Dear Applicant:

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: HCS/005/2020]

On January 10, 2020, the Department of Health and Community Services (the Department) received your request for access to the following records:


I am pleased to inform you that a decision has been made by the Department to provide access to most of the requested information. Access to the remaining information contained within the records has been refused in accordance with the following exceptions to disclosure as specified in the Access to Information and Protection of Privacy Act (the Act):

Policy advice or recommendations
29. (1)(a) The head of a public body may refuse to disclose to an applicant information that would reveal advice, proposals, recommendations, analyses or policy options developed by or for a public body or minister.

Legal advice
30. (1) The head of a public body may refuse to disclose to an applicant information that is:
(a) subject to solicitor and client privilege or litigation privilege of a public body; or  
(b) that would disclose legal opinions provided to a public body by a law officer of the Crown.

Disclosure harmful to the financial or economic interests of a public body
35. (1) The head of a public body may refuse to disclose to an applicant information which could reasonably be expected to disclose:
(c) plans that relate to the management of personnel of or the administration of a public body and that have not yet been implemented or made public, or
(g) information, the disclosure of which could reasonably be expected to prejudice the financial or economic interest of the government of the province or a public body.

Disclosure harmful to labour relations interests of public body as employer
38. (1) The head of a public body may refuse to disclose to an applicant information that would reveal:
(b) labour relations information the disclosure of which could reasonably be expected to:
(i) harm the competitive position of the public body as an employer or interfere with the negotiating position of the public body as an employer.

Disclosure harmful to personal privacy
40. (1) The head of a public body shall refuse to disclose personal information to an applicant where the disclosure would be an unreasonable invasion of a third party's personal privacy.

Please be advised that the regulations referenced on page 45 are available publically per the following: https://www.gov.nl.ca/snl/printer/gazette/weekly-issues/2020-2/

Please be advised that pages 57-58 and 78-79 have been within their entirety under s. 38(1)(b)(i) as it comprises information that could impact ongoing labour negotiations. Page 75 has been withheld in its entirety under s. 29(1)(a). Please be advised that page 82 has been withheld in its entirety under s. 40(1) as it contains information that could identify patients.

Please be advised that you may ask the Information and Privacy Commissioner to review the processing of your access request, as set out in section 42 of the Access to Information and Protection of Privacy Act (the Act). 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.

The address and contact information of the Information and Privacy Commissioner is 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.

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 Completed Access to Information Requests 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 709-729-7010 or by email at MichaelCook@gov.nl.ca.

Sincerely,

Michael Cook
Manager of Privacy and Information Security
/Enclosures
Access or correction complaint

42. (1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52 (1) or 53 (1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21;

(b) a decision respecting an extension of time under section 23;

(c) a variation of a procedure under section 24; or

(d) an estimate of costs or a decision not to waive a cost under section 26.

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.
Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45 (2).
Information Note
Department of Health and Community Services

Title: Physician Resource Forecast for Family Medicine

Issue: To provide an overview of the Newfoundland and Labrador Medical Association’s (NLMA) Physician Resource Forecast for Family Medicine, which was publicly released on November 27, 2019.

Background and Current Status:
- The NLMA is developing a 10 year, evidence-based physician resource forecast for family medicine. To assist with this, the NLMA contracted Dr. David Peachey of the Nova Scotia health care consulting firm Health Intelligence Inc. to produce a family physician resource forecast for the province.
- The Department of Health Community Service (HCS) officials attended a presentation discussing Dr. Peachey’s work on November 26, 2019.
- On November 27, 2019, the NLMA publicly released an executive summary and conducted a news conference on Dr. Peachey’s findings. See Annex A for the executive summary. The full technical report has not yet been released and may not become available for a further week or more. Upon receipt of the final report (inclusive of more detailed information about the report’s methodology), further departmental analysis is required, including a fulsome costing analysis.
- The executive summary notes that there are 629 licensed, practicing family physicians recorded in the NLMA membership database as of September 2019, but that the number of full-time equivalent (FTE) family physicians carrying out community-based family practice services is estimated to be 431.
- The report forecasts that an additional 59.6 FTE family physicians are needed immediately to address the current shortage in today’s workforce. This includes 24 additional FTE family doctors in Eastern Health, 12 in Central Health, 12.4 in Western Health, and at least 11.2 in Labrador-Grenfell Health.
- The summary also forecasts that approximately 20 additional family doctors per year will be needed in the remaining nine years of the forecast period, for a total of 243 additional family doctors over the coming decade to meet the predicted needs of the population.

Analysis:
- Dr. Peachey acquired data from the NLMA, Newfoundland and Labrador Centre for Health Information (NLCHI), and national databases to conduct his analysis. Dr. Peachey also consulted with key stakeholders from HCS, the regional health authorities (RHAs), and the College of Family Practice – Newfoundland and Labrador, among others.
- To perform the analysis, an adjusted population needs-based model was used. This approach allows for specific modifications to compensate for known additional population needs, including:
- Unattached patients;
- Age-gender standardization of the population;
- Use of collaborative health teams;
- Burden of illness;
- Needs of Indigenous peoples;
- Care of older adults;
- Mental health and addictions;
- Ambulatory care sensitive conditions; and
- Diversion of emergency department volume to family medicine.

- HCS notes that the current analysis is solely based on content in the executive summary and presentation provided by Dr. Peachey on November 26, 2019. Further analysis is warranted when the full report is available.

- It is acknowledged in the executive summary that the projection model used by Dr. Peachey has limitations and that not all factors within it are predictable (see page 17).

- There has been coverage of this report in the media, mainly focusing on the forecasted need to recruit 60 new family physicians to address shortages. The leader of the opposition, Mr. Ches Crosbie, stated publicly that he urged the provincial government to implement the recommendations of the NLMA without delay and that shortage of family doctors has reached “crisis levels”.

Family Physician Recruitment
- The Canadian Institute for Health Information reports that in 2018, Newfoundland and Labrador had 138 family physicians per 100,000 population, which is above the Canadian average of 122. Physician Services division does not currently have comparative data from across the country.

- The table below shows that the overall family physician head count has increased almost 15 per cent in the last nine years, from 536 to 614. This is slightly less than the head count of 629 cited in the executive summary. Considering only fee-for-service (FFS) family physicians, the head count has increased 28 per cent from 367 to 470. The province has more family physicians now than it has ever had.

<table>
<thead>
<tr>
<th>Family Physician Head Counts (as of March 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaried</td>
</tr>
<tr>
<td>FFS</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Source: HCS Medical Services

- The growth suggested by Dr. Peachey would be approximately three times the actual growth experienced in the past equivalent period.
- Despite a 21 per cent increase in FFS physician numbers from 2011 to 2018, office-based visits (i.e., the primary work of a FFS family physician) have grown little (1.2 per cent) over the same period as shown in the following table.

**Selected FFS GP Utilization Data (units of service paid)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Office</th>
<th>Home</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Diagnostic Therapeutic</th>
<th>Sessionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>2,037,383</td>
<td>88,902</td>
<td>132,209</td>
<td>79,336</td>
<td>281,367</td>
<td>308,725</td>
</tr>
<tr>
<td>2012-13</td>
<td>2,046,745</td>
<td>86,798</td>
<td>129,119</td>
<td>77,444</td>
<td>279,693</td>
<td>271,683</td>
</tr>
<tr>
<td>2013-14</td>
<td>2,021,886</td>
<td>85,587</td>
<td>124,237</td>
<td>61,101</td>
<td>296,139</td>
<td>301,176</td>
</tr>
<tr>
<td>2014-15</td>
<td>2,068,490</td>
<td>91,524</td>
<td>99,100</td>
<td>58,525</td>
<td>330,466</td>
<td>319,234</td>
</tr>
<tr>
<td>2015-16</td>
<td>2,057,023</td>
<td>91,877</td>
<td>87,814</td>
<td>59,097</td>
<td>329,493</td>
<td>315,662</td>
</tr>
<tr>
<td>2016-17</td>
<td>2,100,008</td>
<td>89,528</td>
<td>95,461</td>
<td>63,937</td>
<td>307,439</td>
<td>322,186</td>
</tr>
<tr>
<td>2017-18</td>
<td>2,073,570</td>
<td>83,786</td>
<td>95,655</td>
<td>65,929</td>
<td>230,307</td>
<td>333,803</td>
</tr>
<tr>
<td>2018-19</td>
<td>2,060,917</td>
<td>79,734</td>
<td>93,530</td>
<td>71,445</td>
<td>232,134</td>
<td>336,510</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td>1.2%</td>
<td>-10.3%</td>
<td>-29.3%</td>
<td>-9.9%</td>
<td>-17.5%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

Source: HCS Medical Care Plan (MCP)

- HCS is aware that there are vacancies for family physicians across the province. However, due to the fluid nature of the fee-for-service (FFS) model, it is difficult to quantify the exact number of vacancies in the province.

