Line and the Gambling Help Line: Offer 24/7 crisis intervention services.
The Mental Health and Addictions System

Services for Acute Care Inpatient Psychiatric Services (119 beds across the province)

- **Eastern Health**: 49 adult beds at Waterford Hospital, 18 adult beds at Health Sciences Centre and 9 youth beds at the Janeway;
- **Central Health**: 20 adult beds at the Central Newfoundland Regional Health Centre in Grand Falls-Windsor; and,
- **Western Health**: 23 adult beds and 4 pediatric beds at Western Memorial Hospital in Corner Brook.

Services for Specialized Inpatient Mental Health Services (84 beds)

- **Waterford Hospital**: 84 beds for specialized mental health treatment, psychiatric rehabilitation, forensic, dual diagnosis and seniors’ mental health.
The Mental Health and Addictions System

Services for Residential Treatment

- **The Recovery Centre** (St. John’s): Inpatient withdrawal management services for ages 16 and over (19 beds)
- **Humberwood Treatment Centre** (Corner Brook): Adult addictions (10 beds)
- **The Hope Valley Youth Treatment Centre** (Grand Falls-Windsor): Specialized addictions treatment services for youth age 12-18 (12 beds)
- **The Tuckamore Centre**: Specialized treatment for youth with complex mental health needs age 12-18 (12 beds)
- **Harbour Grace Treatment Centre**: Adult addictions with opening expected in early 2016 (18 beds)
The Mental Health and Addictions System

Services for Specific Populations

- **Youth:**
  - Janeway Family Centre (St. John’s) and Blomidon Place (Corner Brook) provide specialized mental health treatment to children and youth; and,
  - The Bridges Program (St. John’s) offers urgent mental health treatment to youth.

- **Addictions Services:**
  - The Rowan Centre (St. John’s) offers adolescent day treatment addictions services for youth; and
  - Opioid Treatment (Methadone Maintenance Treatment) services offered in St. John’s, Gander, Grand Falls-Windsor and Corner Brook

- **Eating Disorders:**
  - Centre for Hope (St. John’s) offers treatment for eating disorders for adults and youth over the age of 15; the Adolescent Medicine Program through the Janeway for under age of 15.

- **Trauma:**
  - Arriva Program (St. John’s) offers specialized treatment for survivors of trauma.

- **Chronic and Persistent Mental Illness:**
  - Three Assertiveness Community Treatment Teams located in Corner Brook, Grand Falls-Windsor and St. John’s offer services for people with severe and persistent mental illness; and,
  - Community Care Supportive Housing Program in Conception Bay South

- **Geriatric Services:**
  - Geriatric Mental Health Day Treatment Program at the L.A. Miller Centre, St. John’s.
The Mental Health and Addictions System

Regional Health Authority Staff

- Over 900 staff employed in mental health and addictions programs in the RHAs. Some of which include:
  - 70 Psychiatrists;
  - 65 Psychologists;
  - 23 Youth Outreach Workers;
  - 20 Case Managers in rural areas; and,
  - 19 Mental Health Promotion and Addictions Prevention Staff

Provincial Mental Health and Addictions Staff

- Provincial Director of Mental Health and Addictions
- 4 Mental Health and Addictions Consultant positions
Need for a New Strategy

What We Heard
Summit on Health Care

- **Coordination and continuity:** Team management is important.
- **Awareness of services:** More education and open discussion on mental illness is necessary.
- **Wait times:** The wait times to access mental health care and treatment are too long.
- **Prevention and promotion:** Focus on prevention and promotion and more resources for schools.
- **Community services and supports:** More mental health services needed for stress management and youth.

All-Party Committee on Mental Health and Addictions

- **Access:** Improve access and wait times, increase investments in mental health resources and affordable and supportive housing.
- **Quality:** Provide more patient-centred care, enhance use of inter-disciplinary teams in primary health care clinics, and offer professional development and educational opportunities for staff.
- **Promotion and prevention:** Reduce stigma through education and awareness, supporting the social determinants of health, and promoting positive mental health in schools.
- **Policy and Programming:** Apply appropriate mental health and harm reduction lenses, and increase engagement opportunities with individuals with lived experience in the early stages of program development.
- **Community:** Continue to build relationships with community-based partners, and enhance the delivery of programs and services within the communities where people live and work.
Provincial Leadership

Division Priorities / Next Steps

- **Secretariat support for the All-Party Committee on Mental Health and Addictions:** Committed to reconvene by January 31, 2016, and to produce final recommendations to be tabled in the House of Assembly in 2016.

- **The development of a new Mental Health and Addictions Strategy.**

- **Stigma reduction:** *Understanding Changes Everything* public awareness campaign: Workplace Program partners to receive training in *The Working Mind*, an education-based program that focuses on mental health promotion in the workplace, in early February 2016.

- **E-health services:** Innovative e-health technologies to support mental health by offering early interventions and self-help/self-management to support wellness and recovery (Bridge the gAPP, Strongest Families and the BreathingRoom).
Provincial Leadership

Division Priorities / Next Steps

- **Addictions treatment standards and outcome monitoring**: Development and implementation of addiction treatment standards, methadone maintenance capacity building and outcome monitoring for youth with addictions (Drug Treatment Funding Program).

- **Wait times and clinical efficiency**: Monitoring wait times for program and services to enhance access and clinical efficiencies and the continued work on the provincial indicators report and standardized electronic clinical assessments.

- **Mental Health Care and Treatment Act evaluation**: Mandate to review and evaluate the Act every five years. Next review and evaluation must be completed by 2017.
Provincial Leadership

Division Identified Gaps

- Services and supports in schools (ex. counsellors & psychologists)
- Integrated services and supports for transitional aged youth (16-25 years)
- Coordinated services for people with autism
- Affordable and supportive housing
- Specialized day hospital program and inpatient program for eating disorders
- Quality mental health and addiction services in correctional settings
- Caregiver supports
- Secure care/withdrawal management legislation for youth
- Gaps in NLPDP coverage for effective treatments
Thank you
What is Primary Health Care?

- Primary Health Care (PHC) is typically a person’s first point of contact with the health care system.

- It can include interactions with providers such as counsellors, family doctors, occupational therapists, pharmacists, social workers, and others.

- PHC includes a range of community-based services and proactive health policies focused on maintaining and improving health and wellbeing.

- PHC includes a strong focus on health promotion, prevention, chronic disease management, and public health.

- Effective and efficient PHC systems are designed to respond to both individual and population health needs.
Case for Reform

- Aging population becoming sicker:
  - By 2036, 31% of population over the age of 65
  - 13 of the 20 most common chronic diseases in Canada are linked to age

- Some of the worst population health in the country
  - 63% of residents have at least one chronic disease
  - 88% of seniors have one or more chronic diseases
  - 70% of the population is overweight or obese
  - 76% of the population does not eat the recommended amount of fruit and vegetables

- We spend $5,181 per person on health care, $1,163 or 29% more than the Canadian average and more than any other province.
Case for Reform

- Evidence suggests that health systems with a strong foundation in PHC are the most effective in terms of outcomes and the most economically sustainable.
- Evidence demonstrates that proactive PHC delivered by interdisciplinary teams improves health outcomes, increases patient satisfaction, and reduces turnover.
- NL lags behind all other provinces in terms of PHC reforms initiated or completed.
- NL is one of the last provinces to introduce PHC reforms such as an electronic medical record and the establishment of formal models of team-based care.
- Local health professional groups, academics, and RHAs have identified provincial government support for PHC reform as essential to improving health outcomes.
Learning From Others

• Evidence from across Canada and abroad clearly demonstrates that higher quality care is provided in community-based interdisciplinary settings.

• Improved management of chronic disease allows people, particularly seniors, to continue living independently.

• Focusing in on complex, high cost and at-risk populations can improve return on investment.

• Lower overall health care costs come from a healthier more stable population requiring fewer acute interventions.
Past Reform Efforts

- Between 2000-2006 NL received $9.7 million in federal funding to create and implement a PHC Framework.

- Federal funding was used to establish an Office of PHC and regional PHC networks in 8 communities.

- Evaluation of the PHC networks found minimal or no improvements in health outcomes or access to local services.

- Recent data compiled by Memorial University’s PHC Research Unit demonstrates that there was no sustained improvement in health outcomes for individuals living in the 8 communities.
Learning From Past Reform

• A lack of clear focus, stakeholder unwillingness to participate, limited ability to share medical information, and provider compensation issues resulted in inadequate progress.

• Frontline workers felt the agenda was too ambitious given their limited resources.

• There was a lack of focus on the systemic changes required to enable continued reform.

• Past initiatives did not succeed in integrating family physicians and other providers such as community pharmacists and paramedics.
Learning From Past Reform

- Data sharing, inadequate coordination, and the lack of electronic medical records (EMR), a pharmacy network, or an electronic health record were major obstacles to supporting regional teams.

- Alternative compensation models necessary to allow providers to fully participate in PHC networks were never implemented.

- The new 2015 Framework takes a more incremental and collaborative approach to developing PHC reform priorities.

- A strong focus has been placed on ensuring lessons learned are incorporated.
Engagement

• Beginning in June of 2014, the department embarked upon an extensive public engagement process to determine priority areas for PHC reform.
  – November 2014 – January 2015 engagement sessions in 13 communities
  – Online feedback, phone, email, mail
  – Direct consultation with key stakeholders
  – Health Summit with 275 experts and stakeholders
  – Regular consultation with frontline RHA staff

• The engagement process provided an opportunity to develop consensus among stakeholders on the need to participate in reform efforts.
Advisory Committee

• In June of 2014 an Advisory Committee was established to aid in developing a PHC reform plan.

• The Committee was formed following consultation with providers and academics.

• Members include nurses, paramedics, pharmacists, physicians, social workers, RHAs, patients, academics, evaluation experts, and others.

• The Advisory Committee played a central role:
  – Building consensus on the need for reform
  – Ensuring that key stakeholders were willing to participate in reforms
  – Identifying a vision, principles, goals, and priorities
New Framework

Vision: Individuals, families, and communities are supported and empowered to achieve optimal health and well-being within a sustainable system

- Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador was approved in the fall of 2015 and includes:
  - 4 overarching goals and 17 objectives
  - A process for continued stakeholder collaboration
  - A commitment to the social determinants of health including housing, income, and education
  - Suggested actions for implementation
  - A commitment to evaluation and continuous improvement
New Framework

Framework Goals:

- **Goal 1:** Engaged individuals, families, and communities sharing responsibility for prevention, early intervention, and self-management;

- **Goal 2:** Individuals and families attached to a collaborative primary health care team;

- **Goal 3:** Timely access to comprehensive, person-focused primary health care services and supports; and,

- **Goal 4:** Connected and coordinated services and supports across the health and social sectors.
Actions and Implementation

• Objectives will be achieved by collaboratively developing and implementing concrete actions.

• Seven working groups will include representation from across government and the health and social sectors.

• Action Plans will be created on an annual basis and updated to reflect current fiscal realities and policy directions.

• The proposed incremental approach will allow for measured progress and stakeholder buy-in through collaborative identification and implementation of reform initiatives.
System Sustainability

- PHC reform will require upfront investments before any health system cost reduction or avoidance can be realized.

- Evidence shows that with time health outcomes can be greatly improved and real cost reductions can be realized.

- Provinces such as British Columbia have been able to show tangible cost savings and real improvements in health.
  - In British Columbia new physician remuneration options were paired with chronic obstructive pulmonary disease (COPD) management training. An initial investment of $3.4M resulted in cost avoidance of over $10M.
  - Similar results were demonstrated in the areas of diabetes and chronic heart failure.
Current Actions

• The department is focusing on the 5% of high frequency health system users who drive almost 65% of costs.
  – The best opportunity for a high return on investment
  – Maximum improvement in outcomes
  – Mapping high frequency users across the province

• Increased efforts have been placed on deploying nurse practitioners to rural communities where physician retention has been a significant issue.
Current Actions

- A new Division of PHC has been created with responsibility for PHC reform, chronic disease, and cancer control.

- Chronic Disease Self-Management program has expanded to include Labrador and increased access via telehealth.

- Community partners have been engaged in the creation of the Downtown Health Care Collaborative.
  - Brings together Choices for Youth, Stella’s Circle, the Gathering Place, the Salvation Army, End Homelessness St. John’s, Eastern Health, and MUN to coordinate service delivery across multiple community sites.
  - Focused on improving care and increasing access to services for frequent users of the health care system living with mental health and addictions issues.
  - Includes a shared Electronic Medical Record to increase collaboration between providers.
  - Designed as prototype for developing multi-site interdisciplinary teams and community governance structures.
• New NLMA agreement includes $4.5 million for improvements to primary care.

• The Primary Care Renewal Program requires consensus between the department and NLMA in allocating funding aligned with PHC reform efforts.

• Three priority areas include:
  – New condition-based fee codes to increase access to care and facilitate participation in teams
  – Local divisions of family practice linking family physicians and regional health authorities
  – Medical education and change management programs aligned with PHC reform efforts

• The new model is based on reforms in British Columbia, Alberta, and New Zealand.

• Model relies on funding that would otherwise be applied to existing fee codes.
Post-reform Changes

- Increased community engagement and citizen participation in health service delivery

- More awareness of available health and social services

- Improved navigation of the health system and increased access to care

- A focus on treating the upstream causes of poor health through greater linkages between health outcomes and social determinants

- Improved ability for people to proactively manage their own health

- Highly functioning interdisciplinary primary health care teams with all professionals working at full scope

- Reduced demand for acute care services and prescription drugs
Next Steps

- Development of new interdisciplinary teams throughout the province.

- Implementation of PHC Framework by establishing relevant working groups.

- Review all currently deployed PHC resources within RHAs.

- Identify frequent users and implement interventions to stabilize health and reduce need for acute care services.
Next Steps

- Begin implementation of the new Primary Care Renewal Program in collaboration with the NLMA.

- Continue implementation and evaluation of new team-based Downtown Health Care Collaborative.

- Stabilize access to PHC in Corner Brook area while supporting inter-disciplinary collaboration.

- Evaluate and expand new model of Nurse Practitioner led primary care clinics.
Newfoundland Labrador

Long Term Care
Procurement Update
Overview of Presentation

1. Overview of the Procurement Process
2. Value for Money Analysis
3. Action Being Taken
4. Considerations for Next Steps
Background

• Aging population, by 2022 there will be a need for 635 new LTC beds across the province
• In the absence of LTC beds, acute care beds are being utilized at a much higher cost
• Direction was provided to procure 360 beds through an alternative procurement model
Procurement Model

- Private provider to build, own, maintain and operate the LTC facilities and RHAs purchase the service through a 25 year service contract
- Distribution of the **360** beds:
  - 120 – North East Avalon
  - 70 – Gander
  - 50 – Grand Falls-Windsor
  - 120 – Corner Brook (on site of future acute care hospital)
Procurement Process

- Departments of HCS & TW issued an RFP for the NL Long Term Care Project – June 30, 2015
- Partnerships BC led the procurement process in conjunction with GNL staff
- Fairness Advisor and Financial Advisor were contracted to assist and advise throughout the process
- RFP closed August 24, 2015 and validity ends January 31, 2016
Close to Home:
A Strategy for Long-Term Care and Community Support Services
2012-2022
Strategy Overview

- A 10 year strategy (2012-2022) that is flexible and responsive to changing demographics and the public's desire to receive supports closer to their homes
- Informed by extensive consultation with key stakeholders prior to its release in June 2012
- 5 priority directions:
  - Healthy Living and Wellness
  - Person-Centered Service
  - Family and Informal Caregiving Support
  - Quality Services and Service Delivery, System Sustainability
- 18 associated goals and 71 proposed actions to support the vision of a sustainable system; promoting independence and quality of life for the individual
Vision

“Individuals and families requiring long-term care and community support services will achieve optimal independence and quality of life in their homes and communities.”
Accountability

- The strategy will have a formal evaluation in five years (2017) and again in 10 years (2022)
- Accountability framework with a requirement for public reporting every three years
- Provincial committee has been established to oversee the strategy implementation (DHCS and RHA representation)
Strategy Costing

- June 2012, the Strategy was estimated to result in total new annual investments of $256 M, resulting in a cumulative investment of $1.6B by 2022.
- Due to fiscal constraints not all activities identified in the strategy for Years 1 to 4 were implemented, thus investments were lower than estimated:

<table>
<thead>
<tr>
<th>Total Investments From Years 1 – 4 (fiscal 2012 thru 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed in Strategy</td>
</tr>
<tr>
<td>$132M</td>
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</table>

- Action items for Year 5 (2016-17) to be identified and put forward for consideration in the 2016 Budget process
Summary of Key Initiatives Implemented/Ongoing

- Planning Project-LTC bed projection
- Home Support Review
- Paid Family Caregiving option under Home Support
- Enhanced Care in PCH
- Rapid Response Teams
- Standardized client assessment (RAI-HC and MDS 2.0) in the LTC CSS sector
- Significant HR commitments to the RHAs
- Home Support Program Growth funding
- Home Support hourly subsidy rate increase of $5.17 over 3 years with an associated increase to the financial ceiling
- Increased Personal Care Home (PCH) Subsidies, introduction of respite beds in PCHs
- Restorative care beds
Other Actions from the Strategy

- Pilot of age-friendly transportation models grant
- Increase palliative care comfort rooms
- Home Support Program Growth funding
- Continued modernization of LTC facilities
- Reviewing and updating standards
Physician Assisted Dying (PAD)
Physician Assisted Dying (PAD) Overview

- *Carter v. Canada*
- F/P/T Legislative Responses
- QC legislative scheme
- Federal Government Actions
- Provincial and Territorial (PT) Actions
- NL Actions

- Next Steps
  - Intergovernmental
  - GNL Workplan
Carter v. Canada

- February 6, 2015 - the SCC decision in Carter v. Canada struck down the Criminal Code prohibition against PAD for a competent adult who:

  (1) clearly consents to the termination of life and (2) has a grievous and irremediable, though not necessarily terminal, medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
Carter v. Canada (cont’d)

• Declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow governments time to respond.
• On December 3, 2015, the federal Minister of Justice filed a motion for a six month extension of the suspension of the declaration of invalidity by the SCC.
• If extension granted, new date will be August 6, 2016.
F/P/T Legislative Responses to *Carter*

- Federal Govt may choose to amend the *Criminal Code*.

- Federal Govt may also legislate on certain aspects of PAD provision.

- PTs are considering advice from ON-led PT Expert Advisory Group to enact legislation and develop policy.
QC's PAD legislative scheme

- QC legislation - PAD (euthanasia) in cases where the condition is terminal ("end-of-life") and as part of broader end-of-life care options.
- Quebec Court of Appeal on December 9th granted leave to the province to appeal QC lower court's interlocutory injunction preventing end-of-life legislation from taking effect while the Criminal Code provisions are still in effect until February 6, 2016 (or August 6, 2016 if extension is granted).
- Quebec Court of Appeal ruling means that end of life legislation came into effect on December 10, 2015, pending the QC Court of Appeal hearing on December 18, 2015.
- Will continue to monitor developments related to QC.
Federal Government Actions

- Federal Expert Panel
  - Established to provide advice on a legislative response. Conducted consultations but stalled b/c of election:
  - New federal government extended the deadline for the External Panel’s report to December 15, 2015.
  - Mandate modified - a summary of consultations, not legislative options.
- PM letter to Federal Justice Minister and Attorney General identifies working with PTs (on PAD) as a key priority.
- Application made to the Supreme Court for an extension of six months (August 6, 2016).
- All-Party parliamentary Committee to be established.
- Federal officials will connect in to PT working group.
Provincial/Territorial Actions

- Established (August 2015) PT Expert Advisory Group (Advisory Group) to provide non-binding advice to participating PT Ministers of Health and Justice.
- PTs (not QC; BC in observer capacity), led by ON
- The Final Report submitted to ON Health & Justice Ministers and shared with PTs (additional detail follows).
- A PT ADM (Health & Justice) Working Group established to link the work of the Advisory Group with participating PTs.
Newfoundland and Labrador Actions

- GNL Working Group
  - Chaired by Seniors Wellness and Social Development (SWSD) with Justice and Public Safety (JPS) and Health and Community Services (HCS).
  - Newfoundland and Labrador Medical Association (NLMA) and the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) represented.