- Likewise, while it is understood that patient attachment to a primary care provider is a concern in the province, there is currently no provincial data standard whereby patient attachment can be defined, captured, measured, and tracked.

- To address physician vacancies, HCS has undertaken a number of initiatives to increase physician recruitment and retention. See Annex B for details on the various physician incentive programs offered by HCS.

- Moreover, in response to increased concern regarding physician retirements and patient attachment to primary care providers, the Deputy Minister of HCS directed the Physician Services Liaison Committee (PSLC), a committee comprised of officials from the NLMA and HCS, to focus on these issues.

---

**s. 29(1)(a)**
<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establish a registered nurse (RN), nurse practitioner (NP) and licensed practical nurse (LPN) program: A collaborative practice model to add RNs, NPs, and LPNs to physician practices to increase primary care capacity, enabling attachment of more patients.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Target 2019 and 2020 Memorial University family medicine residents to enter comprehensive family practice: Includes more and larger bursaries, a signing bonus program, an income floor, electronic medical record (EMR) funding, mentor funding, and administrative costs.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Establish Interim Collaborative Practice Sites (ICPS) for unattached patients: to provide continuity of medical services to unattached patients for a limited period of time until they can be attached to a new or expanded community family practice. Requires clinic space, nursing and other staff, and EMR.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Conception Bay North/Trinity Bay South Demonstration Project: To transform family practice in a single region with very high levels of unattached patients. Involves a pilot blended capitation model, expanded provider team working (e.g., NP, RN, LPN, pharmacist, social worker, mental health counselor, and dietician), virtual care, and a non-binding Memorandum of Understanding among key parties.</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Health Care Reform**

- It is positive that the model considered the impact of collaborative teams that include other health professionals such as psychologists, registered nurses and social workers.

- Currently, HCS is working with RHAs, communities and others to transform primary health care delivery into a collaborative team-based model. This approach allows physicians and nurse practitioners to work as a team with other health professionals such as nurses, physiotherapists, and social workers to deliver care that meets the needs of communities.

- To date, HCS has established primary health care teams in 10 communities across the province and are currently working on establishing teams in a further three communities. Many of these communities have trouble with physician recruitment and/or patient attachment.

- HCS provides $4.5 million in annual funding for the Family Practice Renewal Program. This program is a partnership with the NLMA, RHAs and HCS and supports family physicians to
deliver effective primary health care. Recruitment and retention of family physicians is a key priority. HCS believes these networks will be a key asset in attracting more family physicians to practice.

**Action Being Taken:**
- HCS will conduct a full analysis and briefing of the technical report once available.

**Prepared/Approved by:** A. Wells/N. Porter/S. Breen/A. McKenna/K. Stone

**Ministerial Approval:** Received from Hon. John Haggie, MD

**November 28, 2019**
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Annex B
Description of HCS Recruitment and Retention Initiatives

- The Department of Health and Community Services (HCS) has several initiatives that contribute to improved physician recruitment and retention. These include:
  - Working with regional health authorities (RHAs), communities and others to transform primary health care delivery into a collaborative team-based model. Physicians want to work with nurse practitioners, nurses, physiotherapists, social workers and other health professionals to deliver care that meets the needs of communities.
  - Providing $4.5 million in annual funding for the Family Practice Renewal Program (FPRP). This program is a partnership with the Newfoundland and Labrador Medical Association (NLMA) and RHAs. To date, it has supported more than 200 physicians through the creation of four networks. Through these networks, physicians are better positioned to provide effective primary health care. Recruitment and retention of family physicians is a key priority of this work.
  - Providing funding of more than $1.4 million annually in student bursaries, resident bursaries, and travelling fellowships, with associated return-in-service commitments (see Table 1 below):

<table>
<thead>
<tr>
<th>Description</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Resident Bursary</td>
<td>$935,000</td>
</tr>
<tr>
<td>Student Bursary</td>
<td>$157,500</td>
</tr>
<tr>
<td>Travelling Fellowship</td>
<td>$350,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,442,500</strong></td>
</tr>
</tbody>
</table>

Table 1: Breakdown of bursary program funding.

- Approaching municipalities to explore ways to collaborate on improved recruitment and retention of primary health care providers in their communities.

- With respect to the Medical Resident Bursary program, since the program was revised in 2014, HCS has awarded approximately $4.3 million in bursaries to 75 physicians, for a total of approximately 225 years of service (not including 2019-20, for which bursaries are still in progress). To date, just

- With respect to signing bonuses, since the program was established in 2014, HCS has awarded approximately $1.54 million in to 23 physicians, for a total of approximately 69 years of service (not including 2019-20, for which signing bonuses are still in progress). Funding for this program has been fully utilized and the program will no longer be available after 2019-20.
Decision/Direction Note
Department of Health and Community Services

Title: Reimbursement of methadone tablets under the Newfoundland and Labrador Prescription Drug Program (NLPDP).

Decision/Direction Required: # s. 29(1)(a)

Background and Current Status:
- Opiate addiction is a chronic and recurrent brain disease and one of the most challenging addictions to treat. While withdrawal from opiates is not life threatening, the symptoms are so distressing that those addicted become almost exclusively focused on avoiding withdrawal.

- The cost of this illness to the individual and to society is significant; opioid use disorder (OUD) is often associated with a severe decline in the individual's physical and psychological health, unemployment, family disruption, and participation in criminal activities.

- Opioid Agonist Maintenance Treatment (OAMT) is a treatment for opiate addiction. It replaces the drug that the person is dependent on with a prescribed substance that is pharmacologically similar, but safer when taken as prescribed. Methadone is a synthetic opioid mostly used to treat dependence to other opioid drugs such as oxycodone. It is sometimes used to treat severe chronic pain or pain associated with terminal illness.

- OAMT is based on a harm reduction philosophy and represents one component of a continuum of treatment approaches for opioid-dependent individuals. This therapy allows a return-to-normal physiological, psychological and societal functioning.

- Treatment choices for OAMT include options such as buprenorphine/naloxone, methadone and slow-release oral morphine.

- **Buprenorphine** is a partial opioid agonist at the μ (mu) receptor. It is associated with a reduced risk of death in overdose compared to full opioid agonists (e.g. methadone) because it has a ceiling effect to adverse effects such as respiratory depression. This is why many clinicians consider buprenorphine to be a safer drug than methadone. However, buprenorphine’s ceiling effect may also result in limitations since its effectiveness may plateau once a certain serum level is reached. Buprenorphine products indicated for OAMT (Suboxone® and generics) also include naloxone which is included to deter against diversion and injection abuse.

- **Methadone** is a full opioid agonist and, as such, has no ceiling effect. The lack of a ceiling effect can pose an increased risk of harm from overdose, due to drug interactions or other circumstances which can lead to increased methadone serum levels.

- **Slow-release oral morphine** in the once daily 24-hour formulation (e.g. Kadian®) is considered as a third-line treatment option for opioid use disorder. Though this is an off-label use this option may be prescribed for patients who have been unsuccessful with, or have contraindications to first- and second- line treatment options. It is important to note that other formulations of oral morphine, such as twice-daily, 12-hour, or extended-release formulations (e.g. MEsion®) have not been empirically studied for OAMT and are therefore not
recommended for this indication. OAMT Guidelines state that, when used for treatment for OUD, it should be dispensed via daily witnessed doses.