- Other PTs also undertaking work within their respective jurisdictions.
- CPSNL working on a “toolkit” for approval by Council on December 12. Focus on clinical practice.
Final Report of the PT Expert Advisory Group (EAG)

- s.29(1)(a) Non-binding.
- Recommending public release - Decision of PT Health Ministers.
- 43 recommendations - aspects of legislative and policy framework for the safe and responsible provision of PAD as an insured service within the public health care system and within the context of high quality palliative care services.
EAG Recommendations

• A pan-Canadian (FPT) strategy for palliative and end of life care which includes physician-assisted dying a part of a continuum of care.
• Governments, regulators, institutions and professionals work together to ensure equal access and high quality care.
• A strong legislative response is essential.
EAG Recommendations (cont’d)

• Others besides physicians will need to be involved (i.e., NPs, RNs and Pharmacists).
• Pathway identified, including:
  – Who should have access
  – How patients may request PAD
  – How eligibility criteria should be assessed
  – Where physician assisted dying may be provided
  – Appropriate safeguards (assessment by two physicians, reflection time, robust assessment of competency and consent and witnessed patient declarations)
EAG Recommendations for PT Legislation

- 22 of the 43 recommendations should be implemented through PT legislation.
- Includes such things as:
  - Ensuring access to PAD through a physician administered and self-administered regime (i.e. *both* euthanasia and assisted suicide)
  - RHAs to have publicly funded coordinated core system in place
  - Ensure health professionals are protected from liability.
EAG Recommendations for PT Legislation (cont’d)

- Establish requirements for patient declarations
- Not allow substitute decision makers to authorize
- Definition of a ‘Grievous and irremediable medical condition’ in legislation but not include specific diseases
- Provisions for conscientiously objecting health care providers
- System Oversight and Case Review provisions
- Create data bases and establish reviews to ensure compliance.
EAG Recommendations re **Criminal Code**

- Recommending PTs press Federal Government for clarification in the *Criminal Code* of:
  - Protection for health professionals who provide supporting services during the provision of PAD
  - Amendments to allow provision by regulated health professionals (RNs or PAs) acting under the direction of a physician or nurse practitioners
EAG Recommendations re Criminal Code (cont’d)

- Assurance that a valid patient declaration form can be completed at any time following the diagnosis of a grievous and irremediable medical condition when suffering becomes intolerable
- Exception from the criminal prohibition for PAD should be based on patient competency, not age (i.e. could include mature minors)
- Common usage definition of “grievous and irremediable medical condition” without delineation of specific conditions
EAG Recommendations re FPT Collaboration

- Pan-Canadian Palliative and End-of-Life Care Strategy
- Establishment of pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public
Next Steps

- As of February 7, 2016, unless extension granted, PAD will no longer be contrary to the Criminal Code under certain circumstances.

s.30(1)

s.29(1)(a)
Next Steps – intergovernmental collaboration
Next Steps – GNL workplan

s.29(1)(a), s.34(1)(a)(i)

s.29(1)(a), s.30(1)
Thank you
Overview of e-Health and Major NL Health Information Systems

Department of Health and Community Services

December 2015
Agenda

1. Overview of eHealth
2. Key Principles of eHealth
3. Organizations involved in eHealth in NL
4. Types of eHealth Systems
5. Overview of Electronic Health Record (EHR)
6. Overview of Healthcare Information System (e.g. Meditech)
7. Challenges
8. Next Steps
Overview

- eHealth is defined as all of the information, communication and technology tools used across the health system.
  
  - eHealth is the means of ensuring that the right health information is provided to the right person at the right place and time in a secure, electronic form for the purpose of optimizing the quality and efficiency of health care delivery.

  - eHealth should be viewed as both the essential infrastructure facilitating information exchange between all participants in the Newfoundland and Labrador health care system and as a key enabler and driver of improved health outcomes for all Newfoundland and Labrador residents.

- The New Health Shared Services Organization presents an opportunity for efficiencies by consolidating expertise and maximizing investments in eHealth.
Overview (Continued)

- Newfoundland & Labrador Health Shared Services (NLHSS)
  - will provide the governance to effectively operationalize and mature the EHR.
  - will allow the RHA’s to concentrate on delivery of health while it operationalizes health delivery enablers such as the EHR.
  - will allow for the consolidation of RHA and NLCHI IT Infrastructure that will further enable a one patient, one record strategy for the province.
  - will allow for enhanced analytics that will enable effective decision support that is equitable to all RHA’s.
Key Principles of eHealth

- eHealth is about leveraging a collection of IM/IT tools and services that can:
  - Improve prevention, diagnosis, treatment, monitoring and management.
  - Benefit the entire community by improving access to care and quality of care and by making the health sector more efficient.
  - Includes information and data sharing between patients and health service providers, hospitals, health professionals and health information networks.
## Main Organizations Involved in eHealth

<table>
<thead>
<tr>
<th>Organization(s)</th>
<th>Role</th>
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<tbody>
<tr>
<td>Department of Health and Community Services</td>
<td>Sets policy and strategic direction and provides advice and recommendations on eHealth and large IM/IT projects from NLCHI/RHAs</td>
</tr>
<tr>
<td>Regional Health Authorities (RHAs)</td>
<td>Responsible for the implementation and delivery of a wide variety of provincial and regional level Information Management &amp; Technology solutions and services that enable the delivery of Healthcare and support eHealth (i.e. Meditech)</td>
</tr>
<tr>
<td>Newfoundland and Labrador Centre for Health Information (NLCHI)</td>
<td>Responsible for developing and operating the Electronic Health Record, provides leadership and support in planning and alignment of provincial health information system investments and undertakes health research</td>
</tr>
<tr>
<td>Office of the Chief Information Officer (OCIO)</td>
<td>Responsible for operating and maintaining key health system infrastructure such as MCP mainframe and the Client Referral Management System utilized in the RHAs</td>
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Types of eHealth Systems

- Health Information Systems generally exist in one of two categories largely based by scope:
  - **Provincial**: One system serves entire province.
  - **Organizational (RHA Only)**: Siloed systems specific to a particular organization.
- Health Information Systems are also divided by function:
  - **Clinical systems**: those that contain information directly related to client/patient care and case management.
    - Includes Electronic Health Record (EHR) systems.
  - **Administrative (supports clinical)**: Those that contain functionality such as accounting, payroll & HR, payments to clients, business intelligence, adverse event tracking, etc.
- Two main components of eHealth are the Electronic Health Record and the Healthcare Information System (e.g. Meditech).
Health IT Systems at a Glance

- Meditech (Electronic Patient Record)
- Client Referral Management System (CRMS)
- Client Registry
- Provider Registry Diagnostic Imaging/Picture Archival and Communications System (DI/PACS)
- Pharmacy Network
- Interoperable EHR/Labs (Health-e NL Viewer)
- Electronic Medical Record (EMR)
- Public Health Surveillance (PHS) System
- Telehealth
- Public Health Lab
- Dictation Systems
- Health Human Resource Information System (HHRIS)
- Clinical Safety Reporting System (CSRS)
- InterRAI Homecare

- Ambulance Dispatch and Management System (ADAMS)
- Cognos Business Intelligence
- Medical Care Plan (MCP)
- Communicable Disease Control System (CDC)
- Clinical Database Management System (CDMS)
- CIHI Submission Preparation System
- Emergency Health Information System (EHIS)
- Immunization Records System (IRS)
- Medical Transportation Assistance (MTA)
- NLPDP (Eligibility/Claims Monitoring/BI)
- Mass Immunization Registry (MIR)
- Out-of-Province Claims (OOPC)
- SALPHY - Salaried Physicians System
- VaccTrac
- HCS Financial Applications
Electronic Health Record (EHR)

- The Electronic Health Record is a secure and private lifetime record of an individual’s health and care history, available electronically to authorized health providers.
- It facilitates the sharing of data – across the continuum of care, across healthcare delivery organizations and across geographies.
Provider View of EHR

EHR Solution

- Client Registry
- Provider Registry
- EHR
- Domain Repository (Lab)
- Domain Repository (Pharmacy)
- Domain Repository (Diagnostic Imaging)

Common Services

Communication Bus

HAL

EMR

Patient Info
- Patient History
- Drug Profile
- Laboratory
- Diagnostic Imaging

Applications
- Appl
- Appl
Major EHR Components

Operational

- Client Registry
- Provider Registry
- Diagnostic Imaging/Picture Archival and Communications System (DI/PACS)
- Telehealth
- Interoperable EHR (iEHR) Labs
  - Currently EH Labs only
- HealthNL Viewer

In Progress

- Expansion of iEHR Labs
  - Approval recently provided to expand iEHR labs to include CH, WH and LGH
- Pharmacy Network (PN)
  - Adoption is approx. 40%
- Electronic Medical Record (EMR)
  - MOU and contract with vendors signed on October 30th
  - Currently working with NLMA re: implementation
- Public Health/Communicable Disease Systems
  - Department has now invested into an EHA solution called the “Bucket” to make it provincial in scope
Healthcare Information Systems

- Meditech is the primary healthcare information system used by the RHAs.
- There are currently five (5) distinct Meditech systems within the province (CH, EH/LGH, WH, Public Health Lab, St. John’s Nursing Home Board)
- Meditech currently is an interconnected system that includes administrative and clinical modules.
- Meditech has tight integration with Electronic Health Record components (i.e. Client registry, iEHR/Labs, and DI/PACS).
- Meditech systems of LGHA and EHA were integrated recently to create a single patient record.
- There are other information systems used in the delivery of healthcare (i.e. CRMS in community health, PACS, etc.).
Challenges

- Many major systems, like Meditech, CRMS and MCP, are in need of replacement due to obsolescence and inability to meet the demands of the modern healthcare system.
- Many of the current systems are not integrated which does not allow for sharing of information between health care providers (i.e. Meditech and CRMS) and results in an inefficient system.
- The system is limited in addressing many inefficiencies (i.e. more tests, duplication of resources, etc.) without bringing systems together to better position the EHR.
- Without an investment in consolidating the hospital based systems we will never fully realize the benefits of EHR.
- Additional investment is also required to enhance and expand the EHR to include all health information (i.e. EMR and information in physician’s offices).
Next Steps

- Continue to enhance the EHR
  - Expansion of iEHR labs in WH, CH and LGH
  - Increase adoption to the Pharmacy Network with compel date of January 2017
  - Implementation of a Provincial EMR program

- Healthcare Information System (i.e. Meditech)

- Finalize a Provincial eHealth Strategy
  - The Department, RHA’s, NLCHI and the new Shared Service Organization are currently finalizing a Provincial eHealth Strategy to ensure a focused, consistent and strategic approach to health information management and technology in the Province.
  - The strategy will focus on governance (i.e. SSO), IT infrastructure, service delivery, data standards and compliance, data analytics and research and the EHR.
Presentation Overview

- Background and overview of the shared services model.
- Implementation Approach
- Update on the progress to date.
- Next steps.
Background

- Budget 2015 announced the establishment of a new provincial health shared services organization to deliver the following:
  1. Supply Chain Management
  2. Finance & Payroll
  3. Human Resources
  4. Information Technology & Telecommunications
  5. Marketing and Communications
  6. All of the functions of the Newfoundland & Labrador Centre for Health Information (NLCHI)
Why pursue a new Shared Services organization

- Sustainability of health care.
- Promotes better value for money.
- Streamlines non-clinical services, without negatively impacting the delivery of health services.
- Strengthens focus on patient care.
- Reduces costs and improves efficiency
- Consistent with approaches taken by other jurisdictions.
How did we explore this opportunity

- Project commenced Fall 2013.
- Led by Department of HCS and RHAs.
- Deloitte engaged to support this work.
- Two work streams:
  1. Completion of thorough review of Supply Chain
  2. Identification of other opportunities for sharing of other services.
- Report finalized in Fall 2014.
Deloitte Recommendations

- Establish a provincial Shared Services Organization including: Supply Chain, ITT, Human Resources and Finance and Payroll.
- Estimated savings: $18M to $25.7M when fully implemented over a five year period.
- FTE Reduction: 187 to 232 FTES through a combination of attrition and layoffs.
- Invest in enabling technologies, change management and workforce transition.
- A detailed implementation plan included for supply chain but further analysis required in the other three areas.
Further Recommendations

- **NLCHI**
  - All functions of NLCHI to be included in the new Health Services Organization.
  - Benefits include: maximize efficiency, reduce the duplication of management structures and improves integration of provincial e-health initiatives.

- **Marketing and Communications**
  - Included in scope to build synergies, reduce duplication and improve strategic marketing and communication activities among RHAs and NLCHI
Implementation Team

• Announced in August, 2015
• Lead by Tony Wakeham, CEO LGH and includes:
  – Ron Johnson, CIO with Eastern Health
  – Denise Tubrett, ADM, Regional Services with HCS.
• Mandate:
  1. Proceed with the Implementation of Supply Chain.
  2. Develop detailed implementation plan for HR, Finance and Payroll, Marketing and Communications and IT & Telecommunications including NLCHI.
  3. Develop a detailed transition plan and organizational structure to support the new model.
  4. Support recruitment efforts for the CEO
Update on Progress

- Newfoundland & Labrador Health Shared Services Inc. (NLHSS) incorporated.

- Governance in place:
  - Interim Board Appointed
  - Steering Committee in place

- Project Plan finalized.

- Engagement of staff in RHAs and NLCHI

- Consultation with other jurisdictions
Update on Progress

- Workforce Transition Strategy under development.

- Supply Chain Implementation commenced.
Update on Progress

• "Deep Dives" Process finalized and work has begun.
  – 5 Deep Dives - Finance and Payroll, HR, IT, NLCHI and Marketing and Communications
  – Workstreams:
    • Validate the vision for the service delivery model for each function.
    • Conduct Current State Assessment.
    • Design Future State Service Delivery Model.
    • Finalize Transition Plan
Next Steps

- Continue with “Deep Dives”

- Further communication and engagement of stakeholders.
Questions?
Overview

- Division Mandate / Organization
- Facilities / Financial Overview
- Infrastructure Process
- Infrastructure Challenges
- Capital Projects
  - Recent Completions
  - Ongoing/Nearing Completion
  - Design/Planning
  - Unfunded Priorities
- Repairs & Renovations
- Capital Equipment
  - Foundations
Division Mandate

Provides planning, development and oversight of all capital projects including construction of new facilities, repairs & renovations, as well as capital equipment purchases.
Division Organization

Infrastructure Management Division

- ADM
  Regional Services

- Director
  (Vacant)

- Manager
  (Paul Greene)

- Senior Engineer
  (Vacant)
Facilities Overview

- 15 Hospitals
- 23 Health Care Centres
  - Some health care centres provide long term care beds
- 23 Long Term Care Facilities
  - Dedicated for long term care only
- 119 community clinics / public health offices
  - Combination of leased vs owned
Financial Overview

- **Capital Projects:**
  - Budget 2015: $73.7M
  - Fiscal Forecast (2016-17 to 2021-22): $58.2M
    - $14.6M (Springdale); $11M (HSC Substation); $8.7M (CNRHC Labs)
    - No future funding allocated for Waterford or Corner Brook

- **Repairs & Renovations**
  - Budget 2015: $20M
  - Fiscal Forecast (all out years): $20M annually

- **Capital Equipment**
  - Budget 2015: $40M
  - Fiscal Forecast (all out years): $30M annually
Infrastructure Process

• Construction Management of the Department’s Capital Projects is performed by either:
  – Department of Transportation and Works
  – Regional Health Authorities

• Infrastructure Management Division role:
  – Involved in the programming/design of the facilities;
  – Obtaining appropriate Government approvals;
    • Through Government’s Four Stage Infrastructure process
  – Project budget monitoring.
Infrastructure Challenges

• Aging Infrastructure
  – Despite significant investments over the last decade, many of our health care facilities continue to age.
    • Waterford Hospital and parts of the Miller Centre are over 150 years old.
    • Independent assessments of the HSC, which is 40 years old, is in need of over $100M in upgrades.

• Increasing Long Term Care Bed Demand
  – Province’s aging population means increased demand for long term care spaces
    • Projections: 635 new beds required by 2022.
    • Select areas of Province, primarily urban areas.
Capital Projects

• Since 2003-04 approximately 40 capital projects have been approved/announced.

• Capital projects spending/commitments in the last 10 years over $800M:
  – To 2014-15: $700M
  – Budget 2015: $73.6M
  – 2016-17 to 2021-22: $58M
    • Does not include future funding requirements for Waterford or Corner Brook.
Capital Projects

- Recent Completions:
  - St. John’s Long Term Care Facility
  - Youth Treatment Centres (Paradise & GF-W)
  - North Haven Manor & PCR (Lewisporte)
  - Labrador West Health Centre
  - Bonavista Protective Community Residence
  - Placentia West Medical Clinic
  - New Operating Rooms (GF-W)
  - Faculty of Medicine Expansion / Genetics Centre
  - Flower’s Cove Health Centre
Capital Projects

• Ongoing/Nearing Completion (6 projects)
  – Adult Addictions Treatment Centre (Harbour Grace)
    • Construction complete, opening Winter 2016
  – Clarenville Protective Care Residence
    • Construction 99% complete, opening January/February 2016
  – Happy Valley – Goose Bay LTC Extension
    • Construction 90% complete, opening March/April 2016
  – Carbonear Long Term Care Facility
    • Construction 95% complete, construction to be completed this Winter/Spring, Eastern Health to occupy in September 2016
Capital Projects

• Ongoing/Nearing Completion (cont’d):
  – Molecular Imaging Facility
    • Construction 70% complete, opening Summer 2016
  – HSC Emergency Generators Upgrade
Capital Projects

• Planning / Design (9 projects):
  – Corner Brook Hospital
    • Completion of design-bid documents: January 2016
    • No funding provided to move beyond this stage. Assuming a budgetary allocation is provided in Budget 2016, TW indicates that Fall 2016 would be the earliest possible timeframe when a tender could be issued.
    • Assuming a Fall 2016 tender, a likely construction start date would be Summer 2017.
  – Waterford Replacement Facility
    • Functional Program has been completed.
    • Next step will be the development of detailed design documents.
    • No funding provided to move to this next stage.
Capital Projects DUPLICATE SLIDE

- Planning / Design (9 projects):
  - Corner Brook Hospital
    - Completion of design-bid documents: January 2016
    - No funding provided to move beyond this stage. Assuming a budgetary allocation is provided in Budget 2016, TW indicates that Fall 2016 would be the earliest possible timeframe when a tender could be issued.
    - Assuming a Fall 2016 tender, a likely construction start date would be Summer 2017.
  - Waterford Replacement Facility
    - Functional Program has been completed.
    - Next step will be the development of detailed design documents.
    - No funding provided to move to this next stage.
Capital Projects

• Planning / Design (cont’d):
  – Green Bay Health Centre (Springdale)
    • Tender for construction has been issued, closing December 10th.
  – Burin Protective Care Residence
    • Site work ongoing. Design nearing finalization.
  – HSC Electrical Substation
    • Initial design exceeded project budget. Currently reviewing redesign options.
  – CNRHC Endo/Cysto Redevelopment (GF-W)
    • Design underway, anticipated tender Spring 2016.
Capital Projects

• Planning / Design (cont’d):
  – CNRHC Lab Redevelopment (GF-W)
    • Redevelopment is required to maintain accreditation.
    • Central Health currently in process of engaging design consultant.
  – Medical Device Reprocessing Redevelopment (HSC)
    • Design nearing finalization, tender anticipated Winter 2016.
  – Integrated Operating Rooms (HSC & SCM)
    • Four of the seventeen rooms have been completed. Design of next two rooms underway.
    • Project is being cost shared with the Health Care Foundation.
Capital Projects

Waterford Hospital Replacement ($327.5M)
- Functional Program has been completed.
- Next step would be the development of detailed design documents for tendering.

Corner Brook Hospital Replacement ($800M)
- Completion of schematic design documents: January 2016
- No funding provided to move beyond this stage. Assuming funding provided in Budget 2016, TW indicates that Fall 2016 would be the earliest possible timeframe when a tender could be issued.
- Assuming a Fall 2016 tender, a likely construction start date would be Summer 2017.
Capital Projects

HSC Core Infrastructure Upgrades ($35.5M)

- Facility Assessments indicate that the HSC (which is 40 years old) is in need of over $100M in core infrastructure upgrades (e.g. piping, electrical, roofing, windows, etc.)
- $35.5M had been requested in Budget 2015 to address high priority needs but did not get approved.

St. John’s Acute Care Redevelopment

- Includes:
  - new inpatient tower at the HSC;
  - new ambulatory clinic on Northeast Avalon to relocate some clinics from the HSC to relieve pressure on that site;
  - new parking garage;
  - new Public Health Lab
Capital Projects

Faith Based Long Term Care Homes Core Infrastructure Upgrades ($33M)
- Includes Agnes Pratt, St. Luke’s, St. Pat’s and Glenbrook Lodge
- Aged facilities which require upgrades to core infrastructure systems (e.g. piping, electrical, roofing, windows, etc.)
- $4M had been requested in Budget 2015 to address high priority needs but did not get approved.

Two (2) new Cancer OR’s ($7.75M)
- Originally announced as part of the Hebron settlement agreement with ExxonMobil in January 2013.
- Planning/Design had been underway, however, the funding was removed from the Department’s forecast in Budget 2015.
New Cardiovascular Hybrid Operating Room (at HSC) ($2.5M)

- Announced in November 2015 as part of the Vale settlement agreement.
- No funding has yet been allocated in the Department’s forecast.

James Paton Redevelopment – Gander ($23M)

- To complete the last remaining sections of the hospital that have yet to be upgraded (e.g. OBS/Gyne).
- Department had previously been provided with $16.25M to continue with the redevelopment, however, the funding was removed from the Department’s forecast in Budget 2015.
Bonavista Hospital Replacement

- Facility is in need of significant infrastructure upgrades, as well the layout of the facility does not lend itself to optimizing resources or work flow. Construction of a replacement facility was the preferred option.
- Funding had been requested in Budget 2015 to move forward with the redevelopment but did not get approved.

New Protective Care Unit at the John M. Gray Home – St. Anthony

- Current PCU is a redeveloped inpatient wing which does not have the appropriate layout to serve the intended population.
Capital Projects

Paddon Home

- In Budget 2015, the Department requested $750,000 to begin planning for the redevelopment of the Paddon Home into a Primary Health Care Clinic.
- Estimated cost of redevelopment is [redacted] no funding approved.
- Recently, the Department has had discussions with the Labrador Friendship Centre (LFC) on possible transfer of the facility to the LFC with the Department committing to fund a maximum of $1M in repairs and renovations to the facility.
  - LFC currently in the process of developing a Business Plan for future use of the Paddon Home.
Repairs and Renovations

• 2015-16 Budget Allocation: $20M

• Annual Process:
  – Each of the RHA’s submit a listing of their top 30 R&R funding requests for the upcoming year.
  – Once the budget allocation has been established, officials prepare tentative recommendations which are reviewed/approved by Minister.
  – For 2015-16:
    – $18M has been committed/expended to date;
    – $2M uncommitted/remaining in contingency.
Capital Equipment

• 2015-16 Budget Allocation: $40M
• Annual Process:
  – Each of the RHA’s submit a listing of their top 60 new and replacement capital equipment funding requests for the upcoming year.
  – Once the budget allocation has been established, officials prepare tentative recommendations which are reviewed/approved by Minister.
  – For 2015-16:
    – $35M has been committed/expended to date;
    – $5M uncommitted/remaining in contingency.
Capital Equipment (Foundations)

• 14 Foundations across the Province
• Process:
  – At various times throughout the year, each of the Health Care Foundations submit funding requests to the Department in support of annual fundraising events (e.g. Radiothons, telethons, etc.)
  – Funding comes from within the $40M capital equipment allocation and is provided at the Minister’s discretion.
    • 2014-15: $555,000 provided in total to all Foundations
    • 2015-16: $495,000 provided to date, Budget: $650,000
Questions?
Information Note
Department of Health and Community Services

Title: Newfoundland and Labrador Health Shared Services Organization

Issue: To provide background information and current status on the implementation of health shared services in Newfoundland and Labrador.