- In May 2018, the Newfoundland and Labrador Pharmacy Board (NLPB) adopted Standards for the Safe and Effective Provision of OAMT. Pharmacists participating in OAMT must dispense methadone using an unflavoured, commercially-prepared 10 mg/ml methadone solution and add a sufficient quantity of liquid to bring it to a final volume of 100ml.


- Physician OAMT Standards note that when writing a prescription for methadone it is recommended that it is mixed with Tang or juice to a final volume of 100ml.

- Patients stabilized on daily witnessed methadone dosing can be considered for take-home doses up to a maximum of 6 per week, or 13 in special circumstances (i.e. documented travel).

- Take-home doses should be initiated starting with one take-home dose per week, slowly progressing to additional take-home doses per week based on routine assessments of patient stability. This usually takes months.

Analysis:

- Methadone is available in liquid and tablet formulation under the following brand name products and Health Canada approved indications.
  
  o **Metadol:** (Methadone Hydrochloride Tablets, Oral Solution and Concentrate) is indicated for the relief of severe pain. In general, METADOL, as an analgesic, should not be used in opioid naive patients.
  
  o **Metadol-D:** (Methadone Hydrochloride Tablets, Oral Solution and Oral Concentrate) is indicated for:
    - The detoxification treatment of opioid addiction (heroin or other morphine-like drugs) as well as the maintenance treatment of opioid addiction (heroin or other morphine-like drugs). Patients prescribed Metadol-D should be carefully monitored within a framework of medical, social and psychological support as part of a comprehensive opioid dependence treatment program.
    - Metadol-D tablets are not manufactured or being marketed in Canada.
    - Metadol-D is not indicated as an as-needed (prn) analgesic.
  
  o **Methadose:** (Oral Concentrate only) is indicated for substitution treatment in opioid drug dependence in adults. Methadose is not indicated as an as-needed (prn) analgesic.

- Under the NLPDP, Metadol tablets are considered under Special Authorization for palliative or chronic non-malignant pain only. Metadol-D and Methadose Oral Concentrate are considered under Special Authorization for OAMT only.

- Metadol-D tablets have not been reviewed by any expert review committees and as such are not considered for coverage under the NLPDP.
• A scan of the following clinical practice guidelines failed to find support for treatment with methadone tablets for OAMT, with one exception that they may be made available in a limited context (e.g. travel):
  o CRISM National Guidelines for the Clinical Management of Opioid use Disorder (2018);
  o CCSA Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder (2018); and,

• A survey of the Atlantic Provinces and British Columbia shows that methadone tablets are not considered in the treatment of OAMT as it is not in keeping with current Clinical Guidelines.

Alternatives:

Prepared/Approved by: P. Clark/J. O'Dea/P. Smith/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

December 2, 2019
Decision/Direction Note
Department of Health and Community Services

Title: Review of Residential Supports and Services for Community Support Services, Mental Health and Addictions, and Children and Youth in Care Programs.

Decision/Direction Required:
• Whether to allocate $150,000 from the Provincial Home Support review implementation budget to complete a comprehensive review of residential services for clients of Community Support Services (CSS), Mental Health and Addictions (MHA), and Children and Youth in Care (CYC) Programs.

Background and Current Status:
• The proposed review would include programming under Community Support Services (CSS), Mental Health and Addictions (MHA) and Children Seniors and Social Development (CSSD). Specifically:
  o Adults with disabilities, including adults with autism and Fetal Alcohol Spectrum Disorder (FASD);
  o Adults living with long-term mental illness;
  o Long-term residents of the Waterford Hospital;
  o Adults living with severe addictions;
  o Children and youth in the care and custody of a Manager of Children, Seniors and Social Development, under the Children, Youth and Families Act; and
  o Children and youth with complex mental health concerns and receiving treatment in a residential setting (e.g. Tuckamore Youth Treatment Centre and Hope Valley Centre).

Community Support Services
• In 2018/19 4,035 adults (18-64 years old) with a disability (physical and intellectual/developmental) received residential and community supports through CSS with a total expenditure of approximately $176 million.

• Adults with disabilities who receive supports from CSS live in a variety of residential arrangements such as their own home, with relatives or non-relatives (board and lodging), alternate family care (AFC), co-operative housing (Co-op), and individualized living arrangements (ILA).

• Individuals, their families and advocacy groups are highlighting the lack of choice for individuals with disabilities in supportive living arrangements as well as concern for continued institutionalization of some individuals with intellectual disabilities and complex needs.

• Many individuals remain in their family’s home long past their same-aged peers, with family members who are aging and limited in the support they can provide, or live in housing situations not of their choice.
• While it is generally agreed that the AFC option is an inclusive, community-based, fiscally efficient means to support individuals with an intellectual disability, there has been a steady decline in recruitment and retention of AFC providers. Existing providers are aging and some are discontinuing the provision of service.

Mental Health and Addictions
• Adults living with long-term mental illness (LTMI) or addictions issues experience significant barriers to appropriate living arrangements. Some individuals are homeless, while others live in a variety of residential options, however, availability and quality of supportive housing vary across the regional health authorities.

• MHA residential arrangements include living in own home, living with relatives or non-relatives (board and lodging), ILAs (room and apartment rentals), community care homes (CCH) (Eastern Health only), family care homes (Eastern Health only), and temporary shelter or transitional housing (e.g. CHOICES for Youth, Stella’s Circle, John Howard Society, Wiseman Centre). Living with relatives is the most common living arrangement.

• The CCH program was established in the early 1950s to provide 24 hour supervised housing for patients discharged from the Waterford Hospital. Originally, there were 21 homes with a total of 266 beds. Currently there are 13 homes with a total of 166 beds. As of 2016, there were 155 individuals living in a CCH at an average cost per client of $6,334 a month.

• CCHs began following personal care home standards in the 1990s. However, there are significant differences in these programs. For example, CCHs are intended to provide supportive living arrangements to persons with SPMI, usually discharged from the Waterford Hospital; not personal care to older people.

• Family Care Homes is a community based, boarding home program started in 1985 that offers a medium level of support and supervision in a family environment for one to three adults with (LTMI) with a focus on integration and recovery. Current home operators are aging and not accepting new clients and EH has not been actively recruiting new operators due to low demand. There are currently six clients and four operators.

• As of April 2019, there are approximately 241 people receiving service from Assertive Community Treatment (ACT) teams in the province (90 in EH, 85 in CH, 66 in WH).
Currently, there is no ACT team in Labrador-Grenfell Health (LGH). Case management services are provided to people within LGH.

- Starting in 2020, services for people with LTMI and addictions will increase to two ACT teams and 13 flexible assertive community treatment (FACT) teams available throughout the province. This community program will significantly increase the number of people served with LTMI and addictions and appropriate housing and community supports is an essential component of successfully supporting individuals within the community.

- Individuals living with addictions require supportive, barrier-free housing arrangements with a housing first model approach. For those just completing residential addictions treatment, there are no sober living homes, resulting in a gap for those looking for residential support while in recovery.

- The total expenditures in 2018/19 for mental health residential services (community care homes, non-relatives services, relative home services, own apartment home services, transition home and other residential services) was approximately $14 million.

- Homelessness and substandard housing are significant issues facing the mental health and addictions population, particularly those living in larger urban centers, young people, Indigenous people, and those involved with the criminal justice system. Furthermore, due to stigma, there are likely individuals who are not known to the system. Without appropriate housing and community supports, people with LTMI and addictions are disadvantaged in obtaining/maintaining recovery, wellbeing and meaningful life of their choosing.

- Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador captured concerns about service options available for individuals with mental health and addiction issues, as well as, the impact on mental health for caregivers. A number of the recommendations found in the Towards Recovery Action Plan (2017) support the need for a review of residential options including:
  - Recommendation #9: Prioritize supporting programs that use a housing first approach to provide the required services to help people stay well in their homes;
  - Recommendation #10: Amend the Residential Tenancies Act to provide authority to effectively deal with inadequate properties, including boarding homes and rooming houses;
  - Recommendation #12: Includes identifying a Plan to replace the current Waterford Hospital (which includes more services provided in the community and closer to home); and
o Recommendation #19: Review the eligibility criteria for community support services and increase access to interventions with proven effectiveness for the treatment of autism spectrum disorder and other developmental disabilities.