Background and Current Status:
- Budget 2015 announced the establishment of a new provincial health shared services organization (SSO) to deliver supply chain management, finance, payroll, human resources, information technology and telecommunications (ITT), and marketing and communications functions for the four Regional Health Authorities (RHAs) and to bring the Newfoundland and Labrador Centre for Health Information (NLCHI) into the SSO. Consolidating NLCHI’s mandate will optimize the shared services approach by fully integrating the ITT functions in the provincial health system and also reducing the duplication of management and administrative structures.

- This initiative is part of the sustainability work that the Department of Health and Community Services (HCS) and the RHAs have been pursuing to streamline non-clinical services, without negatively impacting the delivery of health care services.

- Government first directed that HCS and the RHAs investigate sharing support services following a consultant’s report in 2012 indicating that potential savings could be up to $18M. In fall 2013, Deloitte was engaged to develop an implementation plan for supply chain and identify opportunities for other support services. The fall 2014 final report recommended a stand-alone SSO, an implementation plan for supply chain integration and that finance, payroll, human resources and ITT should be consolidated but further detailed analysis was required. Deloitte estimated 10-12 months would be needed to establish the SSO, operationalize supply chain services and complete a more detailed analysis.

- Deloitte estimated annual net savings in the order of $18M to $25.7M over a five-year period when fully implemented with estimated position reduction of 187 to 232 FTEs, to be achieved primarily through attrition. The majority of these savings, $7.8M to $11.6M, relates to improving supply chain services and were estimated based on the detailed analysis. It includes savings from position reduction of 26 to 31 FTEs but also savings from joint procurement and improvements in transportation. Deloitte estimated savings in the other areas by benchmarking against other jurisdictions with high level savings in the order of $10.2M to $14.1M with estimated position reduction of 161 to 201 FTEs.

- Deloitte also recommended that investments (estimated $40.8M to $58.1M) will be required mainly related to consolidating multiple corporate and clinical information management systems maintained by each RHA into a common system. These investments are required and will need to be incurred regardless of the implementation of a SSO. In fact, the SSO will provide an opportunity to pursue these improvements in a more coherent, integrated and efficient manner.
If approved, these investments will be funded through HCS’s annual Capital Equipment budget.

Analysis:
- With a budget of approximately $1.8B, RHAs require a wide range of services to support health care delivery. A further $26M supports the operations of NLCHI. Currently, support services are managed separately by each RHA and NLCHI, with some exceptions, and are generally not standardized. Economies of scale, especially regarding combined purchasing power and the pooling of expertise, have not been optimized. Coupled with outdated information systems, this means these services are fragmented and lack automation, thus most work is transactional, not strategic.

- By bringing together non-clinical support services under a SSO, efficiencies can be achieved through process and product standardization, logistical efficiencies, improved economies of scale and removal of overlapping roles and responsibilities.

- Every province has some form of shared services to support the delivery of health services. Shared services models in other provinces have met and/or exceeded their goals of better services and cost savings. Examples include: New Brunswick (FacilicorpNB), Saskatchewan (3SHealth) and BC (Health Shared Services BC).

- In August 2015, an Implementation Team was announced to oversee the transition process for the new health shared services organization. The team is led by Tony Wakeham, CEO, Labrador-Grenfell Health and includes Ron Johnson, Chief Information Officer with Eastern Health and Denise Tubrett, Assistant Deputy Minister, Regional Services with HCS. These officials have been seconded from their permanent roles to support the transition.

- The team’s mandate is to: proceed with the implementation of supply chain; develop a detailed implementation plan for finance, payroll, human resources, marketing and communications and ITT including NLCHI; develop a detailed transition plan and organizational structure to support the new model; and support the recruitment efforts for the CEO. The team’s guiding principles include achieving position reduction through attrition and delivering services in a decentralized model (i.e. services are located at the regional level) rather than centralizing in one location. The team has been directed to report back to Cabinet with the results of its work in early 2016.

- The new organization was incorporated on October 30, 2015 under the legal name of NL Health Shared Services Inc (NLHSS). The Minister of HCS was appointed as the shareholder of the corporation. An interim board was appointed comprised of two directors, the Deputy Ministers of HCS and the Human Resource Secretariat. A permanent board will be appointed by Cabinet when the detailed implementation plan is approved. A steering committee comprising the CEOs of the RHAs and NLCHI and the Deputy Minister of HCS is in place to oversee the work of the Implementation Team.
- There has been significant engagement with staff at the RHAs and NLCHI to seek input in building the detailed implementation plans. Transition teams, comprising representatives of the RHAs, NLCHI and various departments, are in place to provide advice on human resource, communications, change management and supply chain services.

- The Implementation Team is currently finalizing the approach for conducting the further detailed analysis. While most of this work will be done by the Implementation Team, external expertise may be required.

Prepared/approved by: T. Wakeham/D. Tubrett/R. Johnson/B. Clarke
Reviewed by: K. Norman in consultation with Communications Branch, FIN and JPS/T. King, Cabinet Secretariat

November 20, 2015
Information Note
Department of Health and Community Services

Title: Federal/Provincial/Territorial (FPT) Health Agenda

Issue: To provide an overview of upcoming intergovernmental discussions / negotiations related to Health Care.

Background & Current Status:
- The new federal government has signaled its intent to re-engage with PTs on matters related to Health following a lengthy period in which the federal government had largely disengaged from what traditionally had been the most active sector of intergovernmental relations. Multilateral discussions are anticipated to commence at the upcoming FPT Health Ministers Meeting in Vancouver, January 19-21, 2016.

- The federal Liberals have committed to “re-start a conversation with Premiers to strengthen the health care system and ensure that it can meet current needs and the challenges that come with an aging population”. The Liberals have also promised to ‘reengage’ in areas of health policy where there is a direct federal responsibility, such as First Nations’ health, health promotion and support to caregivers. These commitments can be found in Liberal Party Leader Justin Trudeau’s September 2, 2015 letter to Premier Paul Davis, in his role as Chair of the Council of the Federation (COF) (Annex B; Premier Davis’s letter to federal party leaders is included as Annex A). Commitments are also found in the Liberal party platform (Annex C) and the Prime Minister’s mandate letter to the new federal Health Minister, Jane Philpott (Annex D).

Health Accord
- The mandate letter directs Minister Philpott to negotiate a Health Accord. Minister Philpott has indicated that this is a high priority for the federal government and she plans to act quickly. She has already had bilateral courtesy telephone calls with most, if not all, PT Health Ministers, including Minister Steve Kent. She has indicated her intent to attend the scheduled January 2016 Health Ministers Meeting.

- The mandate letter states that the Accord should include the following elements:
  o A long term funding agreement.
  o Support for the delivery of more and better home care services. This includes more access to high quality in-home caregivers, financial supports for family care, and, when necessary, palliative care – related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians.
  o Pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, increase efficiency and improve outcomes for patients.
  o Improved access to necessary prescription medications. This will include joining with PT governments to buy drugs in bulk, reducing the cost governments pay for these drugs, making them more affordable, and exploring the need for a national formulary.
  o Making high quality mental health services more available to Canadians who need them.
• PTs expressed their collective views on the federal government’s role in health care and health financing in Premier Davis’s July letter to federal party leaders (Annex A) in which they sought federal support for:
  o the needs and opportunities presented by an aging population, including investments to address the impact of population aging on the fiscal balance between the federal government and provincial-territorial governments;
  o increasing funding through the Canada Health Transfer so that the federal share of Canada’s health care costs is at least 25% of all health care spending by provinces and territories. This additional investment would help address innovation and transformation in health care systems; and
  o providing supports to families such as affordable quality childcare and supports for affordable and social housing.

Other issues
• The Liberal government has committed to legalize, regulate and restrict access to marijuana. As a first step in the process to legalize marijuana, the federal government has indicated it will establish a FPT Task Force consisting of public health, substance abuse and public safety experts. This initiative will be co-led by the federal Ministers of Health, Justice and Public Safety and Emergency Preparedness.

• As part of a broad Aboriginal policy agenda which includes implementation of the 2005 Kelowna Accord and the recommendations of the Truth and Reconciliation Commission, the Minister of Health was mandated to work with the Minister of Indigenous and Northern Affairs to update and expand the Nutrition North program, in consultation with Northern communities.

• Public health priorities identified in the federal mandate letter include: increasing vaccination rates; introducing new restrictions on the commercial marketing of unhealthy food and beverages to children, similar to those now in place in Quebec; bringing in tougher regulations to eliminate trans fats and to reduce salt in processed foods; improving food labels to give more information on added sugars and artificial dyes in processed foods; and introducing plain packaging requirements for tobacco products.

• Another pressing issue of the federal government is responding to the Supreme Court of Canada’s decision on Physician Assisted Dying. A separate information note is provided on this topic.

Analysis:  s.29(1)(a)
Mental health is a key priority for NL and PTs collectively. The federal government’s interest in creating new centres of excellence to specialize in this area may be worth exploring given adolescent mental health has been identified as a priority.

While all PTs supported the COF call for federal support for health issues relating to Canada’s aging population, a focus on seniors and aging in a new agreement will likely be particularly advantageous for NL given the unique needs and challenges of NL’s aging population. The Liberal commitment ($3 billion over 4 years) to deliver more and better home care services for Canadians is in line with NL’s Close to Home: A Strategy for Long-Term Care and Community Support Services, which was created to strengthen long-term care and community support services throughout the province and may present an opportunity for the Atlantic region to leverage funding for regional initiatives.
Annex C

SUMMARY OF FEDERAL GOVERNMENT PLATFORM AND COMMITMENTS - HEALTH RELATED (2015)

Federal/Provincial/Territorial
- Hold annual First Ministers Meetings.
- Re-engage with PTs; a more collaborative relationship with Premiers.
- Reengage in areas of federal responsibility, including health promotion, support to caregivers, and First Nations’ health.

A New Health Accord
- Restart conversation with Premiers to strengthen the program (health care) and ensure that it can meet current needs and the challenges that come with an aging population.
- Negotiate a new Health Accord with provinces and territories, including a long-term agreement on funding.

Seniors
- Invest $3 billion over the next four years to deliver more and better home care services for all Canadians. This includes more access to high quality in-home caregivers, financial supports for family care, and, when necessary, palliative care.
- Invest $20 billion over 10 years on "social infrastructure," which includes affordable seniors' housing and seniors' facilities.

Caregivers
- Make the Employment Insurance Compassionate Care Benefit more flexible, inclusive, and easier to access, representing an investment of $190 million per year.

Innovation
- Develop a pan-Canadian collaboration on health innovation.
- Work with PTs to overcome obstacles to innovation in health care delivery and disseminate and scale up successful new practices, e.g. ways to use genomics in precision medicine.

Pharmaceuticals
- Improve access to necessary prescription medications.
- Join with provincial and territorial governments to negotiate better prices and buy drugs in bulk.
- Support and disseminate research and best practices to reduce unnecessary over-prescribing of medications, particularly for the elderly.
- Improve reporting on adverse drug reactions and ensure more research and follow-up on reported adverse effects.
- Continue to ensure timely approvals for new medicines.
- Consult with industry and review the rules used by the Patented Medicine Prices Review Board to ensure value for money on brand name drugs.

Mental Health
- Make high-quality mental health services more available to Canadians who need them, including veterans and first responders.
• Implement an integrated approach to ensure access to acute services, tertiary care referrals, housing, primary care, and multidisciplinary team management.

• Establish a pan-Canadian Expert Advisory Council on Mental Health, particularly to advise on the implementation of the Mental Health Commission of Canada’s recommendations.

• Create new centres of excellence that will specialize in mental health, PTSD, and related issues for veterans and first responders.

Marijuana

• Legalize, regulate, and restrict access to marijuana.

• Create a federal/provincial/territorial task force, and with input from experts in public health, substance abuse, and law enforcement, to design a new system of strict marijuana sales and distribution, with appropriate federal and provincial excise taxes applied.

Public health/health promotion

• Introduce new restrictions on the commercial marketing of unhealthy food and beverages to children, similar to those now in place in Quebec.

• Bring in tougher regulations to eliminate trans fats, similar to those in the U.S., and to reduce salt in processed foods.

• Improve food labels to give more information on added sugars and artificial dyes in processed foods.

• Increase funding to the Public Health Agency of Canada by $15 million in each of the next two years, to support a national strategy to increase vaccination rates and raise awareness for parents, coaches, and athletes on concussion treatment. This will be based on the best science and will support existing provincial and territorial efforts.

• Introduce plain packaging requirements for tobacco products, similar to those in Australia and the United Kingdom.

First Nations Health

• Renew the relationship between Canada and Indigenous Peoples.

• Re-engage in a renewed nation-to-nation process with Indigenous Peoples to make progress on issues including health and mental health care, housing, infrastructure, community safety and policing, child welfare, and education.

• Implement the objectives of the Kelowna Accord in a manner that meets today’s challenges.

• Enact the recommendations of the Truth and Reconciliation Commission.

• Lift the 2% cap on funding for First Nations programs.

• Examine social determinants of health, renew commitments to Nutrition North, and end First Nations reserve boil-water advisories within 5 years.

Physician Assisted Dying

• Immediately begin consultations for physician assisted death to meet the Supreme Court’s deadline of February 6, 2016.¹

• Immediately appoint an all-party special committee to consider the ruling, consult with experts and Canadians, and make recommendations for a legislative framework.

Other

- Consult with provinces, territories, and other stakeholders to introduce a National Disabilities Act.
- Work with Health Canada, CBS, and HM-QC to end the ban that prevents men who have had sex with men from donating blood, adopting a policy that is non-discriminatory and based on science.

Information/open data/access to personal information

- Update the Access to Information Act to ensure government data and information are open by default, in formats that are modern and easy to use.
- We will make it easier for Canadians to access information by eliminating all fees, except for the initial $5 filing fee.
- We will expand the role of the Information Commissioner, giving them the power to issue binding orders for disclosure.
- To ensure that the system continues to serve Canadians, we will undertake a full legislative review of the Access to Information Act every five years.
- We will accelerate and expand open data initiatives, and will make government data available digitally, so that Canadians can easily access and use it.
- Create a central, no-fee website for personal information requests.
Title: Ambulance Operator Contract Negotiations

Issue: To provide an update on ambulance contract negotiations

Background and Current Status:
- The Human Resources Secretariat (HRS), with the Department of Health and Community Services (HCS), commenced negotiations with the ambulance industry in fall 2012. Concepts from the 2013 Road Ambulance Review have been incorporated into negotiations.

- Industry is represented by three provincial Ambulance Operator Associations representing 45 private and community ambulance operators:
  - NLCAOA: Newfoundland and Labrador Community Ambulance Operator Association – 22 Public Utility Board (PUB) assigned community operator licenses;
  - NLPAOA: Newfoundland and Labrador Private Ambulance Operator Association – 10 PUB assigned private operator licenses; and,
Prior to negotiations, the annual cost of ambulance services was $51M. The additional cost committed in these negotiations is $8.2M in 2015-16 and $7.1M in 2016-17 and in future years. These increases bring the total cost of the program to $59.2M in 2015-16 and $58.1M in 2016-17 and future years. The table below indicates the expected cost increases.

<table>
<thead>
<tr>
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<th>2015-16 Cost</th>
<th>2016-17 Onward ($)</th>
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<tr>
<td></td>
<td>($ including retroactive - Base and One-time)</td>
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<tr>
<td>NLCAOA</td>
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<td>NLPAOA</td>
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<td>Overtime*</td>
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<td><strong>Total</strong></td>
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<td><strong>$7,160,400</strong></td>
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*NAAS and Independent operator amounts assume a December 1 implementation date. Amounts will change if the implementation date is delayed.

Analysis: s.35(1)(f)

s.30(1)(b)
Government implemented the new service agreements with the NLCAOA early Summer 2015 and the NLPAOA effective December 1, 2015. NLPAOA agreed to delay implementation of the Return Transfer Policy until January 18, 2016 to provide time for further dialogue. NLPAOA have indicated they may be open to some revision of the Return Transfer Policy. NLCAOA and the three independent operators have been notified of this delay and have expressed no concern to date.

Action Being Taken:
- HCS will work with NLCAOA, NLPAOA and the Regional Health Authorities to prepare for implementation, on December 1, 2015, of the new service agreements. Implementation of the new Return Transfer Policy will be delayed until January 18, 2015 to allow HCS and HRS time to further understand concerns of NAAS and NLPAOA.
- HRS and the HCS will continue to negotiate with the NAAS when instructed by Government.

Prepared/approved by: J. Letto/H. Hanrahan/C. MacDonald Newhook/M. Harvey/ D. Tubrett/G. Williams/B. Clarke
Reviewed by: K. Norman/T. King, Cabinet Secretariat

November 26, 2015

Cabinet Secretariat Comment:
- The Department of Finance, the Human Resources Secretariat, the Labour Relations Agency and the Communications Branch have no concerns.
Information Note
Department of Justice and Public Safety

Title: Physician-Assisted Dying

Issue: Preparing for the effective date of the Supreme Court of Canada (SCC) decision in Carter v. Canada on physician-assisted dying (PAD).

Background and Current Status:
- On February 6, 2015 the SCC decision in Carter v. Canada struck down the Criminal Code prohibition against PAD in the case of a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable, though not necessarily terminal, medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The SCC decided that nothing in this declaration would compel physicians to provide assistance in dying, and that the Charter rights of patients and physicians will need to be reconciled in any legislative and regulatory response to the SCC judgment.

- The declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow governments time to respond. The federal government may choose to amend the Criminal Code and potentially enact legislation relating to certain aspects of PAD. Provinces and territories may also determine it is necessary to legislate and develop policy in relation to PAD. Provincial and Territorial Colleges of Physicians and Surgeons will also likely introduce guidelines for physicians. The SK College has already issued a policy on PAD, while other Colleges (MB, AB) have published draft statements.

- On December 3, 2015 the federal government applied to the SCC for a 6 month extension of the suspension of the declaration of invalidity (to August 6, 2016). That request was supported by letters from several provinces (SK, MB, NS, PEI) and an affidavit from ON. The federal government’s application may be opposed. QC has sought an exemption from the suspension of invalidity in so far as it affects medical aid in dying under QC’s Act respecting end-of-life care. All materials related to the federal government’s application are required to be filed by December 15, 2015. It is anticipated that the SCC will rule fairly quickly on this application, although the exact timing is unknown.

- QC, after several years of consultations, passed legislation providing for PAD (“medical aid in dying”) in cases where the condition is terminal (“end-of-life”) and as part of broader end-of-life care options. This legislation came into effect on December 10, 2015. On December 1, 2015 the Quebec Superior Court held that as long as the declaration of invalidity in Carter remains suspended, the QC medical aid in dying provisions are in conflict with the Criminal Code and are therefore rendered inoperative by the doctrine of federal paramountcy. This order was issued within an ongoing challenge to the QC legislation on various grounds by a QC physician and a patient with a disability. On December 9, 2015 the QC government was granted leave to appeal this decision. The appeal will be heard by the QC Court of Appeal on December 18, 2015. In the meantime, the QC legislation came into effect as scheduled on
December 10, 2015. Media reports suggest that there remain significant unresolved issues with respect to the implementation of PAD in QC.

- There have been calls from many groups, including the Canadian Medical Association, for a uniform national approach to PAD.

**Provincial level activity:**
- Within the Government of Newfoundland and Labrador (GNL), Seniors Wellness and Social Development (SWSD) is coordinating with Health and Community Services (HCS) and Justice and Public Safety (JPS) on this issue. SWSD chairs a working group and HCS is the communications lead.

- The working group, which involves DM and ADM level representation from the three departments, JPS lawyers, HCS and SWSD policy advisers, the Newfoundland and Labrador Medical Association (NLMA) and the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) has been established. The CPSNL is the regulatory body for physicians in the province. Meetings are held on a biweekly basis.

- Each Province and Territory is also undertaking work within their respective jurisdictions.

**Federal activity:**
- The former federal government established a Federal External Panel to consult with Canadians on options to respond to the SCC decision. The new federal government has extended the deadline for the External Panel’s report to December 15, 2015 and has modified the Panel’s mandate such that they are only to present a summary of their consultations, not any legislative options.

- The Prime Minister’s Mandate Letter to Federal Justice Minister and Attorney General Jody Wilson-Raybould identifies one of the Minister’s top priorities as to “lead a process, supported by the Minister of Health, to work with provinces and territories to respond to the Supreme Court of Canada decision regarding physician-assisted death.”

- The federal government has also confirmed its intention to introduce a motion that Parliament establish an all-party special parliamentary committee with members from the House of Commons and the Senate to study the issue, engage in essential consultations with Canadians, and make recommendations on a federal government response.

- An FPT Working Group on PAD has been established to act as a link between the Federal Panel and the PT Group and to provide an inter-jurisdictional forum for discussion, information sharing and coordination related to PAD.