Children, Seniors and Social Development
- As of March 31, 2019 there were 985 children and youth in care with a total expenditure in 2018/19 of approximately $102 million. This budget includes costs associated with both placements (e.g., foster homes, residential placements) and other financial supports and services children and youth in care and foster parents are entitled to receive.

- Children and youth who are unable to remain safely at home due to maltreatment by a parent, may enter into the care of CSSD when alternate family arrangements cannot be made. Placement options for children and youth in care include:
  o Placement in foster homes with relatives or others who have a preexisting significant relationship with the child or youth;
  o Regular foster homes for children and youth who do not present with complex needs;
  o Specialized foster homes for children and youth with complex needs who can be cared for without in home staffing supports (CSSD operated);
  o Family-based care placements for children and youth with complex needs that require staffing to support caregivers (operated by family-based placement provider licensees); and
  o Staffed residential placements for children and youth with complex needs who cannot be cared for in a family-setting (operated by residential placement provider licensees).

- When children and youth require care, family settings are the preferred option from both a clinical and financial perspective. CSSD prefers a family environment for the care of children and youth and this approach is supported by the Children, Youth and Families Act. CSSD is working to increase capacity in foster homes and family-based placements as these options are the preferred environment to meet the best interests of children and youth in care. However, CSSD is experiencing the same challenges to recruit and retain foster homes as most provinces and territories. Access to foster homes and other placement options varies throughout the province with some areas having greater success in the recruitment and retention of placements than others.

- Staffed residential placements are designed to ensure children and youth who cannot be supported in a family-based environment due to a range of complex social, emotional, developmental, behavioural, and medical needs are provided safe, community-based, staffed living arrangements, where their needs are met in a caring and supportive environment. There are four residential placement types:
  o Emergency placement homes (EPHs)
  o Group homes (GHs)
  o Individualized living arrangements (ILAs)
  o Hybrid homes, which have both EPH and GH placements.

- In some circumstances, CSSD has had to rely on out of province placement options for children to receive assessment, treatment, or other therapeutic care when the necessary
services have been unavailable in this province. Often, children or youth who have been, or would have been, placed in out of province facilities are placed in ILAs in an effort to meet their needs locally.

Analysis:

- Adults with disabilities and/or with mental health and addiction issues sometimes face distinct housing barriers that can lead to insecure housing and inappropriate living arrangements. In some cases, individuals are living in a higher level of support arrangement for a longer period than the level of support would indicate (e.g. use of personal care homes, long-term care facilities, and specialized care facilities such as the Waterford Hospital.)

- In the case of MHA, the current state of residential services and supports is less well understood, developed or guided by provincial policy as is in the CSS program. Included in this review will be a descriptive analysis of the population and services being utilized.

- HCS is committed to improving home and community supports as indicated in its 2017-2020 Strategic Plan. HCS has heard from people with lived experience, family members, service providers, communities and advocacy groups across the province through engagement efforts including:
  - Provincial Home Support Program Review;
  - Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador;
  - Individualized Funding engagement events led by the Newfoundland and Labrador Association for Community Living in partnership with the Department of Children Seniors and Social Development; and,
  - A needs assessment conducted by the Autism Society of Newfoundland and Labrador.

- Common themes throughout these consultations were:
  - The need for individualized supports and services that allow people to live full and inclusive lives in their own homes and communities;
  - The need to improve access to housing options that maximize individual choice; and,
  - The need to have options that are responsive to changing needs of people, as they move through the life span.

- The Provincial Home Support Review (2016) recommended significant changes and improvements in the quality of services delivered with an enhanced focus on integration of care, an expansion of residential options, and to look at opportunities for sharing of services and supports. This would create opportunities for improvement that could increase community residential options and increasing the level of choice for individuals.
CSSD experiences a high demand for in care placements and is challenged to meet the placement needs of children and youth in care. Low availability of foster homes and other family-based options, and children and youth with complex needs or large sibling groups, at times has resulted in children and youth who would be best matched in a family setting being cared for by staffed residential placements. Residential placements are the most costly placement option and the least preferred method of care for children and youth.

Since 2014, CSSD has increased the quality and accountability of residential placements for children and youth in care; first through development of standards of care and service agreements, followed by the introduction of a licensing and regulatory framework under the Children, Youth and Families Act. CSSD maintains a high level of oversight in each residential placement as both the regulator and the custodian of the children and youth in each placement.

ILAs are residential options used to support individuals when it has been determined that no other living arrangement is appropriate. These arrangements are costly and significantly impact human resources. There is evidence that some children and youth placed in ILAs would be better served in group or family environments.

There is also evidence that suggests residential placements such as group homes and ILAs are sometimes challenged to manage the complex needs of children and youth who are placed in these homes.

CSSD is working to increase capacity in foster homes and family-based placements as these options are accepted as being the preferred environment to meet the best interests of children and youth in care.

Both CSS and MHA are within HCS, however programming intersects with services provided through CSSD for children and youth in care. Policy and program reform in both MHA and CSS aims to improve collaboration with CSSD programming to support improved outcomes for children and youth.

Children and youth living in CSSD residential settings often transition as adults into programming provided through HCS. Given the intersections and support for enhancing collaborative partnerships, CSSD has joined with HCS to complete a joint review of residential services.

A comprehensive, robust review of the current residential service model will identify gaps in residential living options in CSS, MHA, and CYC programming. It will assess the effectiveness of current residential options, determine the potential to modify or expand existing arrangements, and identify opportunities to develop new community-based models of service delivery.

A review is necessary to also understand how gaps in non-residential support services for CSS, MHA, and CYC clients impact the efficacy and effectiveness of residential service models.
- This review will examine existing residential supports and services and provide recommendations for improvement within a framework that is responsive to an array of needs, ranging from low to complex, and includes these key elements:
  - choice and control;
  - person-centered practice;
  - least restrictive and inclusive;
  - access to and independence in home and community environments;
  - a housing-first philosophy; and,
  - trauma informed, recovery and well-being, incorporating harm reduction principles.

- The deliverables of the review will include:
  - Current state assessment of residential supports for adults with disabilities and/or mental health and addictions issues and children and youth in care;
  - Descriptive analysis of current residential service models for CSS, MHA and CYC and their users;
  - A jurisdictional scan of residential supports and service models;
  - A literature review of evidence-based and innovative residential supports and services models for each of the areas identified;
  - Comparison of the current Newfoundland and Labrador residential service models with evidence-based or promising models identified in the jurisdictional scan and literature review for each of the areas identified;
  - An analysis of potential opportunities for partnerships with community-based groups in supportive living arrangements for children, youth and adults;
  - Analysis of the trends and factors that will impact the demand and use of residential services over time including:
    - Youth transitioning to adulthood who may require supportive living options
    - Aging of family and alternate family caregivers
    - Number of available foster homes
    - Changing needs of children and youth in care
    - Expanding access to community-based residential support options for adults with mental health and/or addictions issues
  - Recommendations that will improve and broaden the array or residential supports with a view to achieving desired outcomes in a cost-efficient manner; and,
  - Implementation plan for the recommendations including an analysis of anticipated impact (cost considerations, expected response by service providers and users) and a change management approach to address any anticipated barriers or challenges.

- The review will include consultations with key stakeholders throughout the province including individuals and families, advocacy groups, service providers and administrators, community, government and agencies.
Alternatives:
- Allocate $150,000 from the Provincial Home Support review implementation budget to complete a comprehensive review of residential services for clients of CSS, MHA, and CYC programs. \(\text{s. 29(1)(a)}\)

Pros:
- Provides an opportunity to gain a comprehensive understanding of current residential services for children, youth and adults, gain insight into gaps, and identify improvement opportunities that will meet client needs more appropriately and efficiently.
- Will help ensure an adequate array of community supports is available following the replacement of the Waterford Hospital.
- Provides an opportunity to respond to recommendations identified in the Provincial Home Support Review around the promotion and sharing of residential services and supports across the RHAs.
- Responds to concerns raised by the public, advocacy groups and service users.

Cons:
- Funding of $150,000 is required. \(\text{s. 29(1)(a)}\)

- Complete a review using internal resources:

Pros:
- No additional cost.

Cons:
- Competing priorities could cause delays in the completion of work and not address the concerns of clients and caregivers in a timely manner.

Ministerial Approval: Received from Hon. John Haggie, MD
December 16, 2019
Information Note
Department of Health and Community Services

Title: Provincial Audiology Services Staffing and Wait Times

Background and Current Status:
- Provincial Audiology Services include:
  - diagnostic Services (sudden hearing loss and children are given high priority);
  - early Hearing Detection and Intervention Program (EHD); newborns are given high priority;
  - Provincial Hearing Aid Program (PHAP); and,
  - Cochlear Implant Program (CI).

- Audiology services are delivered through the four regional health authorities (RHAs).

- Provincial oversight for PHAP and CI is provided by Eastern Health.

Audiology Staffing:

Table 1: Current Status of Audiology Staffing

<table>
<thead>
<tr>
<th></th>
<th>Provincial</th>
<th>Eastern Health (EH)</th>
<th>Central Health (CH)</th>
<th>Western Health (WH)</th>
<th>Labrador-Grenfell Health (LGH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent audiologist</td>
<td>20 (6 unfilled)</td>
<td>10 (1 unfilled maternity vacancy till March 2020)</td>
<td>5 (4 unfilled)</td>
<td>4 (1 unfilled)</td>
<td>1 (0 unfilled)</td>
</tr>
<tr>
<td>Permanent audiology verbal therapist</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Permanent audiology technician</td>
<td>1</td>
<td>-</td>
<td>Permission granted to fill one audiologist position temporarily with a audiology technician; recruitment in progress</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

- Recent Job Evaluation System (JES) reviews of Audiologist I positions submitted by individual audiologists in CH and WH have made recruitment and retention more challenging. These individual reviews resulted in a ranking below the Audiologist I job class profile point band which in turn places the position in a lower pay level. Rankings below or above the point band are assigned a letter (starting with A if the ranking is above the point band and starting
with M is the ranking is below the point band). The Audiologist I positions submitted for review resulted in an Audiologist IM ranking which is assigned a pay level of CG-40 as compared to a CG-41 for Audiologist I.

**Health Professional Bursary Program**

- Audiologists are included on the list of eligible health occupations for a Health Professional Bursary.

- To support the recruitment of health professionals in Newfoundland and Labrador (NL), HCS offers the Health Professional Bursary Program through the RHAs to provide financial assistance to students enrolled in certain health related education programs who accept employment in a difficult-to-fill position.

- A $5,000 bursary is available per year (1950 hours) of service commitment, for up to two years (3900 hours), or $10,000. If RHAs have been unsuccessful in offering an approved bursary and can provide evidence of ongoing recruitment challenges, they may apply for an enhanced bursary, up to $20,000 with a four-year service agreement.

- In 2019-20, HCS approved one audiologist bursary in each of WH (Corner Brook; $10,000; still available) and CH (Gander; $20,000; awarded).
  - 2015-16: 1 awarded out of 1 requested
  - 2016-17: 1 awarded out of 1 requested
  - 2017-18: 1 awarded out of 2 requested
  - 2018-19: 0 awarded out of 4 requested (no candidates came forward to accept student bursaries)

**Wait Times**

- Wait times are measured by referral date to appointment date for audiology.

- RHAs across the province are now working towards standardizing priority rankings using urgent (P1), semi urgent (P2) and routine (P3) classification scheme.

- EH – data are limited but EH provided the following:
  - Diagnostics: high priority clients are seen within three weeks
  - PHAP: routine clients are seen within nine months
  - CI: data not available due to the complex coordination required between audiology, ENT, surgery and financial requirements, which creates variability in wait times
  - EHDI: no wait list; may have wait time if sedation is required

- CH
  - Diagnostics: urgent, six weeks; semi urgent, 15 months; routine, 28 months
  - PHAP: routine, 28 months
  - Blitz days (i.e. workflow strategy used several days a month to increase the number of urgent and PHAP patients seen, from 6 to 12 patients/day, with charting time done post regular hours using overtime) significantly reduces the PHAP 28 months wait time
  - EHDI: no wait list; may have wait time if sedation is required
- The EHDI is using ENP (Electroneurophysiology technologist) to do a secondary ABR (Auditory Brainstem Response) screening which in turn decreases the number of false positive referrals

- WH
  - Diagnostics: urgent, two weeks; semi urgent, up to 6 months; routine, 31 months
  - PHAP: routine, 31 months
  - EHDI: no wait list; may have wait time if sedation is required

- LGH is collecting data; it is not currently available.

Prepared /Approved by: K. Paterson/A. Bridgeman/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

December 11, 2019
Decision/Direction Note
Department of Health and Community Services

Title: Authorization to Prescribe Regulations (Amendment)

Decision/Direction Required: Whether to approve the attached Authorization to Prescribe Regulations (Amendment) made under the authority of the Pharmacy Act, 2012.

Background and Current Status:
- Under the Pharmacy Act, 2012 (the Act), the Newfoundland and Labrador Pharmacy Board (the Board) is responsible for regulating the practice of pharmacy and the pharmacy profession in the public interest.

- In 2015, the Authorization to Prescribe Regulations (the Regulations) made under the Act came into force. These Regulations permitted pharmacists to be able to prescribe in the following instances:
  o providing an interim supply of drugs;
  o extending a prescription;
  o adapting a prescription;
  o therapeutic substitution;
  o prescribing non-prescription drugs; and
  o prescribing for minor ailments.

Preventable Diseases
- The main focus of the amendments is to allow pharmacists to be able to prescribe for preventable diseases. The term "preventable diseases" is used instead of "travel vaccines" as the conditions that a pharmacist will be able to prescribe vaccines for goes further than just travel related conditions.

- Currently, pharmacists are able to inject vaccines for the prevention of preventable diseases. Under the Administration of Drug Therapy by Inhalation or Injection Regulations, made under the authority of the Act, pharmacists are permitted to administer
vaccines via injection when the vaccine does not require a prescription or where the vaccine has been prescribed by an authorized prescriber. However, pharmacists are not currently authorized to prescribe many vaccines and it would be necessary for the client to first see their physician to obtain a prescription and then the pharmacist could fill the prescription and administer the vaccine. The proposed amendments would remove the requirement for an individual to first see their physician and obtain a prescription.

- The list of preventable diseases included in the draft amendment was selected based upon what is currently allowed in the other Atlantic Canadian provinces. The Board had requested that HCS use the other Atlantic Provinces as a comparator for what should be included in Newfoundland and Labrador for prescribing for preventable diseases. In New Brunswick and Prince Edward Island, the list of preventable diseases is included in regulations while in Nova Scotia, the list of preventable disease is contained in standards of practice, as are minor ailments. Prescribing for preventable diseases is also currently permitted in Alberta, Manitoba, Saskatchewan, and Quebec.

- The Board acknowledged that the primary preventable diseases that they want included are Hepatitis A and Hepatitis B (the TWINREX vaccine). The Board advised that this is where they expect to receive the most uptake from customers. Of the preventable diseases being permitted to be prescribed through these amendments, Hepatitis B, HPV and Varicella are all currently included as part of the provincial immunization schedules for school aged children.

- The Regulations currently allow pharmacists in Newfoundland and Labrador to offer for sale and administer vaccines that are Schedule II or III vaccines, including influenza. These are vaccines that do not require a prescription.

- In order to be allowed to prescribe, pharmacists must receive authorization from the Board, which includes a requirement to complete a Board approved orientation program. This is a current requirement for pharmacists to be able to prescribe for minor ailments and the other allowed areas under the Regulations, and pharmacists will not have to complete any additional training course in order to prescribe for the preventable diseases. However, pharmacists will be required to work within their own competency, training level and skill.