**Provincial/Territorial activity:**
- The Provinces and Territories (not QC; BC in observer capacity), led by ON, established a nine member PT Expert Advisory Group (Advisory Group) to provide non-binding advice to participating PT Ministers of Health and Justice to assist PTs in deciding what policies and
procedures should be implemented within their jurisdiction in response to the Supreme Court’s decision.

- The Final Report, dated November 30, 2015, was shared with PT Health and Justice Ministers on December 2, 2015.

- A PT ADM (Health & Justice) Working Group has been established to link the work of the Advisory Group with participating PTs.

PT Expert Advisory Group Final Report:
- The Final Report of the Advisory Group was shared with PT Health and Justice Ministers on December 2, 2015. Their advice to governments is non-binding.

- The Final Report contains 43 recommendations, including 22 that are recommended to be implemented through P/T legislation (preferably based on a single model statute). A summary of the Final Report and its recommendations is included in the attached Annex. The Report recommends features of a legislative and policy framework for the safe and responsible provision of PAD as an insured service within the public health care system and within the context of high quality palliative and end-of-life care.

- The Advisory Group noted that their recommendations may need to be revised upon action that may be taken by the federal government in the near future.

Analysis:
- As of February 6, 2016, unless that date is extended by the SCC, PAD will no longer be contrary to the Criminal Code.
The College of Physicians and Surgeons is developing a guideline document that focuses on matters more directly related to the clinical provision of the service. This document is being informed by similar documents being prepared by Colleges in other jurisdictions.

Next Steps:
Prepared/approved by: B.Barrowman, C.MacDonald Newhook in consultation with HCS and SWSD/

- The Final Report is confidential at this stage and is intended only for internal use by P/T Governments.
- Advice is meant to assist PTs in deciding whether, and if so, how to enact legislation, and what policies and procedures to implement within their jurisdictions. Advice is non-binding.
- The Advisory Group noted that their recommendations may need to be revised upon action that may be taken by the federal government in the near future.
- The Advisory Group outlined its views with respect to regulation, that:
  - there are three key actors in the regulatory system for PAD – the federal government, the P/T governments, and the health professional regulatory bodies. A pan-Canadian regulatory framework should include: (1) core features established in the Criminal Code; (2) additional procedural safeguards and provisions to ensure access in provincial legislation (preferably based on a single model statute); and (3) additional guidance for health care professionals established through their regulatory authorities;
  - harmonization of regulation across jurisdictions is critical to the public interest;
  - intergovernmental and cross-jurisdictional collaboration is essential;
  - an efficient and effective oversight system is essential to ensure responsible governance and public trust in the regulatory system;
  - a strong legislative response is needed to ensure access to PAD for all individuals who meet the eligibility criteria, to ensure that PAD is provided only to individuals who meet the eligibility criteria, and to reconcile the sometimes competing interests of health care providers and institutions and patients; and
  - PAD should be integrated into existing end-of-life processes and mechanisms as much as possible.

Summary of recommendations:
1. Develop and implement, preferably in collaboration with the federal government, a pan-Canadian strategy for palliative and end-of-life care, including PAD.
2. Collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of PAD in Canada.
3. Ensure access to PAD, including both physician-administered and self-administered PAD.
4. Require all regional health authorities to have an effective publicly-funded coordination system in place to ensure patient access to PAD.
5. Ensure PAD is publicly funded. All aspects, from counselling about end-of-life options to assessment and provision of PAD should be included as insured services in P/T health insurance plans.
6. PAD should not be on the exclusion list for interprovincial reciprocal billing.
7. Request that the federal government amend the Criminal Code to explicitly protect health professionals who provide supporting services during the provision of PAD.
8. Request that the federal government amend the Criminal Code to allow the provision of PAD by a regulated health care professional (registered nurse or physician assistant) acting under the direction of a physician or nurse practitioner. Ensure no regulatory barriers prevent these health care professionals from providing PAD.

9. Ensure that health professionals are protected from liability for acts/omissions in good faith and without negligence in the provision of PAD.

10. Make legislative/regulatory changes, if necessary, to require life insurance claims to be paid for deaths resulting from PAD.

11. Establish requirements to ensure a patient declaration form is completed and witnessed by an independent third party to confirm a patient’s request for and consent to PAD.

12. Request that the federal government make clear in the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for PAD made through a valid patient declaration form may be fulfilled when suffering becomes intolerable (i.e. even if patient has lost competency by that time).

13. Within one year, in collaboration with the federal government, study whether patient declaration forms completed prior to diagnosis of a grievous and irremediable medical condition might also be considered valid.

14. Substitute decision makers should not be given the legal authority to consent to / authorize PAD on behalf of an incompetent patient.

15. Create a patient information form to gather demographic data on those requesting PAD and the reasons for the request.

16. Collect data from the patient’s initial request to the time of signing the death certificate and/or completion of request (e.g. patient withdrawal of request, physician denial of request).

17. Recommend that the federal government make clear in the Criminal Code that eligibility to PAD is to be based on competence rather than age.

18. Define “grievous and irremediable condition” as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions should not be listed in legislation or regulation.

19. Request that medical regulatory authorities develop guidance for physicians to ensure criteria for access to PAD have been met and procedural safeguards respected.

20. Use existing processes in the health care system to assess competency and consent.

21. Access to PAD should be available only to those eligible for publicly-funded health services.

22. Two physicians must assess the patient to ensure that all criteria are met.

23. Where physician supply is limited, enable virtual physician assessments (via telemedicine) or if necessary, transport reviewing physicians to the patients for assessment.

24. For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.

25. Not recommended to establish an appeal process for situations in which attending and/or reviewing physician concludes eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

26. A prescribed waiting period is not recommended. The time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.

27. PAD should be available where patients live (including in hospitals, long term care facilities and at home), except certain conscientiously objecting facilities.
28. There should be no requirement that a physician be present at a self-administered assisted death.
29. Following provision of PAD, physicians should file a report with a Review Committee to enable the review of each case.
30. PAD should be listed as the manner of death on medical certificates of death, and the medical condition that qualified the patient for PAD should be listed as the cause of death.
31. Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including PAD, regardless of their personal beliefs.
32. Conscientiously objecting health care providers should be required to inform patients of the fact and implications of their conscientious objection to PAD. Any ongoing treatment must be provided in a non-discriminatory manner.
33. Conscientiously objecting health care providers should be required to either refer or transfer care to another health care provider, or to contact a third party and transfer the patient’s records through the coordination system described in Recommendation 4.
34. All institutions should be required to inform patients/residents of any institutional position on PAD, including any limits on its provision.
35. Prohibit any requirement by institutions that patients give up the right to access PAD as a condition of admission.
36. Prohibit any requirement by institutions that physicians refrain from participation in PAD outside the non-participating institution.
37. Non faith-based institutions, whether publicly or privately funded, must not prevent PAD from being provided at their facilities.
38. Faith-based institutions must either allow PAD within the institution or make arrangements for timely and safe transfer of the patient to a non-objecting institution for assessment and potentially, provision of PAD.
39. Establish a Review Committee system to review all cases of PAD after the provision of the service to ensure compliance with relevant legislation and health professional regulatory standards, and transparency and accountability.
40. Distinct from the case review system, PTs should establish (preferably in collaboration with the federal government) a pan-Canadian Commission on End-of-Life Care to provide system oversight and report to the public.
41. Ensure coordination across funders and F/P/T governments on a research strategy to inform implementation and continuing development of end-of-life care, including PAD.
42. Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula, continuing education programs, and training related to the provision of PAD for students, physicians and health professionals.
43. Provide public education about PAD and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

- The Advisory Group identified that the following recommendations be implemented through P/T legislation - Recommendations 3-5, 9, 11, 14-16, 18, 21, 22, and 29 -39.
- One member believed that these recommendations could be implemented through professional regulatory standards rather than legislation.
- Recommendations 7, 8, 12 and 17 concern matters which the Advisory Group recommended that PTs request the federal government to address in Criminal Code amendments.
Information Note
Department of Health and Community Services

Title: All-Party Committee on Mental Health and Addictions (APC)

Issue: To provide an overview of the APC, work completed to date, and next steps following the 2015 general election.

Background and Current Status:
- A first of its kind in Newfoundland and Labrador, the APC was established following a private members’ motion on January 21, 2015, that was supported by all members of the House of Assembly.

- The mandate of the APC is to conduct a full review of the provincial mental health and addictions system to identify gaps in services and areas for improvement. Upon conclusion of its review, the APC will submit recommendations to the House of Assembly with the objective of improving mental health and addictions programs and services in the province.

- The APC consists of four government members, including the committee chair, two members from the official opposition and one member from the third party, as well as one alternate member from each group.

- The APC is structured as a Committee of Executive Council with secretariat support provided by the Department of Health and Community Services.

- The APC has taken a multi-pronged approach to its review of the mental health and addictions system. This includes:
  - Hosting several presentation and dialogue/discussion sessions throughout the province;
  - Receiving public submissions and feedback online, by email and telephone;
  - Holding meetings with executive and mental health and addictions staff in each regional health authority;
  - Touring health care facilities and Her Majesty’s Penitentiary; and
  - Hearing from experts on best practices in mental health care delivery.

- Public consultation sessions were held in Labrador City, Happy Valley-Goose Bay, Corner Brook, Grand Falls-Windsor, Marystown and St. John’s. As a result of these sessions, the APC has heard from 65 mental health and addictions stakeholder groups, received 64 public presentations from individuals, families and organizations, and held round table sessions with 255 participants. Public consultation transcripts, submissions and raw data from dialogue/discussion sessions have been posted online at www.BeHeardNL.ca.

- The Newfoundland and Labrador Centre for Health Information (NLCHI) reviewed the public consultation transcripts to identify and code major themes and sub-themes. The five key themes that have emerged from the consultations to date include the need to:
o Improve access to services and supports by increasing investments in mental health resources and affordable and supportive housing, addressing wait times and providing more resources in the school system.
o Enhance quality of care by providing more patient-centered care, increasing the use of multi-disciplinary teams in primary health care clinics and providing ongoing professional development and educational opportunities for staff.
o Focus on the promotion of positive mental health and prevention of mental illness by reducing stigma through education and awareness, supporting the social determinants of health and working with schools on the promotion of positive mental health and early intervention.
o Improve policy and programming by applying appropriate mental health and harm reduction lenses and increasing engagement opportunities for individuals living with mental health and addictions in the early stages of program development.
o Strengthen community supports by continuing to build relationships with community-based partners and enhancing the delivery of programs and services within the community in which individuals live and work.

- APC representatives held a media conference on October 26, 2015, and released a progress report of the committee’s work to date. Members acknowledged that the work to fulfill the committee’s mandate is not yet complete, and advised that the APC would continue its work following the general election.

Analysis:
- During its last business meeting on October 6, 2015, APC members agreed that current committee members would meet, informally if necessary, following the election to discuss a plan for transition and moving forward, regardless of the election outcome. It was also mutually agreed that while there is no current end date for the committee, its mandate should be fulfilled in 2016.

- The progress report recently released to the public states that the committee should reconvene by January 31, 2016, to determine a plan for work outstanding, including:
o Presentations from experts and stakeholders not yet consulted;
o Consultation with Aboriginal communities; and
o Conclusion of public consultation sessions, including visits to Clarenville and Port aux Basques.

Action Being Taken:
- The work of the APC is currently on hold pending the 2015 general election. The committee will reconvene by January 31, 2016.

Prepared / Approved by: G. Hussey/G. Webber/K. Stone
Deputy Minister Approval: [Signature]
Ministerial Approval: [Signature]

November 13, 2015
Information Note
Department of Health and Community Services

Title: Provincial Physician Recruitment

Issue: To provide an update on the current supply of physicians in the province and to identify challenges and opportunities in physician recruitment and retention.

Background and Current Status:
- As of March 31, 2015, there were 1,199 physicians in Newfoundland and Labrador - 577 general practitioners and 622 specialists. This is the highest number of physicians the province has ever had. This was a net increase of 16 physicians over March 30, 2014.

- As of March 31, 2015, there has been a net increase of 162 physicians (65 general practitioners and 97 specialists) since 2009 – this represents an increase of approximately 16%.

- The vacancy rates for physicians are derived from information submitted by recruitment personnel at the RHAs. As of June 2015, they were as follows:
  - EH – 6%
  - CH – 8%
  - WH – 10%
  - LGH – 33%.

- Since 2010, approximately $26 million has been invested in retention bonuses for salaried physicians, the majority of which are practicing in rural parts of our province.

- Since 2004, 633 bursaries have been awarded to 342 physicians, a total investment of approximately $14.77 million.

- To address the issue of physician recruitment and retention, the province has:
  - Physician Recruitment Coordinator positions at each of the RHAs;
  - Physician leadership positions at RHAs that have a focus on physician recruitment/retention;
  - Expanded Memorial University’s Medical School and increased class size by over 30% in September 2013;
  - Enhanced the provincial bursary program available to medical students and residents;
  - Introduced a new provincial signing bonus program, with the NLMA, to promote recruitment for difficult-to-fill positions.

- In 2013, Government eliminated the Newfoundland Health Board’s Association and the funding for two staff at the Provincial Physician Recruitment office located in the Faculty of Medicine.

- The Physician Services Division inherited the responsibility to maintain the Provincial Physician Recruitment Office; however, with a complement of only four staff, there have
been significant challenges maintaining the appropriate relationships with students and residents, with the regional physician recruiters at each of the RHAs, and with the Faculty of Medicine Undergraduate and Postgraduate program directors.

- Memorial University's Family Medicine program created new rural streams for 2015, allowing more residents to train in rural settings for the majority of their two year residency. This program matched 100% of their 33 FM positions for 2015, which is the first time this has happened since 2010:
  - Eastern - 10
  - Central/Western - 10
  - Goose Bay/ Northern - 6
  - Nunavut/Northern - 4
  - Other - 3.

- Recently, representatives from CanAm Recruiting met with the Minister and departmental officials to propose that they provide the province with their expertise in the recruitment of physicians to fill local needs.

- There has also been a proposal received recently from another individual who is attempting to establish a recruitment firm in NL.

Analysis:
- Historically, NL has had significant challenges recruiting physicians to rural areas, as well as to specific specialist positions in urban areas. This is not unique to NL and in fact, providing services in rural areas is a challenge across the country.

- According to the Canadian Institute for Health Information (CIHI), in 2014 approximately 36% of practicing physicians in NL were international medical graduates (IMGs — obtained their MD degree outside Canada). This is the second highest in the country. The Canadian average is 25% (Saskatchewan - 53%, Manitoba - 34%, Alberta - 33%, BC - 30%, NS - 30%, Ontario - 28%, NB - 25%, PEI - 18% and Quebec - 10%). Source: Supply, Distribution and Migration of Physicians, 2014: Data Table 19.

- Additional information from CIHI indicates that between 2010 and 2014, provinces such as Alberta and Ontario have increased the number of IMGs by 26.5% and 28.5%, while in NL the increase has been 3.3%. During the same time period the percentage of physicians who are Canadian trained increased by 17.1% in Alberta, 13.3% in Ontario and 19.4% in NL. Source: Supply, Distribution and Migration of Physicians, 2014: Summary Data Table 1.

- The Federation of Medical Regulatory Authorities of Canada is working with the provincial and territorial Regulatory Authorities to meet the requirements under the Agreement on Internal Trade (AIT). This will provide national standards for licensure including those required for IMGs, the majority of which will be under a provisional license. When completed, this will permit physicians with a provisional license in one province to have
easier mobility to another province should an opening exist for a physician with a provisional license.

- The challenge of physician recruitment is further complicated by a number of factors such as:
  - Practice location
  - Physician support and mentorship
  - Family support
  - Professional isolation.

- Additionally:
  - Turnover of IMGs is higher than that of MUN and Canadian graduates (Maria Mathews, MUN);
  - Peer-reviewed research on physician recruitment indicates that it is best to focus on recruiting physicians who are trained locally as retention is much higher (Mathews, MUN).

- The province does not have an official physician resource plan and therefore the determination of the provincial needs has been based on the Regional Health Authorities’ (RHAs) best estimates. In doing so, the RHAs have considered that services would be maintained in the current locations.

- Service locations in the province include many sites with a small number of physicians, leading to professional, personal and family isolation (particularly for family physicians but also for specialists). This isolation negatively affects recruitment of MUN graduates to these sites, as well as retention of IMGs who practice there.

- There has been an increase in the number of MUN graduates practicing in NL:
  - CIHI indicates that between 2009 and 2014, the number of practicing MDs in NL who received their MD degree in Canada increased by 25%;
  - Statistics from 2003-04, 2008-09 and 2013-14 (5-yr intervals) show a steady increase in overall proportion of physicians practicing in NL who had earned MDs at MUN:
    - 2003-04 – 41.3%
    - 2008-09 – 46.4%
    - 2013-14 – 48.6%
  (HCS Annual Physician Supply Reports).

- The Department works with the RHAs to strategically invest financial and human resources focused on the recruitment of MUN-trained physicians.

- Recruitment of physicians who are the right fit both professionally and personally is a complex process that can take years.

- In areas where this has worked well the RHAs have:
  - Become actively involved in the training programs at MUN’s Faculty of Medicine;
  - Built relationships with MUN students and residents over several rotations (training within the RHA) spanning several years;
Engaged physician leaders in the respective specialty areas to become more active in the recruitment process;
- Developed processes for mentorship of new physicians;
- Provided peers to support new physicians during their first six to twelve months of practice;
- Engaged communities in welcoming families into the community and supporting them.

- Spending such a significant amount of time working with the physician leaders in a particular area allows for making more strategic recruitment decisions based on fit within a long-term plan, as opposed to knee-jerk reactions filling immediate vacancies with any qualified physicians.

- The goal of more strategic selection of physicians is better and more sustainable service provision as a result of reduced turnover/better retention, better trained physicians, better cohesion with physician groups and reduced vacancies.

- Despite even the best recruitment strategy, short term needs will always exist and RHAs will, at times, have to fill vacancies with the first available qualified physician. Or special circumstances will require assistance in searching for a high-level position. In such situations, the RHAs have utilized the services available through the Provincial Physician Recruitment Office for posting job ads and reviewing responses to postings. Periodically however, the RHAs will engage various recruitment firms on an ad hoc basis in order to help meet their demands.

Section 29(1)(a)
- The majority of IMGs recruited at WH respond to advertisements on the Practice NL website, the WH website, other advertisements, or through word of mouth of practicing physicians. Alternatively, recruitment personnel in St. Anthony found that the websites were ineffective and that recruitment firms were necessary.

- Recruitment personnel at all RHAs have indicated that the loss of the Provincial Physician Recruitment Office at MUN, as well as two full time personnel, has been detrimental to recruitment efforts. A recruiter in St. Anthony indicated that the loss has significantly reduced their ability to recruit physicians, particularly IMGs for hard to fill vacancies.

- The long term goal of the RHAs and the Department is to limit reliance on locums and IMG physicians to fill short term needs, and build a more sustainable and cost efficient system through permanent recruitment of MUN trained physicians.

- The overall strategy of focusing on MUN recruitment seems to be having a gradual and positive effect; however, the lack of financial and human resources for the “Provincial Physician Recruitment Office” has significantly increased the burden on the Physician Recruitment Coordinator positions at the RHAs as well as staff at the Department.

- This burden on the Physician Recruitment Coordinators within the RHAs exacerbates an existing issue of ensuring that the PRCs are doing the work they were intended to do.

- In some cases, it has been difficult to ensure that the appropriate provincial deliverables are provided (e.g., monthly recruitment reports to HCS).
• The lack of a direct reporting relationship to HCS, therefore, limits the ability to direct the work of the PRCs toward a successful and sustainable provincial recruitment strategy.

• The expansion of the Faculty of Medicine will require a more distributive model of student and resident education when more rotations occur in sites outside St. Johns. The family medicine residency training program has developed family medicine stream programs (started July 2015 and fully subscribed) where many family medicine residents will be located at sites other than St. Johns for the majority of their two years of training. These initiatives will provide excellent opportunities for recruitment as the literature has shown that physicians who train in rural sites are more likely to remain in rural sites.

• There are a number of physician recruitment firms that have provided services to the RHAs; however, a further analysis of the experiences of the RHAs in terms of success and costs will need to be explored. In addition, the RHAs will need to be supportive of collectively engaging with an external recruitment firm.

**Action Being Taken:**

• The Department will continue to retain a provincial Physician Recruitment Office located at MUN’s Faculty of Medicine.

• The physician services division worked with representatives from the RHAs, MUN’s Faculty of Medicine, and the CPSNL on a physician recruitment project. A working group has been put in place and meetings have occurred over the past several months toward creating a provincial physician recruitment action plan. This plan is being finalized with the input of the parties.

  o The work of the committee will primarily focus on a MUN oriented physician recruitment strategy. There is consensus by the VPs that this is the best approach to current recruitment and retention challenges. This is supported by research completed by Dr. Maria Matthews – Community Medicine faculty at MUN. However, the report will also explore the current issues with recruiting IMGs.

  o The Department will complete an analysis of the RHAs’ usage of physician recruitment firms to inform the committee. This will include a review of the costs, the CPSNL licensing issues encountered by the RHAs for the physicians from these firms, the duration of time the candidates provided by recruitment firms remain at the original location and/or in the province, and a satisfaction survey. The department will also liaise with other provinces to understand their success and challenges in physician recruitment including the usage of external recruitment agencies.