**Minor Ailments**
- In the Regulations, pharmacists can currently prescribe a Schedule I drug for one of the minor ailments listed in the schedule to the Regulations. Minor ailments are common or uncomplicated health conditions that can be managed with minimal treatment and/or self-care strategies. The proposed amendments will not expand the list of ailments. Rather, they will provide updated wording to better describe the condition or expand the reach of the current condition. A summary of the changes to the list of minor ailments contained in the amendment is attached as Annex A.

**Summary of Other Changes**
- The Regulations currently outline that a prescription cannot be extended where the prescription has already been extended once under the authority of the Medication Management by Community Pharmacists Standards of Pharmacy Practice or the Regulations. The Medication Management Standards no longer exist so the provision relating to the Medication Management Standards is being removed.
• Currently, the Regulations contain a requirement that a prescription can only be extended if the prescription filled immediately previous to it was filled at the same pharmacy. This provision is now being removed as it creates restrictions for hospital pharmacists and is no longer relevant in light of pharmacy prescribing being recorded in the electronic health record.

• The wording in the Regulations describing the types of prescription adaptation that is permitted is being updated to make it clearer for pharmacists and to be more representative of the actual practice of pharmacy and the needs of patients regarding adaption.

• The Board has also revised its Standards of Practice for Prescribing by Pharmacists to reflect the amendments. As part of the revision process, the revised standards were reviewed by the Board's inter-profession Standards Advisory Committee, which includes representation from the College of Physicians and Surgeons of Newfoundland and Labrador and the College of Registered Nurses of Newfoundland and Labrador. The Committee was supportive of the amendments and the revised standards were presented to the Board as being recommended by the Committee.

Analysis:
• Allowing pharmacists to prescribe for certain preventable diseases will provide additional opportunities for individuals to access certain vaccines without first obtaining a prescription from a physician, as is currently required.

• The amendments will also allow individuals to avail of certain vaccines from pharmacists that are also available in the public system. For example, an individual may have somehow missed receiving the Gardasil vaccine for HPV while in school. While the individual may be able to obtain the vaccine for free from the public system if they are still eligible, allowing a pharmacist to prescribe also provides additional opportunities to access this vaccine.

• HCS officials reviewed the revised Prescribing Standards of Practice and provided feedback. It is a requirement of the revised Standards for a pharmacist to be familiar with and consider the provincial immunization schedules when prescribing to individuals, including those who may be eligible under the public health regime. As well, pharmacists must do a patient assessment before prescribing. This can include demographic information, physical characteristics, allergies and intolerances, risk factors, and medical history, including immunization history. Therefore, a pharmacist would generally inquire whether the client has received certain immunizations before they would consider prescribing for the client. A pharmacist must determine whether the prescription is in the best interests of the patient and must ensure that it will not put the patient at increased risk.

• Pharmacists may charge an amount to the client for the act of prescribing and administering the vaccine, in addition to charging the client for the cost of the actual vaccine. Nothing in the amendments requires Government to reimburse pharmacists.

• There is a provision in the revised Prescribing Standards that requires pharmacists to document instances of pharmacist prescribing in the provincial electronic health record. The Board has advised that it and NLCHI are currently working to ensure that vaccine prescribing and administration activities will be fully viewable by anyone with access to HEALTHe NL. It is anticipated that such information will be viewable on HEALTHe NL before the Regulations come into force. Currently, information regarding pharmacist immunization
activity is available in the Pharmacy Network but it is not viewable by all users in HEALTHe NL.

- While pharmacists will upload the prescribing and administration activities into the Pharmacy Network and this will be viewable in HEALTHe NL, it will not go directly into Public Health’s reporting system, CRMS. As a result, it will not automatically be part of Public Health’s reported immunization rates. However, public health nurses will still be able to manually check HEALTHe NL to see whether certain individuals in the school system, for example, received immunizations from pharmacists and can therefore still manually capture this information as part of their reporting. Many of the preventable diseases that are outlined in the amendments are not part of the public health system or are part of the public health system for school age individuals only and therefore are not currently captured in immunization rates.

- Paragraph 59(1)(d) of the Act grants the Board the authority to make regulations, with the approval of the Minister, respecting the scope of practice and expansion of the scope of practice of pharmacists.

- HCS officials worked closely with the Office of the Legislative Counsel and the Board to draft the amendments to the Regulations and if approved, the amendments will come into force on January 31, 2020.

Alternatives:
- Approval of the attached Authorization to Prescribe Regulations (Amendment) (s. 29(1)(a))

Advantages:
- Allowing pharmacists to prescribe for the prevention of preventable diseases will allow additional access points for individuals in the province to receive vaccines and is consistent with the Minister’s current mandate letter.
- Additional prescribing for preventable diseases is consistent with what is permitted in other provinces.
- Amendments are in keeping with Government’s commitment to improving primary health care and allowing health professionals to work to their full scope of practice.
- No anticipated cost implications to Government by allowing pharmacists to be able to prescribe for the prevention of preventable diseases.
- Consistent with the Board’s and the Pharmacists’ Association of Newfoundland and Labrador’s (PANL) request for expanded scope for pharmacists.

Disadvantages:
- Immunization activities by pharmacists for school aged clients will not automatically be entered in the province’s public health reporting system and will instead have to be manually checked in HEALTHe NL by public health nurses.

- Do not approve the attached Authorization to Prescribe Regulations (Amendment)
If the Authorization to Prescribe Regulations (Amendment) is acceptable to the Minister, it should be signed where flagged; see Annex B. The amendment has already been approved and signed by the Board. If approved by the Minister, HCS officials will then arrange for publication of the amendment in the Newfoundland and Labrador Gazette.

Prepared/Approved by: D. Coffin/G. Smith/K. Stone  
Ministerial Approval: Received from Hon. Dr. John Haggie  

December 16, 2019

Annex A: Table of proposed changes to the List of Minor Ailments found in the Regulations  
Annex B: Authorization to Prescribe Regulations (Amendment)
Annex A: Table of Proposed Changes to the List of Minor Ailments Found in the Regulations

<table>
<thead>
<tr>
<th>Current List of Minor Ailments Found in the Regulations</th>
<th>Proposed Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne, Mild</td>
<td>n/a</td>
</tr>
<tr>
<td>Allergic Rhinitis</td>
<td>n/a</td>
</tr>
<tr>
<td>Atopic Dermatitis, Mild-Moderate</td>
<td>n/a</td>
</tr>
<tr>
<td>Callouses and Corns</td>
<td>n/a</td>
</tr>
<tr>
<td>Cold Sore</td>
<td>Cold Sores</td>
</tr>
<tr>
<td>Contact Dermatitis</td>
<td>n/a</td>
</tr>
<tr>
<td>Dandruff</td>
<td>Dandruff and Seborrhea</td>
</tr>
<tr>
<td>Diarrhea (Non-Infectious)</td>
<td>n/a</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>n/a</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>n/a</td>
</tr>
<tr>
<td>Emergency Contraception</td>
<td>n/a</td>
</tr>
<tr>
<td>Fungal Infections of the Skin</td>
<td>Fungal Skin Infections (including athlete’s foot)</td>
</tr>
<tr>
<td>Gastroesophageal Reflux Disease</td>
<td>n/a</td>
</tr>
<tr>
<td>Headache, Mild</td>
<td>n/a</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>n/a</td>
</tr>
<tr>
<td>Impetigo</td>
<td>n/a</td>
</tr>
<tr>
<td>Joint Pain, Mild</td>
<td>n/a</td>
</tr>
<tr>
<td>Muscle Pain, Mild</td>
<td>Musculoskeletal Pain, Mild</td>
</tr>
<tr>
<td>Nausea</td>
<td>Nausea and Vomiting</td>
</tr>
<tr>
<td>Oral Fungal Infection</td>
<td>Oral Candidias</td>
</tr>
<tr>
<td>Oral Ulceration</td>
<td>Aphthous Ulcers</td>
</tr>
<tr>
<td>Pinworms</td>
<td>n/a</td>
</tr>
<tr>
<td>Sleep Disorders, Mild</td>
<td>Insomnia, Mild</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>n/a</td>
</tr>
<tr>
<td>Upper Respiratory Conditions, Mild (cough, nasal congestion, sore throat)</td>
<td>n/a</td>
</tr>
<tr>
<td>Urticaria, Mild (including bites and stings)</td>
<td>n/a</td>
</tr>
<tr>
<td>Vaginal Candidias</td>
<td>n/a</td>
</tr>
<tr>
<td>Warts (excluding facial and genital)</td>
<td>Viral Skin Infections (common and flat warts)</td>
</tr>
<tr>
<td>Xerophthalmia</td>
<td>Dry Eyes</td>
</tr>
</tbody>
</table>
Annex B: **Authorization to Prescribe Regulations (Amendment)**
Title: Request for Waiver of Third Party Liability Account

Decision/Direction Required: Whether to waive the Minister’s entitlement to his share of an amount recovered relating to a third-party recovery from a slip and fall personal injury accident.