• The Medical Consultant in collaboration with the Dean of Medicine organized a day-long meeting in October that engaged partners from the RHA, CPSNL, NLMA, Faculty of Medicine and the DHCS. This meeting was focused on recruitment of primary care physicians and from that meeting actions will be undertaken to support the overall provincial physician recruitment plan.
- While the committee is working on developing an action plan the following is advised to occur: 

\[ s.38(1)(a) \]

Prepared/approved by: D. Fitzgerald/L. Alteen
Deputy Minister Approval:
Ministerial Approval:

December 9, 2015
Information Note
Department of Health and Community Services

Title: In Province Air Ambulance Request for Proposal (RFP) Award Process.

Issue: Unsuccessful vendors have expressed concern over the process and timelines required to prepare, issue, evaluate and award of the In Province Air Ambulance RFP.

Background:

- Government’s Air Ambulance Program (AAP) is a critical element of the province’s healthcare system providing time sensitive transport of patients to the medical services they require. The AAP transports approximately 1,375 patients per year throughout the province and to/from mainland health care facilities.

- The province of NL currently owns two King Air aircraft which are used to complete air ambulance transports throughout Newfoundland and Labrador. Government Air Services (GAS), a division of the Department of Transportation and Works (DTW) own and operate these two Beechcraft King Air 350s which are modified for use as air ambulances; C-GNLO is stationed in St. John’s and C-GNFL is stationed in Happy Valley-Goose Bay.

- Since September 2010, Department of Health and Community Services (HCS) has placed a Provincial Airlines Limited (PAL) Citation II jet on 24/7 retainer to supplement Government air ambulance services.

- In March 2014 Fitch and Associates delivered a preliminary AAP Review Report that recommended HCS should tender for two different aircraft services:
  - A turboprop aircraft similar to the King Air 350 used by GAS to transport patients within the province capable of landing at all provincial airports and airstrips; and
  - The creation of an inventory of long distance air ambulance aircraft providers to be placed on on-demand standing offer contracts for the transport of patients to and from mainland health facilities when required. The aircraft proposed had to be capable of flying non-stop from St. John’s to Toronto on 100% of the flights without refueling.

- The rationale for two separate aircraft services is there is no single aircraft in commercial operation that can fly from St. John’s to Toronto nonstop without refueling 100% of the
time and still have the capability to land at all the required airports and airstrips within the province.

- During the period October to December 2014, HCS with the assistance of Fitch, GPA, Justice and DTW prepared two RFPs:
  - Air Ambulance Aircraft and Aviation Service Provision (In Province)
  - Long Distance Air Ambulance with Medical Team Provision On Demand Standing Offer (Long Distance)

- Both RFPs were issued on December 22, 2014 with a closing date of January 28, 2015.

- For the In Province RFP three proponents responded:
  - Provincial Aerospace Limited (PAL)
  - Exploits Valley Air Services Limited (EVAS)
  - Air Labrador Limited (Air Lab)

- Long Distance RFP three proponents responded:
  - Provincial Aerospace Limited (PAL)
  - Fox Flight Limited (FOX)
  - Latitude Air Ambulance Limited (LAA)

- On February 18, 2015 an evaluation team comprised of HCS, DTW, Eastern Health and Labrador Grenfell Health officials met to evaluate the In Province RFP proposals. The team used the Treasury Board Framework for the Evaluation of Proposals Arising from Requests for Proposals as the evaluation template. The team determined that Provincial Aerospace Limited ranked the highest and should be recommended as the winning proponent.
On September 15, 2015 PAL and HCS signed the In Province air ambulance contract effective September 1, 2015.

Current Actions:

- HCS informed the unsuccessful proponents, EVAS and Air Lab in writing on November 25, 2015. Both proponents have expressed concern with the award both verbally and in writing.

- In response to HCS’s November 25th letter, EVAS’s management phoned, ADM(A) Professional Services, on several occasions expressing concern over the RFP process and requesting a meeting and indicating he would be in contact with the Auditor General and the Government Purchasing Agency. HCS replied in writing offering a meeting December 4, 2015 to review EVAS’s RFP response. HCS’s offer was initially accepted but was subsequently cancelled by the company. EVAS then wrote on December 3, 2015 requesting the RFP’s reference number and the name of the winning proponent. The letter also requested a formal investigation into the RFP process. Prior to HCS’s reply EVAS contacted the Government Purchasing Agency requesting an investigation of the RFP process. It is also understood an official of EVAs has met with officials of the Government Purchasing Agency.

- In response to HCS’s November 25th letter Air Lab responded in writing expressing concern over the RFP process and requesting a review and a report on the RFP award. HCS replied in writing offering a meeting to discuss Air Lab’s RFP response and that HCS would not be carrying out a review. Air Lab has responded both verbally and by e-mail asking for the meeting to be arranged to review RFP process as per section 12.14 of the RFP document. Additionally the Air Lab Official is indicating they have other question not related to section 12.14. HCS is in the process of arranging the meeting.
Title: Syrian Refugee Situation

Issue: To provide an update on the status of the federal government’s plan for the expedited resettlement of 25,000 Syrian refugees and NL response and preparedness initiatives.

Background and Current Status:
- According to the United Nations High Commission for Refugees (UNHCR), an estimated 12 million Syrians have fled their homes since the outbreak of civil war in March 2011. Syria is currently the world’s largest refugee crisis under the UNHCR.

- The federal government is committed to receiving 10,000 Syrian refugees by December 31, 2015 and an additional 15,000 by the end of February 2016. A whole-of-government coordination effort, led by Immigration, Refugees and Citizenship Canada (IRCC) is underway.

- IRCC holds primary responsibility for the arrival and settlement of both privately sponsored refugees (PSRs) and government-assisted refugees (GARs) in Canada. Immediate services and supports, including financial, for the settlement of GARs is provided by the federal government. PSRs are supported by sponsors, who agree to provide the settlement assistance and support that would otherwise be provided by the federal government.

- The Association for New Canadians (ANC) is contracted by the federal government to deliver supports for the settlement of GARs in NL. The ANC also works with organizations that privately sponsor refugees, or may act as a co-sponsor in support of a PSR application. The ANC is developing an action plan to prepare for the arrival of additional refugees.

- The Department of Advanced Education and Skills (AES), Office of Immigration and Multiculturalism, is responsible for the provincial immigration program and provides support to the ANC. NL’s response to the resettlement efforts includes:
  1. An AES request to increase the annual provincial allocation of GARs from 155 up to 250; and
  2. Provision of one-time funding of $50,000 to the ANC for a Private Sponsorship Refugee Coordinator position.

- In addition to providing support through the Resettlement Assistance Program, which includes access to direct services, such as initial reception, orientation and assistance with finding permanent accommodation, navigating the new community, shopping and other basic life skills, and federal income support, at a rate equivalent to provincial Income Support, the federal government has made all Syrian refugees eligible for Type I benefits under the IRCC’s Interim Federal Health Program (IFHP) for up to one year. Type I benefits include basic, supplemental, and prescription drug benefits. Basic benefits includes most services that residents would normally be covered for under their P/T health insurance plans, such as hospital services and services received from a doctor, until the beneficiary qualifies for P/T coverage (e.g., NL Medical Care Plan). Supplemental benefits include limited dental and vision care, services by allied health care practitioners, including clinical psychologists, and a range of other services and products. The prescription drug benefits include medications and other products listed on
PT public drug plan formularies (e.g., the NL Prescription Drug Plan) and other products as determined by IRCC.

- In NL, the MUN Med Gateway program, a volunteer program led by students in partnership with the Faculty of Medicine, ANC and Eastern Health, works with refugees to develop individual medical histories that can be shared with family doctors. The program also helps match participants with family doctors as needed, conducts research about the health needs and issues of refugees, and undertakes other initiatives to benefit refugees as needs are identified.

**Analysis:**

- The federal government’s announcement maintains an election commitment but extends the deadline from December 31, 2015 to the end of February 2016. The extension will allow the federal government to complete all relevant medical and security screening as per existing processes/procedures.

- All P/Ts are supportive of the federal government’s plan. Since November 4, 2015, approximately 900 Syrian refugees have arrived in Canada. This includes approximately 100 GARs and approximately 800 PSRs. The vast majority of these arrivals have gone to BC, AB, ON and QC. In NL, nine PSRs have either arrived or have applications in process. The number of GARs destined for NL has not been determined. Federal government officials indicate that applications with final destinations already identified are being prioritized. As a result, for P/Ts like NL without any GARs confirmed to date, it is unlikely that any will be received prior to January, or February 2016.

- Based on the number of expected refugees in NL (approximately 100), the overall impact on the NL health care system is expected to be minimal.

- The federal government does not have detailed information regarding the demographics and health status of the Syrian refugee population. HCS is collaborating with F/P/T governments and other stakeholders, including RHAs, the ANC, the MUN Gateway Program, and local Health Professional Associations, to gain a better understanding of the health status and extended health needs of any incoming Syrian refugees.

- The risk of communicable disease transmission is low. Other countries have reported no significant outbreaks or increased transmission rates of any infectious diseases of concern.

- Childhood vaccination status, primary health care integration, transition to provincial medicare programs, and the application of dental and other supplemental health benefits under the IFHP are the main health issues for P/Ts, including NL.

- Childhood vaccine coverage in Syria has dropped sharply since 2011. Children under five are likely to arrive without their immunizations or under-immunized. Children over five may also lack documentation. HCS is working with the RHAs to assess the resource implications as information becomes available.

- Under the federal government’s plan, all refugees (i.e., both GARs and PSRs) will arrive with permanent resident status. In NL, as well as some other P/Ts, there is no waiting period for provincial medicare coverage for permanent residents. As the basic benefits under the IFHP are
primarily to support refugees not otherwise eligible for provincial programs, HCS is seeking clarification from the federal government regarding how these benefits will be applied in NL.

- Identifying physicians willing to take on new patients has been identified as a concern. HCS is working with interested stakeholders, such as MUN Gateway and the NLMA to develop a plan to meet the primary health care needs of incoming Syrian refugees. Drawing on available expert guidance specific to the Syrian situation, modified as appropriate for NL, the intention is to develop a balanced approach to health service provision while helping address any concerns health professions may have and increasing knowledge of the IFHP. HCS is assessing whether additional outreach activities to other Health Professional Associations is warranted (e.g., Dental, Optometrists, Pharmacists).

- HCS is also working horizontally with other NL Departments and agencies (e.g., AES, FES-NL, and NL Housing), to assist with coordinating the overall Provincial response.

Prepared/Approved By: C. Bodnar and J. Letto/D. Allison
Approved by:
December 14, 2015
Title: Midwifery Implementation Update

Issue: To provide an update on the implementation of midwifery in Newfoundland and Labrador.

Background:

- Midwives have been regulated in various parts of the Canadian health care system for more than 20 years, beginning in Ontario in 1994. Newfoundland and Labrador, Prince Edward Island and the Yukon remain the only jurisdictions with no provision for regulated midwifery. New Brunswick has legislation in place but there are currently no practicing midwives.

- Registered midwives are experts in normal birth, with a focus is on the entire maternity cycle – prenatal, postnatal and newborn care. Midwives provide care from early pregnancy to six weeks postpartum for healthy women and infants. The basic model of midwifery practice is the same in all regulated jurisdictions in Canada.

- In all the provinces/territories that regulate midwifery, with the exception of New Brunswick which has no practicing midwives, the services of midwives are part of government-funded health care services. Initially in Alberta, midwifery practice was regulated but not covered within government-funded services. Services became part of the publicly funded system in 2009 after strong public reaction and loss of almost all the midwives to other provinces. In the majority of provinces/territories, midwives are salaried employees of health authorities. In Alberta, British Columbia, and Ontario, midwives work in independent, government approved, midwifery practices where midwives are paid by government through courses of care provided.

- There has been a long history of midwifery in Newfoundland and Labrador. Labrador-Grenfell Health had previously utilized Registered Nurses who have midwifery skills (nurse-midwives) in St. Anthony. These individuals were internationally-educated.

- In January 2014, Labrador-Grenfell Health received notification from its insurance provider that it could not provide liability insurance to unregulated midwives. Therefore, Labrador-Grenfell Health had to discontinue the midwifery duties of the nurse-midwives.

- The Implementing Midwifery in Newfoundland and Labrador Report (the Report), commissioned by the Department of Health and Community Service (HCS), and released in February 2014, recommended a five to seven year implementation plan, which included establishing midwifery positions within the regional health authorities by 2016/17, expanding positions in 2017/18 and continuing to grow midwifery services in the province to 20 positions beyond 2018. Not all of the Report recommendations have been implemented as outlined; rather, they are serving as a guide for implementation.
Current Status:

- HCS has taken a number of actions towards the implementation of midwifery in the province.

Regulations:

- A Regulatory and Policy Advisory Committee was established to assist with the development of midwifery regulations under the Health Professions Act. This committee includes practicing midwives, midwifery educators, and a midwifery registrar from another Canadian jurisdiction, as well as representatives from HCS, the Newfoundland and Labrador Council of Health Professionals (NLCHP), and the Association of Midwives of Newfoundland and Labrador (AMNL).

- Regulations have been drafted and are pending final review. The Regulatory and Policy Advisory Committee was consulted throughout the development of the regulations.

- Cabinet approval is required to proclaim the Health Professions Act into force for the profession of midwifery.

- Separate from the Cabinet Paper approval process required to proclaim the Health Professions Act into force for midwives, Ministerial approval is required for regulations. Both Cabinet approval (for the Act) and Ministerial approval (for the regulations) are required before the regulations become law.

Provincial Midwifery Implementation Committee:

- Heather Hanrahan, Assistant Deputy Minister (A), Professional Services has been appointed Implementation Coordinator.

- A Provincial Midwifery Implementation Committee (the Implementation Committee), was established to assist with developing processes and policies to establish and integrate midwifery services in the health care system in the province. The work of the Implementation Committee will be key in integrating midwifery services into the public health care system over the next number of years. The Implementation Committee meets on a monthly basis.

- A number of jurisdictions with practicing midwives were invited to the Implementation Committee meetings to present on key steps and share lessons learned through the implementation of midwifery services in their respective provinces. The Implementation Committee has met with Alberta, Saskatchewan, Nova Scotia, Ontario, British Columbia, and New Brunswick. The information received will help inform the recommended model of midwifery service delivery in NL and next steps.

- In October 2015, the Implementation Committee held information sessions with key stakeholders to provide an overview of the regulations; share accomplishments to date; and
outline next steps. Stakeholders included senior representatives from the RHAs working in children and women’s health and public health, professional associations, regulatory bodies, unions and special interest groups such as AMNL, Friends of Midwifery and the Doula Collective of NL. These sessions were positively received.

**Assessment and Bridging:**

- **HCS has allocated $25,000 to support individuals who may wish to practice, or are currently practicing midwifery in NL, to be assessed.** NLCHP is partnering with Ryerson University in Toronto, Ontario for this purpose. If individuals currently residing in the province wish to be assessed for registration, Ryerson would work with NLCHP to offer a one-time, tailored assessment process. The plan is to call for interested participants once the regulations have been proclaimed.

- Depending on the outcome of the assessment, individuals may also have to complete a bridging program which could take up to nine months full-time. The cost to complete the full Ryerson International Midwifery Pre-registration Program (IMPP) program is approximately $7,000. Individuals would also have to temporarily relocate to Ontario to complete the bridging program and would have to bear all costs related to the bridging.

- Following completion of the bridging program, individuals will be required to write and pass the Canadian Midwifery Registration Exam (CMRE) which is offered twice a year, typically May and October. The regulations in NL will require all applicants to pass the CMRE. All regulated Canadian jurisdictions have this as a requirement.

**Professional Liability Insurance:**

- Proof of professional liability insurance (PLI) upon registration is required under the Health Professions Act. The Report states that, “all Canadian jurisdictions have policies underwritten by Health Insurance Reciprocal of Canada (HIROC), with the exception of British Columbia, where the government underwrites a policy. Midwives in three provinces contribute to PLI costs, whereas government provides funding to cover costs in all other regulated provinces.” In most provinces, the provincial midwifery associations negotiate and provide access to PLI for midwife members.

- HIROC does not provide insurance to private individuals; they only issue insurance policies through organizations. Most provinces have made arrangements for the professional midwifery association to provide access to HIROC insurance for midwives. NLCHP is working to identify a mechanism to provide access to insurance in this province.
Analysis:

- Proclamation of the Health Professions Act into force for midwifery and Ministerial approval of the regulations will not result in the introduction of midwifery into the public health care system at this time.

- Midwifery should be understood to be an “add-on” service that would increase patient choice.

- Implementing midwifery would not increase access in rural and remote areas but would reduce some pressure on hospitals, as the experiences shared by other jurisdictions is that 20 to 25 per cent of midwifery births take place out of hospital.

Next Steps:

- The Implementation Committee will continue to meet on a monthly basis.

Prepared/Approved by: J. O’Malley/D. Coffin/H. Hanrahan
Deputy Ministerial Approval:
Ministerial Approval:
December 10, 2015
Central Regional Health Authority
Information Briefing Note
November, 2015

Title: Budget Pressures – Fiscal 2015-16

Issue:
Central Health (CH) faces a number of pressures in the continuous effort to balance the annual operating budget.

Background and Current Status:
Over the past number of years, the Department of Health and Community Services ("the Department") and CH have been working together to find efficiencies and increase revenue opportunities through a number of initiatives including the operational improvement process (OIP) and the strategic spending project (SPP). Significant savings have been achieved however, some targets have not been achieved and other external factors have had a negative impact on the bottom line.

Operating in a large, complex and ever-changing environment where there is a constant effort to balance the available funding with providing safe, quality and timely health care there are many, many challenges.Outlined below are the largest and most significant budget pressures currently facing Central Health.

Analysis:
Inflation: $900,000
Inflation is an annual, ongoing pressure. Inflation calculations are prepared annually as part of the budget process. Budget 2015-16 did not provide any funding for inflationary pressures and this is creating negative variances within our supplies and services budget.

US Exchange: $450,000
Since the spring of 2014 the Canada/US dollar exchange rate has steadily declined from a high of close to 0.98 (close to par) to a current rate of 0.75. Due to a significant volume of purchases from US vendors this has become a major budget pressure.

WCC Premiums: $1,000,000
Over the past few years CH has seen increases in WCC premiums, especially for our long term care sites. This coupled with increases in salary ceilings for premiums has put significant pressure on the budget. No specific funding has been received to offset these costs.
Ambulance Mileage Subsidy: $475,000
Since the devolution of the road ambulance program to the RHAs, CH has been experiencing higher costs associated with mileage subsidies, primarily paid to private operators, than the budget that was transferred to the RHA for that purpose.

Complex Needs Client: $2,500,000
Significant expenditures are required to support a client with complex needs within the Central area. Formal correspondence related to this matter has been exchanged between the relevant program and finance people at Central Health and the Department. Approval has been granted to proceed with delivering this service but no source of funding has been identified so this will be a significant addition to the projected deficit for Central Health.

Attrition Plan: $1,946,500
Budget 2015-16 had a base budget reduction related to the provincial attrition plan to reduce the public service. There is no plan to achieve these savings at the present time and given the reduction in positions through OIP and a management restructuring exercise there are very limited opportunities where positions can be eliminated without impacting service delivery, access, safety and/or other dimensions of quality. For the current fiscal, projected savings in the Home Support and Personal Care Home budgets have been used to offset this amount.

Lab Reform: $1,054,700
Over the past couple of budget cycles, there have been base budget reductions related to provincial lab reform. There is currently no plan to achieve these savings. For the current fiscal, projected savings in Home Support and Personal Care Home budgets have been used to partially offset this amount.

Physician Overhead: $867,400
A base budget reduction occurred in 2014-15 related to physician overhead. There is no plan to achieve these savings. CH originally identified a potential revenue stream during the operational improvement project related to charging physicians operating out of CH space overhead cost but this was changed to a specific provincial project for which no direction has been received to date.

Operational Improvement: $264,900
Base budget reductions have occurred for the past 3 years related to operational improvement. The gap between the total amount of savings achieved to date and the budget reductions to date is $264,900. Once the savings have been fully annualized, the target amount of total savings is $8,721,000. The amount achieved to date is $6,836,500. The initiatives remaining to implement to achieve the remainder of the savings will be much more
challenging that the initiatives implemented to date especially given the reliance on attrition as a means of staff exiting the system.

**Conclusion:**
- In an effort to mitigate budget pressures, including inflation, Central Health continues with initiatives to reduce spending and increase revenues. The following are some areas where action is being taken or considered:
  - Reductions in discretionary spending where possible
  - Continued emphasis on revenue maximization
  - Product standardization and group purchasing programs for operational and capital procurement
  - Clinical utilization reviews and best practices in various programs
  - Benchmarking to identify areas for further efficiency

**Prepared By:** Kellie Bailey/ John Kattenbusch  
**Approved By:** Rosemarie Goodyear, CEO  
**Date:** November 30, 2015
Central Regional Health Authority
Information Briefing Note
November, 2015

Topic: Recruitment Challenges

Issue:

Central Health continues to face challenges in recruiting health professionals including registered nurses (RNs), licensed practical nurses (LPNs), personal care attendants (PCAs), technologists and both primary care and specialist physicians.

Background and Current Status:

Central Health employs approximately 3200 staff (2300 FTEs) which is comprised of 735 registered nurses (RNs), 433 licensed practical nurses (LPNs), 250 personal care attendants (PCAs), 81 lab technologists, 57 paramedics as well as other professional and support staff. Vacancies exist in most areas; however, the specific numbers can vary at any given time. Currently there are 80 RN vacancies (25 permanent full-time), 40 LPN vacancies, 28 PCA vacancies, 6 Lab Technologists vacancies and 7 Paramedic vacancies throughout the region. There are 3-4 upcoming vacancies due to pharmacist retirements which create a significant loss of senior hospital pharmacy experience as well as the challenge of recruiting to these vacant positions. The change in legislation that requires pharmacy technicians to be licensed by 2017 has the potential to create recruitment challenges as there are very few students enrolled in the program and the system is extremely dependent on the success of the current staff to meet the academic requirements for licensure by the deadline.

With respect to Physicians there are presently 20 vacancies throughout the central region with ten (10) in Family Medicine and ten (10) in specialty areas. The specialty area vacancies in Gander include one Surgical Assistant, two Internal Medicine, one OB/GYN, one Pediatrician, and one Radiologist. In Grand Falls-Windsor we have one Pathologist, one Pediatrician and one Radiologist vacancy. We also have one Regional Palliative Care Physician vacancy that we are attempting to fill.

Some of the challenges specific to physician recruitment include the global shortage of physicians. As well, payment models and rural locations such as Fogo Island and St. Albans impact recruitment efforts. There are also other issues such as candidates applying for positions but not being eligible for licensure and others requiring work permits which can take between six to twenty-four months for processing and approval.
In addition to the immediate challenge of current vacancies there is concern regarding the ability to be able to meet the projected long term need for human resources in some of these areas. Based on projected turnover, Central Health anticipates that we will need 132 full-time RNs over the next 3 years and 222 over the next 5 years. The projected need for LPNs is 101 and 216 respectively for the next 3 and 5 years.

An additional factor impacting an adequate supply of key human resources is the issue of unanticipated leave and short term relief challenges. For example on average Central Health has 24 nurses accessing maternity leave per year. Registered Nurses use approximately 13 days of paid sick leave per year and 22 days of annual leave (vacation) per year. In addition to sick leave and annual leave employees use an average of 1.21 days per FTE days for workers compensation. The ability to maintain adequate relief pools and casual staff is critical in covering these short term and unanticipated leaves.

The current supply provincially for many of these disciplines does not meet our demand. For example we have on average 237 RNs and 50 LPNs graduating per year in the province. The ability to fill vacant positions in a timely manner, recruit long term and manage short term relief and unanticipated leave is critical to providing services on 24/7 basis.

**Analysis:**

These challenges impact staffing levels on a regular basis which then impacts how we provide services to our clients, patients and residents. The challenge is especially significant in areas where there is a high degree of specialization, post graduate training, requirement for extensive orientation and/or a need for a concentrated level of experience to both obtain and maintain competency. For example if we are unable to fill positions in our ICU we may have to transfer patients to another site with appropriate levels of staffing. We have also found ourselves in the position of having to divert patients between our two OBS units due to both nursing and physician staffing levels.

These challenges are particularly highlighted during peak times of vacation. Often times in order to ensure adequate staffing in response to unanticipated and short term relief we are forced to use overtime to cover shifts. This means staff such as RNs and LPNs work on their days off leading to decreased morale, burnout and possible sick leave. In additional, the utilization of this strategy to meet relief needs creates a great strain on our fiscal resources in a time when budgetary constraints are already in place in the organization.

The provincial bursary and incentive program does support recruitment efforts for difficult to recruit positions however each RHA is competing for the same limited number of professionals.
In addition to the provincial bursaries and incentives programs there are other areas we can consider. We need to be exploring more local training opportunities, international recruitment and enhanced supports for orientation. We need a stronger partnership with local and national educational institutions. Having a local School of Nursing in the Central Region would improve our ability to recruit nurses on a timelier basis. A feasibility study that examined the potential to establish a MUN satellite School of Nursing in Central Newfoundland was carried out in 2011 and is now being refreshed to reflect current information. The 2014 report of the RN Workforce Planning Committee recommends increasing RN seats in the province’s Schools of Nursing and it further recommends that 25 of those increased seats be located in Central Newfoundland if feasible. MUN School of Nursing is very supportive of the concept and is partnering with the Town of Grand Falls-Windsor and Central Health to demonstrate that the establishment of a 25 seat satellite school of nursing in GFW can be accomplished in a way that is effective, timely and cost efficient.

Conclusion:

Recruiting for health professionals continues to be a day to day challenge. As a system and organization we need to be more proactive in addressing staffing levels. Many of our short term problems exist because we have not been successful with our long term planning; we know what our anticipated needs are both in the short term and long term. In a system that operates 24/7 this is a constant challenge and one that impacts the service delivery to our clients on a daily basis.

Prepared by: Senior Leadership at Central Health
Approved by: Rosemarie Goodyear, CEO
Date: November 30, 2015
Central Regional Health Authority
Information Briefing Note
November, 2015

**Topic:** Facilitating client flow and ensuring appropriate care for the elderly population in acute care; in particular patients designated Alternate Level of Care (ALC)

**ISSUE:** Approximately 25-30% of the acute care beds at the regional referral sites, James Paton Memorial Regional Health Centre (JPMRHC) and Central Newfoundland Regional Health Centre (CNRHC) service elderly patients, who require alternate level of care (ALC); some of whom are medically discharged awaiting long term care placement. Care in an acute setting is not appropriate for these individuals and in addition it impedes patient flow for the acute care population who can only receive care at a secondary referral site. At present, approximately 50% of the individuals waiting for long term care placement are waiting in acute care facilities. If sufficient Long Term Care beds existed for these patients then better client flow would result with less surgeries needing to be rescheduled and fewer patients waiting in Emergency Room hallways.

**BACKGROUND & CURRENT STATUS:**
Central Health has an aging population. One-third of seniors admitted for an acute medical illness will experience a hospitalization-associated disability. Evidence indicates a decrease in length of stay by 3.2 days for patients who underwent rehabilitation on a regular basis. Given the current cost of providing care in an acute care bed, significant savings can be redirected by increasing rehabilitation to patients with similar conditions and ensuring they are discharged home or to their preadmission setting in a timely manner. The current lack of capacity of Occupational Therapists and Physiotherapists in the system has a direct negative impact on the therapists’ ability to address the assessment, intervention and discharge planning needs of the older adults admitted to the acute care service as identified in a 2013 Age Friendly Acute Care CHRSP study. In 2010/2011, older adults accounted for 31.9% of all acute-care hospital separations in this province and 49.5% of all hospital days. Clearly, older adults place proportionally greater demand on the health system than other age groups, and, as their share of the population grows, we can expect a demand for age-friendly acute care to grow along with it. (Age Friendly Acute Care September 2013 CHRSP)

Analysis of alternate level of care data and impact on client flow:

<table>
<thead>
<tr>
<th>Facility</th>
<th>ALC Days (Total)</th>
<th>Percent ALC Days (Average)</th>
<th>#LOS greater than 15 days (Total)</th>
<th>Percent LOS greater than 15 days (Average)</th>
<th>Percentage Beds Occupied (Average)</th>
<th>Admit Counts (Total)</th>
<th>Discharge Counts (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNRHC</td>
<td>9,885</td>
<td>30%</td>
<td>16,537</td>
<td>51%</td>
<td>92%</td>
<td>3,736</td>
<td>3,751</td>
</tr>
<tr>
<td>JPMRHC</td>
<td>9,428</td>
<td>32%</td>
<td>11,091</td>
<td>38%</td>
<td>97%</td>
<td>2,881</td>
<td>2,869</td>
</tr>
<tr>
<td>NDBMHC</td>
<td>498</td>
<td>10%</td>
<td>2,295</td>
<td>44%</td>
<td>83%</td>
<td>369</td>
<td>368</td>
</tr>
<tr>
<td>BBHC</td>
<td>414</td>
<td>14%</td>
<td>940</td>
<td>32%</td>
<td>65%</td>
<td>302</td>
<td>304</td>
</tr>
<tr>
<td>CPHC</td>
<td>319</td>
<td>17%</td>
<td>807</td>
<td>43%</td>
<td>75%</td>
<td>263</td>
<td>267</td>
</tr>
<tr>
<td>BVPHC</td>
<td>1,052</td>
<td>55%</td>
<td>746</td>
<td>39%</td>
<td>75%</td>
<td>194</td>
<td>193</td>
</tr>
</tbody>
</table>
GBHC | 535 | 24% | 745 | 33% | 69% | 191 | 188
AMGMHC | 0 | 0% | 84 | 29% | 40% | 33 | 34
FHIC | 563 | 33% | 1,010 | 59% | 88% | 75 | 77

*Data extracted from Bed Manager (November 24, 2015)*

*The LOS data in this column refers to all patients in acute care that have not received the designation of ALC.*

**CENTRAL HEALTH CLIENT FLOW DATA: Q2 2015/16 (JULY - SEPTEMBER 2015)**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Average LOS for clients admitted to ED and waiting an inpatient bed/transfer (ERIN time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPMRHC</td>
<td>17.8 hours</td>
</tr>
<tr>
<td>CNRHC</td>
<td>12.9 hours</td>
</tr>
</tbody>
</table>

*Data extracted from Cognos/Meditech (October 1, 2015)*

Surgical Cancellations related to bed unavailability:

<table>
<thead>
<tr>
<th>Year/Site</th>
<th>CNRHC</th>
<th>JPMRHC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>15</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>2015</td>
<td>5</td>
<td>13</td>
<td>18</td>
</tr>
</tbody>
</table>

The table above shows average occupancy in the secondary referral centers ranging from 92-97%. The occupancy rate at which acute care units can most effectively and efficiently function is 85% for high demand areas and 75% for an ICU. The occupancy at our referral centers is on average 7-12% above this and the impact on patient flow is significant most days. Having the lower occupancy would allow the system to respond to the unpredictable demand for service that happens in acute care. There is often acute care capacity in rural sites however moving acute care patients to these sites often entails significant engagement with families and others as there is inconvenience associated with the move for them.

As can be seen from the table above at least 42 elective surgical procedures had to be rescheduled over the past 2 years as a result of unavailability of acute care beds at the secondary referral centers. This is a concern for Central Health and the surgical group at both centers.

**Analysis:**

Central Health has been actively researching the factors that impact client flow and emergency department overcrowding in our local context and collaborating with stakeholders to identify and action areas for improvement.

Discussions are ongoing in the areas of inpatient orthopedics, general surgery, medicine and ambulatory services including community care nursing, palliative care and physiotherapy to enhance understanding regarding impedance to patient flow. Teams are exploring process improvements with physician rounds, referral generation, discharge planning upon admission, discharge timing, transfer times from the Emergency Department and policy development in an effort to strive for a desired future state whereby capacity aligns with demand.

Actions listed below include a combination of pilot projects, funded initiatives and those implemented without dedicated new funding.
Restorative Care
The Restorative Care Unit at Notre Dame Memorial Health Care Centre opened in 2011 to offer slow paced rehabilitation for clients age 65 and over who could benefit from this service. This 5-bed unit provides rehabilitation for patients who are experiencing a decline in overall functioning following their admission to acute care. An overwhelming 97.5% of the patients discharged from Restorative Care agree that it was this program that enabled them to return home or to their pre-hospital setting.

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Restorative Care Stats Yearly</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average LOS</td>
<td>25</td>
<td>29</td>
<td>23</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Admissions</td>
<td>32</td>
<td>30</td>
<td>51</td>
<td>61</td>
<td>30</td>
</tr>
<tr>
<td>Discharges</td>
<td>29</td>
<td>30</td>
<td>50</td>
<td>56</td>
<td>30</td>
</tr>
<tr>
<td>Occupancy Rate</td>
<td>69.3</td>
<td>67</td>
<td>72.25</td>
<td>66.5</td>
<td>81</td>
</tr>
<tr>
<td>Repatriation</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Discharged to</td>
<td>27</td>
<td>29</td>
<td>42</td>
<td>49</td>
<td>26</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*RC closed for two months, data based on full months.

Client Flow Process Improvements
The inpatient orthopedics program has been successful in decreasing the patient’s length of stay for total knee replacement by 22% and total hip replacement by 10%. The Community Care Nursing program, through process improvement, regained 19% of their day for direct recipient care activities. The General Surgery program at one site improved by 11% the percentage of patients transferring from the Emergency Department within the 60 minute benchmark. We have also been successful in reducing the average length of stay for colon surgery patients by 35%.

Community Rapid Response Team
The Community Rapid Response Team (CRRT) started at the Central Regional Newfoundland Health Centre in November 2014 to prevent unnecessary admissions to acute care by providing acute community nursing services and home support to patients within their home. Initially the uptake for the target group was very low. Expansion criteria was approved in May 2014 to include any client, 18 years of age or older who could be cared for safely within their home and who resided between Badger and Botwood. Emergency physicians and family practice physicians have been referring to the program. To further increase referrals, the CRRT have been attending patient rounds at CNRHC to help identify inpatients that could be discharged earlier with the services of the CRRT. To date there have been 142 referrals to the program and services have been provided to 92 of these patients. The remaining patients were not admitted to the program because they refused service (8), required a higher level of care and hospitalization (24) or they fell outside of the catchment area (18).

Long Term Care Transitional Unit
Effective March 24th, 2015, a unit at Central Newfoundland Regional Health Centre (CNRHC) was repurposed as a “Long Term Care Transitional Unit.” This unit accommodates residents waiting for a permanent placement in one of our long term care facilities in the region. As with all transitions, there is still the
paramount need to the right care, by the right provider, regardless of the setting. This is a 15 bed unit and is providing a long term care approach to care in an acute care setting.

**Bed Utilization/Management**

The implementation of the Bed Manager software provides a daily snapshot of our bed occupancy in the organization to physician leaders and administration. This communication tool is intended to facilitate dialogue for optimal bed utilization across the region.

Acute Care Bed Management and Repatriation policies have been developed to provide the procedural steps necessary to undertake promoting the optimization of beds at all our sites. Central Health is utilizing an approach to bed management that encompasses the appropriate utilization of all beds in the region regardless of location. This means that patients who do not require specialist care, as provided at a referral center, may be redirected to the nearest rural site with bed availability for care provision from a primary care physician. This approach ensures that the organization is providing the right care, at the right time, by the right provider and allows us to maximize bed availability across the region.

**Conclusion:**

Data mining and distribution is ongoing with all working groups to show areas of improvement and areas that continue to be a challenge. Despite all the efforts noted above Central Health continues to experience daily occupancy levels that are in the 95% range. This means patients continue to be admitted and wait for a bed on a stretcher in the Emergency Department for extended periods of time. People are waiting months in acute care for a long term care bed. People who live in their own homes or personal care homes come to acute care for admission when their required level of care cannot be provided in their current setting even though they do not have an acute care diagnosis. People who are waiting for elective surgeries will have their procedures rescheduled at short notice as a result of the inappropriate use of acute care beds. All of these situations have implications for impacts on the quality and safety of care provided.

Strategies other than those noted above that have potential to have a positive impact on this challenge include...

- Increasing OT/PT services in acute care- At Central Health the existing PT and OT resources for inpatient care are utilized, as supported through workload evidence, such that there is no ability to support an increased rate of referral without an increase in supply of the professional therapeutic resources.
- Home First – make available additional resources to implement this program which has had success in other jurisdictions.
- Increased Palliative Care Services so that all those wishing to receive palliative care services at home can be supported appropriately.
- Increase number of LTC beds – Central Health worked with consultants, Ernst Young, to complete a recent assessment of the number of LTC beds required in the region.
- Implement in acute care best practices as recommended by the Canadian Stroke Strategy.

**Prepared by: Senior Leadership**

**Approved by: Rosemarie Goodyear, President & CEO**

**Date: November 30, 2015**
Information Note

Title: Priority issues within the Mental Health and Addictions Program, Eastern Health

Background and Current Status:

- **Replacement of the Waterford Hospital:** In 2009 the replacement of the Waterford Hospital was announced. In 2014/15 planning for the new mental health facility was ongoing and resulted in a Master Plan and Functional Program. This project is currently on hold. The aging infrastructure at the Waterford Hospital is concerning. The layout and design of inpatient/residential units do not reflect best practice for mental health care delivery. Many people have spoken about the physical condition of the Waterford Hospital at public sessions held by the Provincial All Party Committee on Mental Health and Addiction and the Community Coalition for Mental Health regarding the impact the infrastructure has on their recovery process, and the stigma generated.

- **External Review – Forensic Services, Waterford Hospital:** On March 13, 2015, a male patient died as a result of a successful suicide attempt on the Forensic Unit at the Waterford. A review and investigation into the occurrence resulted in the termination of three nursing staff due to non-adherence to the Program’s surveillance policy. Quality and Professional Practice Nursing reviews were completed. One of the recommendations in the Quality Review was to conduct an external review of the unit’s operations. The Centre for Addiction and Mental Health in Toronto was contracted and completed the review. A final report with recommendations was received on September 25, 2015.

- **Adult Addictions Treatment Centre, Harbour Grace:** Construction of the new 18 bed Adult Addictions Centre in Harbour Grace has recently been completed and all furniture/equipment is in place. Positions have been recruited and staff have completed the necessary training. The opening of the Centre is delayed due to challenges with Physician recruitment.

- **Access to Mental Health & Addictions Services:** Access to services has been a challenge given lengthy waitlists and difficulties navigating a complex system. As of the end of September 2015, there were 2,377 individuals waiting for services within the Eastern region with an additional 687 individuals waiting to see a psychiatrist. Wait times ranged from no wait to 24 months with a median wait time of 6 months. Additionally, there were 1365 individuals waiting to be assessed though Adult Central Intake.

Analysis:

- **Replacement of the Waterford Hospital**
  It is expected that the public pressure to replace the Waterford Hospital will continue. Emergent situations such as flooding are expected to continue due to the fragility of the plumbing system. Complaints from patients and family regarding the physical condition of inpatient units in particular continue. Media attention to the issue continues as the public and advocates speak on the need to replace the Waterford.
• **External Review – Forensic Services, Waterford Hospital:**
The external review highlights a number of areas for improvement of the forensic unit at Waterford. This occurrence and resulting actions have been in the public forum and it is expected that there will be public interest in the external review report.

• **Adult Addictions Treatment Centre:** Physician recruitment has been challenged by the location of the Centre and limited interest in addictions medicine. In light of the recruitment challenges, Eastern Health is proposing a variation of the model that would be comparable to the program already offered through the Humberwood Treatment Centre in Corner Brook.

• **Access to services:** Factors contributing to the waitlists include increase in referrals and short term vacancies/recruitment challenges.

**Actions Being Taken:**

• **Replacement of the Waterford Hospital:** Capital funding was approved and planning is in progress to separate the Short Stay Unit from the Psychiatric Assessment Unit (PAU) in order to address space and safety issues in PAU. Additional capital funding has been approved for ongoing maintenance of the building.

• **External Review – Forensic Services, Waterford Hospital:** Implementation of the recommendations of the Quality and Professional Practice Reviews is actively being worked on. A communications plan for the External Review has been developed and work on the recommendations has begun. A presentation has also been prepared for staff. There has been a commitment to release the report to the family.

• **Adult Addictions Treatment Centre:** Eastern Health has recently been successful in recruiting a Nurse Practitioner. The plan is to open the facility once this key position is in place.

• **Access to Mental Health & Addictions Services:** Eastern Health introduced a rapid process improvement initiative at the end of September that reduced the number of people waiting to be screened at Adult Central Intake from 1365 to 747 as well as new referrals processed within 6 days down from 89 days. Planning is underway to reorganize primary community services into integrated, interdisciplinary geographically based teams as a means on enhancing accessibility. A new model of service delivery is being considered within this reorganization plan including walk in services, e-health/self-management options and brief therapies. Finally, a provincial Systems Navigator position has been put in place to help individuals/families navigate services.

**Prepared/approved by:** Collette Smith, Interim Vice President, Clinical Services
Isobel Keefe, Regional Director, Mental Health and Addictions
Kim Grant, Regional Director, Mental Health and Addictions

**Prepared for:** Mr. David Diamond, President and CEO
Briefing Note

Eastern Health Sustainability (Budget)

Prepared by: David Diamond, President and Chief Executive Officer

December 05 2015

Decision/Direction Required: For Information Purposes Only

Background:

Eastern Health was enacted effective 1 April 2005. The Authority inherited from its legacy Boards an accumulated operating deficit $77.3M which has increased to $80M at 31 March 2015. Eastern Health balanced its operating budget in the Authority’s first three fiscal years, but, as illustrated in Table 1, for the past seven years (since fiscal 2008/09) has incurred annual operating deficits which have been reduced through year end funding from the province (Stabilization Funding), or through use of revenues already provided to Eastern Health (Deferred Revenue). Had this not occurred, Eastern Health’s accumulated operating deficit would stand, at 31 March 2015, at $203.8M. Fortunately this is not the case as this level of accumulated deficit would considerably strain Eastern Health’s ability to manage its day to day operations.

For 2015/16, Eastern Health has an operating budget of $1.4 B and is projecting a deficit of approximately $42 M. This projected deficit has been communicated to government since July 2015. To date there has not been approval to operate in a deficit position (with a commitment for stabilization money at year end), nor has there been approval to proceed with recommended savings initiatives to mitigate this deficit.

Budget pressures for 2015-16 are anticipated to be approximately $44.5 million. A significant portion of this is the impact of the prior year (2014-15) deficit of $17.4 million (including the delay of implementing several cost saving options) which was carried into the cost base for 2015-16 fiscal year. In addition, budgetary pressures of $27.1 million were realized due to budget decisions to: not fund inflation/utilization cost increases of $8.2 million; introduce a provincial attrition plan that reduced Eastern Health’s budget by $7.1 million; announce Laboratory reform that anticipates savings of $4.1 million; contemplate Fee for Service changes totaling $2.4 million; not fund Leap Year (Feb 2016) expected to cost $2.5 million, introduce an increased HST that will negatively impact Eastern Health’s budget in Q4 by approximately $1.0 million, not fund Special Assistance program equipment ($0.4 million) and initiate a Home
Support rate increase without providing sufficient funds to cover the increased expense ($1.4 million).