Background:
Under the *Medical Care and Hospital Insurance Act*:
- When a beneficiary suffers an injury caused by, contributed to by, or resulting from the negligence, act or omission of a person for which the beneficiary received insured services through the Medical Care Plan and the Hospital Insurance Plan, the beneficiary has the right to recover the amount paid for the insured services from the negligent person.

- The minister shall be subrogated to the rights of an injured beneficiary to recover any amount paid by the minister for insured services provided to that beneficiary.

- The beneficiary and the minister shall share in proportion to their respective losses in any recovery where insufficient funds are available to provide complete recovery to the beneficiary for his or her losses and injuries and to pay the costs of the insured services.

- The minister can waive in whole or in part the minister’s share of an amount recovered where, in the opinion of the minister, the circumstances warrant.

Current Status:
Recommendation:

Prepared/Approved by: P. Gillis/S. Snow/P. Smith/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

November 13, 2019
Information Note
Department of Health and Community Services

Title: Central Health External Review 2018 ( Vaughan Report)

Issue: Progress update on Central Health’s action plan in response to the 2018 external review.

Background and Current Status:
- CH is actively implementing 36 recommendations resulting from an external review in May 2018. These recommendations impact the areas of Governance, Leadership, Clinical Management, Relationships, Succession Planning, and Community Engagement; as well as operational and human resource issues.

- An Implementation Steering Committee (IC) developed an action plan for implementation of the recommendations and has submitted a progress report to HCS on activities up to September 30, 2019 (Annex A).

Analysis:
- The IC have identified 145 activities required to meet the 36 recommendations and are categorized as either “Completed”, “In Progress”, or “To Be Completed”.

- As of September 30, 2019, 104 (72 per cent) of the activities have been completed as compared to 90 (62 per cent) as of June 30, 2019.

- All 36 recommendations are currently “Completed” or “In Progress”. As of this update, there are no recommendations identified as “To Be Completed”.

- The IC has identified that 18 (50 per cent) of the recommendations are now completed as compared to 15 (42 per cent) at the end of June 2019. The recommendations are considered complete when all of the actions identified for each recommendation are complete.

- The following three recommendations were completed during the quarter ended September 30, 2019:
  - 3.0: Government should incentivize collaboration between the municipalities of Grand Falls-Windsor and Gander.
    - Community Advisory Committees (CACs) have been established in both municipalities and meetings have occurred. Multiple community engagement sessions are planned for November 2019 as part of CH’s Strategic Planning activities. CH and HCS senior leadership are meeting every four to six weeks regarding primary health care initiatives, and several initiatives have occurred, eg. utilizing Pre-admission Clinics (PACs) via telehealth, and expansion of telehealth services to multiple sites. Shalloway Primary Health Care Network has been engaged and a Collaborative Services Committee has been established.
  - 6.2: The senior leadership team including CEO, individually and regularly as a routine part of their daily activities walk through facilities engaging staff, listening to staff and clinicians and develop action items to incorporate into senior leadership agendas for discussion, action and follow-up.
    - Several leadership forums have occurred during 2018 and 2019. Staff engagement sessions are scheduled for fall 2019. VPs are meeting regularly with directors. VPs
are implementing iLead Teams within their areas of responsibility, as well as establishing leadership rounds processes. Management job descriptions are being revised to include accountability for leadership rounds and patient safety leadership rounds.

- 9.1: Engage towns of Grand Falls-Windsor and Gander in joint planning session for health services including the articulation of plans for access to collaborative community-based care.
  - CH representatives have participated in a number of community events. A representative from Municipalities NL sits on the CH Strategic Planning Steering Committee. CH is establishing bi-annual meetings with the Board Chair and CEO with town representatives; both towns are included in stakeholder meetings with Board of Trustees; town representatives were invited to Accreditation Canada partners session; and both towns are engaged in the strategic planning process. Public consultations were conducted during summer 2019.

- The remaining 15 recommendations were completed by June 30, 2019 and are listed in Annex B.

- The table below identifies the number of “In Progress” recommendations and actions by theme:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendations</th>
<th>“In Progress” Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Completed</td>
</tr>
<tr>
<td>Governance</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Leadership</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Management</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Relationships</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Succession Planning</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Operational/HR</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>18</td>
</tr>
</tbody>
</table>

**Action Being Taken:**
- CH is continuing work to implement the remaining recommendations and will provide HCS future updates quarterly, at a minimum.

- CH will issue a public release of the progress to September 30, 2019.

**Prepared/Approved by:** P. Barnes/A. Bridgeman/H. Hanrahan/K. Stone

**Ministerial Approval:** Received from Hon. John Haggie, MD

**November 1, 2019**
Annex A

### External Review Recommendation & Action Summary – September 30, 2019

There are 36 recommendations in total.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>4/36 (11%)</td>
<td>6/36 (16%)</td>
<td>8/36 (22%)</td>
<td>13/36 (36%)</td>
<td>15/36 (42%)</td>
<td>18/36 (50%)</td>
</tr>
<tr>
<td>In Progress</td>
<td>22/36 (61%)</td>
<td>28/36 (78%)</td>
<td>26/36 (72%)</td>
<td>23/36 (64%)</td>
<td>21/36 (58%)</td>
<td>18/36 (50%)</td>
</tr>
<tr>
<td>To be Completed</td>
<td>10/36 (28%)</td>
<td>2/36 (6%)</td>
<td>2/36 (6%)</td>
<td>0/36 (0%)</td>
<td>0/36 (0%)</td>
<td>0/36 (0%)</td>
</tr>
</tbody>
</table>

**Update on Actions** – For the 36 recommendations, there are currently 145 actions. Below is a summary of the status of the actions for comparison purposes showing progress over time.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>22/144 (15%)</td>
<td>54/145 (37%)</td>
<td>55/145 (38%)</td>
<td>76/145 (52%)</td>
<td>90/145 (62%)</td>
<td>104/145 (72%)</td>
</tr>
<tr>
<td>In Progress</td>
<td>36/144 (25%)</td>
<td>52/145 (36%)</td>
<td>65/145 (45%)</td>
<td>56/145 (39%)</td>
<td>49/145 (34%)</td>
<td>37/145 (26%)</td>
</tr>
<tr>
<td>To be Completed</td>
<td>86/144 (59%)</td>
<td>39/145 (27%)</td>
<td>25/145 (17%)</td>
<td>13/145 (9%)</td>
<td>6/145 (4%)</td>
<td>4/145 (3%)</td>
</tr>
</tbody>
</table>
## Annex B