It was not anticipated that inflationary/utilization pressures would not be funded and we have little control with respect to the attrition of staff over the next five years, therefore it is difficult to project the impact of this budget reduction for 2015-16 and onward.

Budget reductions relating to Laboratory Reform and Fee for Service changes are provincial initiatives that have not been implemented.

Without approval to action current or future savings initiatives identified, or an increase in budget, pressures for 2015/2016 are projected to be approximately $61 M.

During the winter of 2015, Eastern Health proposed savings initiatives to achieve approximately $35 M over five years. Approval was obtained from government for initiatives amounting to approximately $19M over the next 3 years ($8.3 M to be achieved in fiscal 2015-16). There are other savings initiatives which should be considered in the short term, including Steam complexity food services implementation - $2.0M; cancellation of Homewood Contract $700,000; microbiology automation $ 1.0M; etc.

Additionally, Eastern Health has conducted benchmarking reviews to compare performance with peer organizations primarily in Ontario. Data for 2013/14 indicates potential for savings of $75 M if the organization could obtain performance at the Median level. Benchmark reports will be available based on 2014/15 performance in January 2016, which will provide an updated view of potential areas of savings opportunity.

Analysis:

Eastern Health has been experiencing significant budget pressures over the past five years but has been aggressively managing the operational deficit to a low in 2014/15 of $17.4 M (1.2% of budget). It should be noted that the Operational Improvement Initiative has resulted in Eastern Health curtailing spending significantly over the past three years which is evident by the fact that our expenditures have only increased by 2.5 percent annually over the past five years inclusive of new programs, negotiated salary increases and inflationary pressures. For 2015/16, unfunded items have negatively impacted the budget such that the projected deficit is approximately $42M. The opportunity to mitigate this deficit has been significantly reduced by required approvals from government not forthcoming.

Given that Eastern Health spends approximately 70% of its budget on compensation, balancing the budget will be very unlikely without staffing impacts and change of service models.

Eastern Health continues to look at ways to improve our operational and clinical performance, reduce the costs of operations, and achieve a balanced budget. In this light, Eastern Health has incorporated a Program Budgeting and Marginal Analysis (PBMA) process to guide resource
allocation decisions in a manner that is explicit, rigorous and transparent. The health authority has also undertaken a Clinical Utilization Review which was completed to ensure the organization uses its available clinical resources appropriately, effectively and efficiently to meet the health needs of the people it serves.

Recommendations:

1. Eastern Health requires direction on the current projected deficit of $42M.
2. A process should be determined as soon possible to allow Eastern Health to proceed on previously identified savings initiatives.
3. A discussion between government and RHA’s at the earliest convenience to discuss parameters in terms of the extent of savings required in this fiscal year and for the next fiscal year. This should include a discussion on guidelines RHA’s could use to make local decisions on systems transformation to achieve sustainability.

TABLE 1
## Eastern Regional Health Authority
### Deficit History

(000,000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Surplus (Deficit) Before Stabilization Funding and Deferred Revenue $M</th>
<th>D of H Stabilization Funding $M</th>
<th>EH Deferred Revenue $M</th>
<th>Accumulated Deficit $M</th>
<th>Provincial Plan Revenue $M</th>
<th>Year over Year Increase in Provincial Plan Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening deficit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>71.9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2008-09</td>
<td>21.3</td>
<td>17.7</td>
<td>3.6</td>
<td>71.9</td>
<td>891.0</td>
<td>-</td>
</tr>
<tr>
<td>2009-10</td>
<td>22.0</td>
<td>22.0</td>
<td>-</td>
<td>71.9</td>
<td>981.6</td>
<td>10.18%</td>
</tr>
<tr>
<td>2010-11</td>
<td>25.7</td>
<td>22.7</td>
<td>3.0</td>
<td>71.9</td>
<td>1,027.7</td>
<td>4.69%</td>
</tr>
<tr>
<td>2011-12</td>
<td>17.2</td>
<td>12.5</td>
<td>4.9</td>
<td>71.7</td>
<td>1,083.0</td>
<td>5.87%</td>
</tr>
<tr>
<td>2012-13</td>
<td>8.3</td>
<td>-</td>
<td>-</td>
<td>80.0</td>
<td>1,122.1</td>
<td>3.14%</td>
</tr>
<tr>
<td>2013-14</td>
<td>27.5</td>
<td>27.5</td>
<td>-</td>
<td>80.0</td>
<td>1,102.8</td>
<td>-1.72%</td>
</tr>
<tr>
<td>2014-15</td>
<td>18.0</td>
<td>18.0</td>
<td>-</td>
<td>80.0</td>
<td>1,140.8</td>
<td>3.44%</td>
</tr>
<tr>
<td>2015-16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,193.1</td>
<td>4.59%</td>
</tr>
</tbody>
</table>
Briefing Note

Eastern Health Sustainability of Medical Lab and X-Ray Services in Category B Facilities

Prepared By: David Diamond, President and CEO

December 11, 2015

Decision/Direction Required: For information purposes only.

Background and Current Status:

The current model of laboratory and x-ray service provision in Category B Facilities within Eastern Health is not sustainable given current workforce challenges. Category B Facilities include Bell Island, Bonavista, Grand Bank, Old Perlican, Placentia, St. Lawrence, Trepassey and Whitbourne.

Historically, Category B rural facilities were staffed by Combined Lab and X-Ray Technicians. This dual role allowed for efficiencies. However, the qualifications for these Combined Technicians have changed and the 18 month training program discontinued. The role can be filled with Registered Laboratory Technologists who have completed an additional 16 month x-ray skills program but uptake on this program by technologists willing to locate in rural facilities has been minimal.

Laboratory and Diagnostic Imaging have had challenges staffing all eight sites within allocated budgets. Most Combined Technicians have now exited the workforce. Current services are inconsistent, reduced or curtailed as a result of these staffing issues and other retirements are pending. Extensive recruitment efforts, including providing educational incentives and salary continuance during educational leave, have been largely unsuccessful.

Additionally, significant amounts of standby and emergency call back is required to provide 24 hour coverage, with little or no relief for vacation or illness.

Analysis:

A transparent discussion is required with stakeholders, including providers and communities, regarding the challenges and the need for change. New approaches/models are required if the services required to support rural health care delivery are to be maintained. Considerations include:
- Significant increases in operating budgets to employ both Laboratory Technologists and X-Ray Technologists to do work once completed by single Combined Technicians. This is an expensive option for low volume operations. Alternatively, additional financial incentives could be considered to attract X-Ray Technologists to complete Lab training.
- Currently operating hours for lab and x-ray coverage are not standardized and this needs to be done to provide equitable coverage within reasonable operating budgets.
- Other options include the provision of x-ray services during day shift hours and transport emergencies to the nearest larger facility afterhours; and implement point of care testing in laboratory for a limited menu of tests.
Major Issues for Labrador-Grenfell Health

Recruitment and Retention:
- Nursing staffing - primarily currently in the coastal community clinics.
- Pharmacy – critical vacancy in St. Anthony and impact on reduction in market adjustments for management pharmacists.
- Recruitment of Obstetrician/Gynecologist for Labrador West.
- Family Physician vacancies in Happy Valley-Goose Bay, St. Anthony, Forteau, and Roddickton.
- Physiotherapy vacancies in Happy Valley-Goose Bay and Labrador West.
- Diagnostic Imaging, especially ultrasound services, in Happy Valley-Goose Bay – being covered by contracted locums.
- Eastern Health Flight Team – instability and resulting pressure to provide escorts from LGH.

Prepared by: Barbara Molgaard Blake
Approved by: Tony Wakeham
Date: November 27, 2015
Information Note
Labrador-Grenfell Regional Health Authority

Title: Access to Primary Health Care

Issue: To provide a summary of current challenges, experienced by residents of the Labrador-Grenfell Health Region, in accessing primary health care services.

Background and Current Status:

- Primary Health Care is the day-to-day care needed to protect, maintain or restore our health. For most people, it is both their first point of contact within the health care system and the health services they use most often. Primary Health Care is not the specialized treatment received in a health care facility like a hospital or a cancer care clinic (Premiers Summit on Health Care – Discussion Document). Within Labrador-Grenfell Health, Primary Health Care services are provided by physicians, nurses (nurse practitioners, regional nurses, nurses, licensed practical nurses), social workers, dieticians, audiologists, speech language pathologists, mental health and addictions counsellors, physiotherapists, occupational therapists, pharmacists, clinical psychologists, behavior management specialists, child management specialists and paramedics.

- Two issues impacting access to Primary Health Care services in the Labrador-Grenfell Health Region include:
  1. Recruitment/Retention of Primary Care positions
  2. Wait times and Waitlists

1. Recruitment/Retention of Primary Care Positions:

While Labrador-Grenfell Health has had much success in recruitment overall, recruitment/retention of family physicians, nurse practitioners, regional nurses, pharmacists, physiotherapists, and clinical psychologists continue to be a significant issue. This impacts the consistency of care for clients and drives wait times and recruitment costs and resources. There are currently a number of vacancies in primary care positions. These positions are identified in Table 3 of the Appendix.

Reduced access to primary care providers significantly affects our ability to meet the health needs of the population. We know that people having a continuous relationship with a primary care provider improves life expectancy, decreases costs and improves health outcomes. A significant number of clients in the Labrador-Grenfell Health region do not have access to their own primary care provider.

Lack of timely access to a primary care provider also causes inefficiencies and costs both in quality of care and health care resources. For example, in 2013-14, only 62% of all visits to the Emergency Room at the Charles S. Curtis Hospital, St. Anthony, were for true emergency care patients. The remainder were visits much more typically appropriate for an office visit with a primary care provider.

2. Wait times and Waitlists:

It is recognized that the length of wait time for an appointment is a barrier to accessing health services in the Labrador-Grenfell Health region. The demand for service is exceeding Labrador-Grenfell Health’s ability to respond in a timely manner. Some services where clients experience lengthy delays include: Physiotherapy, Occupational Therapy, Speech Language Pathology, Audiology, and Mental Health and Addictions.
Specific wait time information is identified in Tables 1, and 2 of the appendix.

Analysis:
- Delays in access to Primary Health Care Services have a negative impact on the health of individuals from a prevention, screening, early intervention and treatment, and overall quality of life perspective.
- Delays in access also create a greater reliance on acute care services, including visits to emergency rooms, admission rates, and lengths of stay.

Action Being Taken:

- **Increased the use of Telehealth**: In fiscal 2014-15, there were 3,371 telehealth sessions used by Labrador-Grenfell Health. This number increased from 2,959 in 2013-14 and 2,037 in 2012-13, representing a growth of 65 per cent in the use of Telehealth since 2012. For remote and rural health authorities such as Labrador-Grenfell Health, the use of technology such as telehealth for mental health and addictions services, inclusive of psychiatry, has become an increasingly important and effective medium to connect clients and their healthcare providers. The use of telehealth has and continues to grow significantly:
  - **Mental Health and Addictions Telehealth consults**:
    - 2012-13: 295
    - 2013-14: 485
    - 2014-15: 574
  - **Tele-psychiatry consults (included in the above)**:
    - 2012-13: 271
    - 2013-14: 438
    - 2014-15: 517

- **Focus on clinical efficiency**: Labrador-Grenfell Health has implemented wait time targets and utilization targets (client appointments per day). In addition, Labrador-Grenfell Health, in conjunction with the Department of Health and Community Services and other Regional Health Authorities, is working with X32 Healthcare, a consultant group, to improve efficiencies in Emergency Room (ER) operations, with a goal of reducing ER wait times. X32 Healthcare visited the three ER sites at hospitals in the Labrador-Grenfell Health region in November 2015.
  - **Prioritization**: To reduce risk associated with waiting, most programs have identified prioritization standards, and intake process to ensure that those who are in greatest need receive the service first and clients are referred to other available services, where available, while waiting.
  - **Policy Development**: To improve the efficiency of appointment schedules, Labrador-Grenfell Health has introduced “No Show” and “Cancellation” policies in selected program areas. These policies are designed to reduce the impact of lost time due to clients not showing or cancelling their appointments.
  - **Promotion of Self-Management**: Expansion of Improving Health My Way – Self Management Program, including piloting use of telehealth to deliver the program.
• **Ongoing Recruitment**: Recruitment efforts continue for difficult to recruit positions including availing of all incentives/initiatives offered through the Department of Health and Community Services. In particular, Labrador-Grenfell Health has been approved to offer an Enhanced Labrador Nursing Bursary Program for students from Labrador enrolled in an undergraduate Bachelor of Nursing degree and an Enhanced Nurse Practitioner Grant to support four current Labrador-Grenfell Health regional nurses in obtaining their Nurse Practitioner qualification.

• **Expansion of the “Norfam Program”**: The Northern Family Medicine Program (“Norfam”) was recently expanded to accommodate a greater number of first year and second year residents. As of July 1, 2015, NorFam had six first year residents and six second year residents based at Happy Valley-Goose Bay. The term for first year residents has been increased from four months to one year and for second year residents from seven months to one year. This increase in capacity is having a direct positive impact on client access to primary care services at the Labrador Health Centre and community clinics on the North Coast of Labrador. A majority of the family physicians on staff at the Labrador Health Centre in Happy Valley-Goose Bay are products of the NorFam program.

December 11, 2015
Table 1: 2015-2016 Wait Times and Wait Lists (As of September 30, 2015)

<table>
<thead>
<tr>
<th>Rehab Services</th>
<th>Benchmarks</th>
<th>Waitlist Volume</th>
<th>Length of Wait (Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Urgent</td>
<td>27</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>(2 weeks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>599</td>
<td>196 days</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>Urgent</td>
<td>23</td>
<td>13 days</td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>12</td>
<td>37 days</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>78</td>
<td>99 days</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>42</td>
<td>52 days</td>
</tr>
<tr>
<td><strong>Speech Language Pathology</strong></td>
<td>Urgent</td>
<td>0</td>
<td>2 days</td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>0</td>
<td>6 days</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>8</td>
<td>28 days</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>38</td>
<td>49 days</td>
</tr>
<tr>
<td><strong>Audiology</strong></td>
<td>Urgent</td>
<td>14</td>
<td>24 days</td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>10</td>
<td>10 days</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>169</td>
<td>162 days</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>172</td>
<td>38 days</td>
</tr>
</tbody>
</table>
Table 2: Access – Mental Health & Addictions – Regional

<table>
<thead>
<tr>
<th>Benchmark/Target</th>
<th>Comments</th>
<th>Waitlist Volume</th>
<th># of Active Clients</th>
<th># of Client Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority 1</td>
<td>80%</td>
<td>70.18%</td>
<td>155</td>
<td>780</td>
</tr>
<tr>
<td>Priority 2</td>
<td>80%</td>
<td>65.28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority 3</td>
<td>80%</td>
<td>85.72%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mental Health and Addictions Client Priority Classification & Description:

<table>
<thead>
<tr>
<th>Urgency</th>
<th>Description</th>
<th>Acceptable Time Frame</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Has definite symptoms that are life threatening and require immediate attention</td>
<td>Service provided immediately.</td>
<td>100% within benchmark</td>
</tr>
<tr>
<td>Priority 1</td>
<td>Severe psychosocial impairment, psychiatric symptomatology or severe interruption in Activities of Daily Living (ADL). Major impairment or deterioration in several life areas (e.g., mood, self-care, physical wellbeing, family, work, and school) related to mental health/addiction issues.</td>
<td>0-30 days</td>
<td>80% within benchmark</td>
</tr>
<tr>
<td>Priority 2</td>
<td>Moderate psychosocial impairment, psychiatric symptomatology or moderate interruption in Activities of Daily Living (ADL). Moderate impairment or deterioration in several life areas (e.g., mood, self-care, physical wellbeing, family, work, and school) related to addiction/mental health issues.</td>
<td>0-90 days</td>
<td>80% within benchmark</td>
</tr>
<tr>
<td>Priority 3</td>
<td>Mild psychosocial impairment, psychiatric symptomatology or mild interruption in Activities of Daily Living (ADL). Mild impairment or deterioration in several life areas (e.g., mood, self-care, physical wellbeing, family, work, and school) related to addiction/mental health issues.</td>
<td>0-182 days</td>
<td>80% within benchmark time frame</td>
</tr>
<tr>
<td>Active Client</td>
<td>A client who is &quot;actively&quot; engaged in receiving clinical services. These clients would have received service during this quarterly reporting period.</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Primary Care Area</td>
<td>Current and Known Upcoming Vacancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Labrador City                         | 1 Nurse Practitioner* (will be filled in January 2016)  
2 Physiotherapists (includes one TFT maternity leave)  
1 Mental Health Counselor (TFT)           |
| Churchill Falls                       | 1 Regional Nurse (anticipated to be filled in February 2016)                                       |
| Happy Valley-Goose Bay                | 1.5 Physiotherapists  
3.5 Family Physicians  
1 Occupational Therapist (with Mental Health and Addictions)  
1 Clinical Psychologist (offer pending licensure verification)  
1 Regional Nurse (Mani Ashini Community Clinic in NWR/Sheshatshiu) |
| Community Clinics (Port Hope Simpson, Natuashish, Rigolet, Hopedale, Nain, Cartwright, Black Tickle) | 11 permanent full-time Regional Nurse or Nurse Practitioners                                          |
| Forteau                               | 2 Family Physicians  
1 Regional Nurse (anticipated to be filled in January 2016)                                       |
| Roddickton-Bide Arm                   | 2 Family Physicians  
1 Regional Nurse (TFT maternity leave replacement)  
1 Combined Laboratory/X-ray Technologist (TFT maternity leave replacement)                             |
| Flower’s Cove                         | 1 Family Physician  
1 Combined Laboratory/X-ray technologist (TFT maternity leave replacement)                           |
| St. Anthony                           | 3 Family Physicians  
1 Clinical Pharmacist (in addition to TFT vacancy for the Regional Director of Pharmacy position)  
1 Nurse Practitioner (effective February 1, 2016)  
1 Clinical Psychologist (offer pending licensure verification)  
1 Speech Language-Pathologist  
1 Psychiatric Nurse                        |
| Regional                              | 1 Lactation Consultant (TFT maternity leave replacement)                                               |
Title: Budget Pressures 2015-16

Issue: Labrador-Grenfell Health faces a number of budget pressures in the 2015-16 fiscal year.

Background and Current Status:

- Labrador-Grenfell Health provides health and community services to a population of 37,000, covering the communities north of Bartlett’s Harbour on the Northern Peninsula and all of Labrador. Of the four Regional Health Authorities in the province, Labrador-Grenfell Health has the largest geographical area and operates 22 facilities, including three hospitals, three community health centres, 14 community clinics and two long-term care facilities. Delivering health care services in predominantly rural and remote locations brings about its own set of financial challenges.
- Labrador-Grenfell Health projects a deficit in the 2015-16 fiscal year in the amount of $6.8 million. While this is a projection, the Health Authority is closely monitoring its financial position and pursuing Operational Improvement initiatives to work towards a balanced financial position.
- Under the Operational Improvement plan, Labrador-Grenfell Health achieved $8.7 million of the targeted $11.9 million in savings to the end of 2014-15. Labrador-Grenfell Health is continuing to identify and implement efficiencies in an effort to achieve cost savings. However, there are other areas where Labrador-Grenfell Health has encountered significant financial pressures.

Analysis:

- The following is contributing to the projected of $6.8 million deficit:
  - $3.2 million associated with delays in implementing Operational Improvement initiatives, attrition targets and laboratory reform.
  - $2.5 million shortfall in medical evacuation ("medevac") and scheduled client charter ("schedevac") air services, North and South Coasts of Labrador.
  - $700,000 required to address recruitment and retention issues, including, but not limited to, staff vacancies, overtime, callbacks and contracted services.
  - $400,000 required for opening of long-term expansion, Happy Valley-Goose Bay.

Action Being Taken:

- Implementation of Operational Improvement initiatives continued in the 2015-16 fiscal year.
- In collaboration with the Department of Health and Community Services and other Regional Health Authorities, HCM has been engaged to provide an update on benchmarking data.

December 11, 2015
Title: Access to Primary Health Care

Issue: To provide a summary of current challenges, experienced by residents of the Western Region, in accessing primary health care services.

Background and Current Status:

- Primary Health Care is the day-to-day care needed to protect, maintain or restore our health. For most people, it is both their first point of contact within the health care system and the health services they use most often. Primary Health Care is not the specialized treatment received in a health care facility like a hospital or a cancer care clinic (Premiers Summit on Health Care - Discussion Document). Within Western Health, Primary Health Care services are provided by physicians, nurse practitioners, social workers, nurses, dieticians, audiologists, speech language pathologists, physiotherapists, pharmacists, psychologists, behavior management specialists, child management specialists and paramedics.

- Two issues impacting access to Primary Health Care services in the Western Region include:
  1. Wait times
  2. Recruitment/Retention of Primary Care positions

1. **Wait times:**

   Length of wait time for an appointment has been identified as the top barrier to accessing health services in the Western Region (MUN, 2013). The demand for service is exceeding Western Health’s ability to respond in a timely manner, despite significant efforts to improve efficiency. Compounding this issue is the lack of provincial standard wait time definition for most Primary Health Care areas which makes objective measurement and benchmarking challenging. Some services where clients experience lengthy delays include: Audiology, Speech Language Pathology, Developmental Psychology, Occupational Therapy, Behavioral Management Services, Child Management Services and some areas of Mental Health and Addictions. Specific wait time information is identified in table one of the appendix.

2. **Recruitment/Retention of Primary Care Positions:**

   Primary care providers (physicians and nurse practitioners) are an essential component of Primary Health Care Teams, as teams cannot be effective or efficient without access to these providers.

   While Western Health has had much success in recruitment overall (9 vacancies in difficult to fill classifications at the end of March 2015, excluding physicians), recruitment/retention of physicians and nurse practitioners continue to be a significant issue. There are currently 26 vacancies in primary care positions. These positions are identified in table 2 of the appendix.

   Retention of primary care providers is also an issue, as evidenced by the high turn over rate in some positions. For example, the Jeffery’s Medical Clinic had 9 different physicians over a 15 year period. This impacts the consistency of care for patients and drives recruitment costs and resources.

   Reduced access to primary care providers significantly affects our ability to meet the health needs of the population. We know that people having a continuous relationship with a primary care provider improves life expectancy, decreases costs and narrows the gap in health outcomes between the rich and the poor. A significant number of the people in Western Newfoundland do not have access to their own primary care provider. Estimates for number of “orphaned” patients in the Western
Region range from 11% - 20%. Approximately 29% of patients accessing the fast track program at WMRH do not have a family physician.

Lack of timely access to a primary care provider also causes inefficiencies and costs both in quality of care and health care resources. For example, in 2013/14 78% of all visits to the Sir Thomas Roddick Hospital Emergency room were for low acuity patients, which typically are appropriate for office visit with a primary care provider.

Analysis:
- Delays in access to Primary Health Care Services have a negative impact on the health of individuals from a prevention, screening, early intervention and treatment, and overall quality of life perspective.
- Delays in access also create a greater reliance on acute care services, including visits to emergency rooms, admission rates, and lengths of stay.
- Residents' satisfaction with health care services is greatly impacted by access. For example, while clients who receive community based service, rank their experience as a 9.7 out of a possible 10 (Western Health-Patient/Client Experience Survey) complaints received identify access as one of the top three themes. This indicates that most people who are able to access our community based services have good experiences, however, those who cannot access are left unsatisfied.

Action Being Taken:
- Increased the use of Telehealth: The number of booked appointments increased by 16% from 2013-2014 to 2014-2015. In Mental Health and Addictions alone there was an increase from 23 sessions in 2013-2014 to 162 in 2014-2015.
- Focus on clinical efficiency: Including the establishment of regional wait time targets, utilization targets (client appointments per day), and management review of workload data.
- Prioritization: To reduce risk associated with waiting, most programs have identified prioritization standards, and intake process to ensure that those who are in greatest need receive the service first and clients are referred to other available services, where available, while waiting.
- Promotion of Self Management: Expansion of Improving Health My Way – Self Management Program, including piloting use of telehealth to deliver the program.
- Use of Locum Providers: Use of locums when available to cover vacant permanent positions. While this mitigates risk, residents require the continuity of a consistent primary care provider.
- Improving Recruitment Practices: Standardization and improvement of physician recruitment practices including the development of a Physician Human Resource Plan, new policies regarding physician recruitment and sponsorship of physicians through the CSAT program.
- Exploring New Models of Care: Evaluating different models of care for primary care in rural areas including hub and spoke models, exploring strategies for management of orphaned patients.
- Changes to Medical Education: Family medicine residents can now be trained through an identified "Western Stream", increasing exposure of MUN graduates to practice opportunities in our region.
- Ongoing Recruitment: Recruitment efforts continue for difficult to recruit positions including availing of all incentives/initiatives offered through the Department of Health and Community Services.
Table One: 2014-2015 Wait Times (March 31, 2015)

<table>
<thead>
<tr>
<th>Service</th>
<th>Wait Time Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Language Pathology</td>
<td>231 clients waiting for service</td>
</tr>
<tr>
<td>Child Management Specialists/Direct</td>
<td>61 clients waiting for service</td>
</tr>
<tr>
<td>Home Services</td>
<td>Wait time 0 – 17 months</td>
</tr>
<tr>
<td>Audiology</td>
<td>1385 clients waiting for services</td>
</tr>
<tr>
<td></td>
<td>Wait time 61 – 421 days</td>
</tr>
<tr>
<td>Developmental Psychology</td>
<td>77 clients waiting for service</td>
</tr>
<tr>
<td></td>
<td>Average wait time 321 days</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Average Wait time 119 days</td>
</tr>
<tr>
<td>Behavioral Management</td>
<td>Average Wait time 86.2 days</td>
</tr>
<tr>
<td>Mental Health and Addictions</td>
<td>426 waiting for service with intake completed</td>
</tr>
<tr>
<td></td>
<td>168 waiting intake</td>
</tr>
<tr>
<td></td>
<td>Wait times vary across the region</td>
</tr>
</tbody>
</table>

Table Two: Current and Known Upcoming Vacancies in Primary Care Positions

<table>
<thead>
<tr>
<th>Primary Care Area</th>
<th>Current and Known Upcoming Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port Saunders Area</td>
<td>2 salaried family physicians</td>
</tr>
<tr>
<td></td>
<td>1 nurse practitioner</td>
</tr>
<tr>
<td>Bonne Bay Area</td>
<td>2 salaried family physicians</td>
</tr>
<tr>
<td>Deer Lake/White Bay</td>
<td>0</td>
</tr>
<tr>
<td>Corner Brook/Bay of Islands</td>
<td>3 salaried hospitalists</td>
</tr>
<tr>
<td></td>
<td>2 salaried family physicians</td>
</tr>
<tr>
<td></td>
<td>5 fee for service family physicians</td>
</tr>
<tr>
<td></td>
<td>2 emergency department physicians</td>
</tr>
<tr>
<td>Stephenville/Bay St. George</td>
<td>3 salaried family physicians</td>
</tr>
<tr>
<td></td>
<td>2 nurse practitioners</td>
</tr>
<tr>
<td>Port Aux Basque</td>
<td>1 upcoming salaried vacancy</td>
</tr>
<tr>
<td>Burgeo</td>
<td>2 salaried family physicians starting January 2017</td>
</tr>
<tr>
<td></td>
<td>1 nurse practitioner (Ramea)</td>
</tr>
<tr>
<td>Total</td>
<td>22 primary care physicians</td>
</tr>
<tr>
<td></td>
<td>4 primary care nurse practitioners</td>
</tr>
</tbody>
</table>

* This does not include anticipated resignations that have not been submitted and likely underestimates the true needs of the population served by Western Health.
Title: Overcapacity

Issue: The availability of acute care beds is monitored on a continual basis with the main objective to facilitate the admission of patients associated with routine surgical procedures or those awaiting admission from the Emergency Departments. To support management of acute care beds within Western Health, triggers and overcapacity protocols have been developed for all sites. Depending on the availability of beds, the situation will be defined by trigger level 1, 2 or 3 or overcapacity. These definitions are associated with defined responses from staff, physicians and programs within Western Health.

Background and Current Status:

Over the past several years, overcapacity has been an occasional issue for most sites within Western Health and almost a consistent state of operations at Western Memorial Regional Hospital. The table below shows the number of admitted patients to overflow spaces at WMRH for the past 5 years. Fiscal year 15/16 represents cases from April 1 2015 to November 25/2015.

<table>
<thead>
<tr>
<th></th>
<th>2G OVERFLOW</th>
<th>EMERGENCY GROUND FLOOR ENROL</th>
<th>WMH DAYSURG INPATIENT OVERFLOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admit Counts</td>
<td>Patient Days</td>
<td>Admit Counts</td>
</tr>
<tr>
<td>FY2011/12</td>
<td>0</td>
<td>0</td>
<td>238</td>
</tr>
<tr>
<td>FY2012/13</td>
<td>79</td>
<td>274</td>
<td>644</td>
</tr>
<tr>
<td>FY2013/14</td>
<td>87</td>
<td>1,270</td>
<td>733</td>
</tr>
<tr>
<td>FY2014/15</td>
<td>1</td>
<td>101</td>
<td>550</td>
</tr>
<tr>
<td>FY2015/16</td>
<td>426</td>
<td>1,651</td>
<td></td>
</tr>
</tbody>
</table>

- At the same time that admission rates are exceeding bed capacity there is an ever increasing number of Alternate Level of Care (ALC) patients approved and waiting for LTC occupying acute care beds particularly in Corner Brook. The overall ALC rate for Western Health in 2014/15 was 31% and 35% for WMRH. Currently (November 26/15), there are 74 ALC cases at WMRH of which 42 are approved and waiting for LTC (total bed count 217). Part of the bed complement at WMRH includes obstetrics, adult mental health, and intensive care unit for a total of 42 beds. These specialized areas have limited or no capacity for out of service patients which in turn reduces the total number of beds at WMRH that are available on a daily basis for admissions. Coupled with the number of ALC patients, it is not unlikely that WMRH would have less than 100 acute care beds available on a daily basis.
- The average age of patients admitted to Western Health has continues to rise, as age increases the number of co-morbidities and complexities increases placing higher demand on healthcare resources in particular acute care bed access.

<table>
<thead>
<tr>
<th>Average Age (excl OBS/Newborn)</th>
<th>2011/12</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBH</td>
<td>69.93</td>
<td>73.51</td>
</tr>
<tr>
<td>CHC</td>
<td>67.36</td>
<td>72.63</td>
</tr>
<tr>
<td>CLHC</td>
<td>66.14</td>
<td>66.76</td>
</tr>
<tr>
<td>RHC</td>
<td>60.53</td>
<td>70.02</td>
</tr>
<tr>
<td>STR</td>
<td>65.71</td>
<td>67.34</td>
</tr>
<tr>
<td>WMR</td>
<td>57.61</td>
<td>60.87</td>
</tr>
<tr>
<td>Total</td>
<td>59.88</td>
<td>62.89</td>
</tr>
</tbody>
</table>
The median length of time that individuals wait for permanent placement in Level III, and IV LTC facilities varies by facility of choice. Waiting time for CBLTC Home and BBHC remain the highest in the region. In 2014/15, individuals in the region waited a median of 25 days for LTC, however in BBHC, individuals waited approximately 81 days and in Corner Brook LTC Home waited approximately 184 days.

The number of clients placed each year in LTC facilities operated by Western Health continues to increase, primarily due to reduced length of stay of residents in LTC.

<table>
<thead>
<tr>
<th>Location</th>
<th>2010/11</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corner Brook LTC Home</td>
<td>24</td>
<td>51</td>
</tr>
<tr>
<td>Regional</td>
<td>51</td>
<td>179</td>
</tr>
</tbody>
</table>

Analysis:
With the advancing age of patients within our region the pressures of acute care access will continue into the future. Given the number of “approved and waiting long term care” patients at Western Memorial Regional Hospital it is not anticipated that single measures beyond additional long term care will greatly impact bed availability. It has been recognized by new acute care planners (Stantec) that the Western Health region is under resourced between 100-200 long term care beds. The plans for a new Long Term Care Facility in Corner Brook will address this issue significantly.

Actions Being Taken:
A number of different efforts were instituted throughout WMRH and Western Health to support patient flow and improve discharge planning, these include:
- A new model of nursing care.
- Relocation of all nursing managers’ offices to care units.
- Daily bullet rounds to support care planning on all units.
- Posted expected length of stay (ELOS) targets on units and discussed at bullet rounds.
- Mixed gender rooms.
- Changes to Most Responsible Physician assignment.
- New model of hospitalist assignment at WMRH to address Family Practice coverage.
- Targets for Day Surgery versus inpatient surgical admissions.
- Central Intake Clinic for Ortho Surgery patients preparing for joint replacements.
- Enhanced care project with Personal Care Home in Corner Brook region associated with level 2+.
- Opening of fourteen restorative care beds in Corner Brook Long Term Care targeting inpatients at WMRH 65 years of age and older who are at risk of prolonged acute care stay.
- Rapid response team located at WMRH to support avoidance of hospital admissions.
- Repatriation guidelines for acute and long term care to support inter-facility transfers.
- Administrative transfer policies to support safe inpatient care.

Overcapacity is a significant issue for WH, the measures taken thus far have supported improved bed management but the demand for acute care access continues to exceed capacity on a regular basis.
Prepared by: C. Davis, Vice President of Patient Service
K. O'Brien, Vice President of Rural and LTC

Approved by:

November 25, 2015
Information Note # WH 3
Western Health

Title: New Facilities Planning – Replacement of WMRH

Issue: The opportunity to design and build new health facilities requires a significant investment from employees and stakeholders that will need to be quantified and funded based on the future direction of the project.

Background and Current Status:
- Western Health (WH) has, and continues to work with the Department of Transportation and Works (TW), Health and Community Services (HCS), and external consultants to plan and design new facilities to replace the existing Western Memorial Regional Hospital in Corner Brook. WH currently supports this process with the support of four temporary full time positions.
- The future direction for the Long Term Care P3 process, project planning and construction timelines for the new WMRH, and the implementation of a new Shared Services Organization will impact the need for engagement, communication, construction, operational readiness, and transition.

Analysis:
- Enhancing engagement with clients/patients/residents, staff, physicians, and stakeholders will support planning for construction of the best possible facilities in Corner Brook. Enhancing engagement will benefit from the support and involvement of TW and HCS.
- Effective communication helps to manage expectations for facilities design and development. Enhancing communication will benefit from the support and involvement of TW, HCS, and external consultants.
- Operational readiness is an approach to build and implement project management that ensures safe operations during transition phases. Successful operational readiness transforms a facility/building, its operations and its individuals together. Operational readiness is distinguished from operational improvement by virtue of the fact that planned facility design necessitates changes in operations and/or individuals.
- Appreciating that planning assumptions for the new facilities included lean process improvement and electronic solutions to support safe and efficient operations, operational readiness is a priority for WH and will require dedicated resources to ensure comprehensive planning, project management and successful change management. The resources to ensure this may be significantly impacted by future directions for health facility construction and the outcomes of shared services including location of staff and priorities for information technology and management.
- WH has an immediate need to prioritize the operational readiness planning opportunities that require early implementation, achieve successful transformations and manage all of the projects/changes the require implementation prior to building occupancy and anticipates additional human resource requirements to support change during ongoing operations.
- As the schematic design work with the Corner Brook Care Team consultants concludes, WH will use one of the two temporary full time positions to support room level design and detailed construction specifications. As the work progresses, WH will need resources to support comprehensive document management and effective working relationships with TW and/or private providers and, in keeping with construction timelines, resources to support commissioning, transition and evaluation planning and implementation.
Actions Being Taken:
- WH continues to work with TW, HCS, and consultants to support effective communication of directions, decisions and progress on projects.
- WH employees and physicians have invested significant time in planning, and design to provide quality service.
- In 2015-16, WH added two temporary full time positions to support new facilities planning, bringing its total complement of temporary human resources to four. These dedicated resources have been instrumental to supporting Western Health’s involvement in design planning and have initiated work for operational readiness planning.
- WH will continue to ensure that the four positions are used to their fullest as the project progresses but anticipates that our effective leadership / participation in the project will require additional, dedicated resources.
- WH continues to work with HCS on progress updates from the community and stakeholders and recognizes the opportunities for enhancing communication and/or engagement with stakeholders.

Prepared by: L Hoddinott, Vice President Information and Quality

Approved by:

November 25, 2015
Information Note
Department of Transportation and Works

Title: Replacement of Western Memorial Regional Hospital

Issue: To provide background and a status update on the replacement of the Western Memorial Regional Hospital (WMRH) in Corner Brook.

Background and Current Status:
- Following the completion of the original Master Program and Functional Plan for the replacement of WMRH in 2009 and 2010, respectively, the Government of Newfoundland Labrador (GNL) asked Stantec Architectural services to complete a due diligence review of the original assumptions and recommendations.

- In completing its review, Stantec identified additional best practices and efficiencies that could be utilized to better meet the needs of the population, while ensuring affordability and sustainability of the project, and Stantec was accordingly contracted to revise the Master Program and Functional Plan.

- In its review, Stantec took a system-wide approach, which considers all sites where care is provided (at home, in community-based living facilities, acute care hospitals, etc.).

- In March 2013, Stantec submitted its revised Master Program to GNL. The Program recommended a multi-building campus, including:
  - An acute care facility with 160 beds (a decrease from the current bed count of 199);
  - A new long term care facility with 100 beds (to address the issue of approximately 25-30% of current beds at WMRH being occupied by “Alternate level of Care” (ALC) clients, patients who have been medically discharged but are unable to return to their previous place of residence, the majority of whom are waiting for placement in a long term care facility);
  - A 48-bed hostel for medical students/residents and patients/families; and
  - A central utility plant.

- Stantec was engaged to develop a Functional Plan for the project, which provides a detailed space list and staffing requirements.

- In September 2013, TW recommended, and received approval, to proceed with the development of the new WMRH using a Design-Build approach, which engages the services of a Design-Builder to both design and construct the facility.

- To expedite construction activities, TW proposed grouping the buildings in two separate construction packages:
  - Package 1 – Long Term Care facility and Logistics/Utility Building;
  - Package 2 – Acute Care Hospital, Administration Building, and Hostel.
• On December 28, 2013, TW publically issued a two-step Request for Qualifications/Request for Proposals (RFQ/RFP) document inviting design-build teams to make submissions, and five teams submitted proposals.

• In April 2014, GNL directed that the new hospital include space for:
  o A PET scanner in case of increased use and demand; and,
  o Radiation therapy services.

• In Budget 2014, Government announced $500,000 for the study/review of safe radiation service delivery in Western Newfoundland, including a provincial model for the delivery of radiation services.

• Altus Consulting Inc. was contracted to complete a provincial review of Newfoundland and Labrador radiation therapy service delivery models and to provide recommendations based on best practices. The review recommended:
  o The installation of one Linac machine in both Corner Brook and an additional Linac Machine in St. John’s.
  o The construction of two rooms to accommodate radiation equipment (known as bunkers), with the second bunker acting as swing space when the Linac machine would need to be replaced.
  o Construction of the bunkers and the addition of the Linac machine was expected to be completed in St. John’s by 2026; and
  o No further sites for radiation therapy be considered in the province prior to the new service in Corner Brook being fully established and functional.

• In October 2014, Stantec submitted its functional program proposal, which included:
  o Capacity to house a PET scanner, should volume and availability of medical personnel change in the future;
  o Integrated cancer care program including radiation, chemotherapy, planning and support services to provide residents in the region access to services closer to home;
  o Creation of 120 long term care beds in a facility adjacent/attached to the acute care facility, an increase from the originally-proposed 100 beds to maximize staffing efficiencies with respect to the size of resident households and to maximize the building foot print (i.e. no half floor);
  o An increased number of ultrasounds (up to 9 from 7);
  o A reduced number of maternity beds in response to changing regional demographics (from 11 to 6 as the current number was being used at 50% capacity).

• To the end of fiscal March 2015, approximately $32M had been spent on the project with $9.6M budgeted for 2015-16 to carry-on with existing design and site work contracts.

Analysis:
• Stantec’s Master Program was based on the assumption that all existing services currently being provided at WMRH would continue and, where required, expand and did not account for the addition of radiation services.
• In 2013, the original estimated cost for the project at completion of the Master Program was $588M +/-30%.

• In July 2014, a design development contract was awarded to the “Corner Brook Care Team” (CBCT) a collaboration of four companies including: B+H Architects, Montgomery Sisam Architects, PCL Contractors, and Marco Construction.

• In July 2014, TW projected that was a probable outside higher range cost estimate for the project. This figure was supported by Catalyst Consulting a firm based out of Nova Scotia.

• Approval in principle for the platforms was received on July 29, 2014 and for Western Health to share the functional program documents with their program directors for review.

• In April 2015, GNL announced its intention to engage with the private sector for the provision of long-term care beds in the Province.

• Since the original site/building layout/design included the incorporation of the restorative, rehabilitative and palliative care beds as well as food services (i.e. main kitchen to service both facilities), this new direction meant that additional design work was required to incorporate these services back into the planned acute care facility.

• Other significant changes to the Stantec Functional Program and the current planned floor space includes:
  o Increased Medical Imaging Platform by 444 net square metres (28%); and,
  o Relocation of the ICU/CCU from an inpatient floor to the main level next to Emergency, nd the relocation of the Maternity/Child Platform to the same level as the Interventional Platform.

• The redesign of the planned hospital has negatively impacted timelines for the completion of the design development documents by several months.

• To fund the costs associated with this redesign work, TW and CBCT agreed to reduce CBCT’s expected deliverables to the completion of a schematic design rather than a design development package.

• Since its engagement, CBCT has been actively working on the development of the design development documents, including modifications to the original schematic blocking and stacking diagrams to improve flow and efficiency and to reduce the building’s footprint.

• To implement GNL’s new direction for long-term care, TW issued an RFP in July 2015 for the provision of 360 beds across the Province, 120 of which were to be constructed adjacent to the planned new acute care facility.

• TW’s evaluation process for awarding of the RFP is nearing finalization and is expected to be completed by the end of January.
• Site infrastructure has continued in 2015 with the completion of two tenders (awarded in 2014) for water and sewer services and the construction of an underground concrete water storage reservoir.

• Assuming no significant departure from the current facility configuration and floor plans, current anticipated dates of completion are:
  o Schematic Design Documents completion: January 2016
  o Project Budget Update: February 2016
  o Schematic Design Presentation: February 2016
  o Tender for Modified Design Build Contract: Fall 2016
  o Facility Construction Start: Summer 2017
  o Facility completion: Fall 2021

• As part of the Budget 2015 decisions Government removed all funding for this project from the infrastructure framework beyond 2015-16. To the end of fiscal 2015-16 approximately $42M will have been spent on the project.

• In order to advance this project, two broad decisions will be required over the next several months:

Action Being Taken:
• Design work is continuing under the CBCT as outlined above.

Prepared/approved by: G. Leja/C. Grandy
Deputy Minister Approval: L. Companion

December 13, 2105
Transition Briefing Book 2: December 2015
Supplementary Material

1. Department of Health and Community Services - Strategic Plan 2014 - 2017


5. Improving Health Together: A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador


8. Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015 – 2025


10. Newfoundland and Labrador Strategic Health Workforce Plan 2015-2018