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action(s) Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3 Medical Staff Bylaws are required to remove CEO as final authority for approval of credentialing and privileging of physicians. The responsibility for credentialing and privileging of physicians should be a Board responsibility based on the recommendations of the RHA Credentials Committee</td>
<td>Dr. Vogel has been hired to lead this work. Two physician forums have taken place and a third is planned for fall 2019. A lawyer has been contracted to draft the proposed changes to the bylaws which will remove the CEO as final approval and give physicians a place at the governance table.</td>
</tr>
<tr>
<td>3.4 Amend Board Bylaws to open meetings to the public beyond the annual meeting. In camera meetings should be confined to matters pertaining to finance, legal and human resource issues only</td>
<td>Board Bylaws have been redrafted and public meetings have been occurring since December 2018.</td>
</tr>
<tr>
<td>3.5 The Board should devote at least one meeting annually to risk assessment and risk mitigation</td>
<td>A session with HIROC, a national company specializing in healthcare risk management and patient safety, occurred October 2018 and another is scheduled for September 2019. Quarterly reviews of compliance is being provided by the CEO to the Board. An approach for reporting risk mitigation initiatives to the Board has been identified and will commence in September 2019.</td>
</tr>
<tr>
<td>4.1 All physician leaders should complete the Physician Manager Institute (PMI) leadership program</td>
<td>CH has introduced the requirement for completion of physician leadership education, and a process to support physician participation has been developed.</td>
</tr>
<tr>
<td>4.2 All hiring should be posted and completed through Human Resources and based on defined competencies</td>
<td>Reaffirmed processes for all recruitment activities to occur through Human Resources division. Any exceptions to established process requires senior leadership approval.</td>
</tr>
<tr>
<td>4.3 There should be a full-time Vice President of Medicine for the RHA</td>
<td>Recruitment ongoing for the full-time permanent position of Vice President of Medicine. The positions of VP- Medical Services and Chief of Staff have been merged.</td>
</tr>
<tr>
<td>5.6 CH will work with HCS to evolve a programmatic approach to clinical services across the RHA</td>
<td>The Medical Advisory Committee developed a plan to implement regional clinical chiefs for each program offered at CH. CH representatives are participating in the development of a Provincial Model of Clinical Services. The Departmental Chief positions will align with Directors in Program areas.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Action(s) Taken</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>6.0 Implementation of a clinical management on call system to support point of care staff after hours and on weekends</td>
<td>CH has developed a clinical on-call protocol and implemented the on-call process.</td>
</tr>
<tr>
<td>6.1 Locate senior management offices equally between Central Newfoundland Regional Health Centre (CNRHC) and James Paton Memorial Regional Health Centre (JPMHC)</td>
<td>Executive offices have been relocated equally between CNRHC and JPMHC; the offices of the CEO and Vice President of Medical Services have been relocated into CNRHC. Senior leaders have dedicated time for JPMRHC and CNRHC.</td>
</tr>
<tr>
<td>7.1 CH should promote and support the success of a ‘grow your own’ recruiting and retention as one of its primary recruiting and retention strategies</td>
<td>Improvements have been made to recruitment practices, including engagement with educational institutions and improved oversight and support of clinical placements.</td>
</tr>
<tr>
<td>9.0 Develop an RHA Patient Navigator position to assist patients and families chart their way through the healthcare system</td>
<td>A literature review has been completed and includes input from staff and public on the focus area. A Patient Navigator job specification has been developed, based on best practices and stakeholder feedback. Position will be posted in June 2019.</td>
</tr>
<tr>
<td>9.2 Strengthen the Community Advisory Committee (CAC) relationship with the Board by having the chair of each CAC attend the Board Meeting to report on current issues</td>
<td>CACs have been established in Grand Falls-Windsor and Gander. All CAC meeting minutes are provided to the Board of Trustees for information and discussion. CACs meet annually to discuss committee activities.</td>
</tr>
<tr>
<td>10.0 Address the issue of having Paramedics responsible for security in Emergency Departments and Hospitals</td>
<td>A Manager of Security, Emergency Management Systems and Business Continuity has been recruited, and a contract is now in place for on-site security services.</td>
</tr>
<tr>
<td>10.1 Paramedics required to be stationed at “The Junction” have no bathroom facilities</td>
<td>Reviewed staff complement for hospital based ambulance service in Baie Verte and Springdale. Changes have been made to the coverage of ambulance services which sees the ambulance at the Junction on a less frequent basis.</td>
</tr>
<tr>
<td>10.2 Infection Prevention and Control reports to management without senior authority to require clinical attention</td>
<td>Reporting structure has been realigned to ensure authority in place to require clinical action on recommendations.</td>
</tr>
</tbody>
</table>
Information Note
Department of Health and Community Services

Title: Client Survey - Income Support Medical Transportation Assistance Program (ISMT).

Issue: Provide an overview of the survey plan.

Background and Current Status:
- In June 2018, the administration of portions of the ISMT program (i.e. Avalon region, methadone services) were transferred from the Department of Advanced Education, Skills and Labour (AESL) to the Department of Health and Community Services (HCS). ISMT provides medical transportation to Income Support clients.

- At the time of the transfer, HCS signed an agreement with Bell to provide an Answering Call Device (ACD) queue for staff answering incoming client calls.

- In September 2018, when province-wide coverage of the ISMT program was moved from AESL to HCS, many incoming client calls were either unanswered, or were not answered in a timely manner due to the lack of ISMT resources to manage the ACD.

- By November 2018, ISMT were receiving approximately 300 incoming calls a day with only a limited number being answered. As clients continued to experience long response times or no service delivery, backlogs in the ISMT program became a matter of public concern.

- As a remedy to the significant call volume, HCS signed a call service agreement with Telelink. This agreement would have all daytime calls answered by Telelink Operators as opposed to ISMT's Client Service Officers (CSO) through the Bell ACD queue.

- Telelink Operators would ask the client a series of questions and email the information to a HCS email address. CSOs would be responsible for returning the client call and servicing the request.

- One year post-transfer of the ISMT program from AESL, clients were still experiencing long delays in phone call response times and were frustrated by interactions, or lack thereof, with ISMT staff.

- In July and August 2019, HCS hired an additional 10 temporary CSOs to manage call response times. Along with the additional staff, ISMT also implemented processes to prepare for the return of the previous in-house answering service (i.e. Bell ACD queue). HCS felt an ISMT client's first point of contact should be with a CSO and not a Telelink Operator.

- On October 15, 2019, approval was granted to reinstate the initial call service agreement with Bell and bring ISMT's answering services back in-house. Associated with that decision, short client telephone surveys, post change, would be conducted. HCS would use the results of these surveys to determine client satisfaction and to make improvements, where possible, for an overall positive client service experience.

- On November 19, 2019, the ISMT's daytime telephone system was switched over from Telelink to the Bell ACD queue and CSOs once again began answering and servicing its incoming client calls.
Analysis:
- A short client telephone survey (Annex A) was developed in collaboration with the Policy, Planning and Evaluation Division.

- The survey was developed in consideration of client surveys offered for other departmental telephone services, such as the HealthLine and the Automated Notification System. In its current draft, the survey includes six questions and should take clients approximately five minutes to complete. Clients are asked about the level of service they received, the length of time they waited to speak with a CSO and the professionalism of the CSO and their overall satisfaction with the ISMT program. Clients are not required to share any personally identifiable information, including personal health information.

- The surveyor will be a HCS employee, independent of the ISMT Program. The surveyor will instruct all potential respondents that the survey is not mandatory and results will remain totally anonymous.

Action Being Taken:
- The short telephone survey will be conducted no later than one month after returning to the in-house answering service. Potential respondents will be randomly selected from a list of ISMT program clients that have received program service since November 19, 2019 and have agreed to complete a short survey.

- The surveyor will contact the necessary number of clients to complete 50 surveys.

- Survey results will be assessed to identify possible improvements to overall client service.

Prepared/Approved by: S. Snow/N. Porter/P. Smith/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

November 28, 2019
Annex A

Medical Transportation Assistance Program (MTAP)
Income Support Client Experience Survey

Hi, my name is __________________, and I am calling from the Department of Health and Community Services to discuss your recent experience with the Income Support Medical Transportation Assistance Program (IS MTAP).

As a user of IS MTAP, we would like to ask you a few questions about your experiences. This will help us make improvements and ensure the program is meeting your needs. The survey should take about five minutes to complete and is voluntary. Your responses will be kept confidential and your name and/or personally identifying information will not be associated with your answers.

If you have any questions, or would like to stop the survey at any time, please let me know.
Thinking of the most recent time you used IS MTAP, please answer the following questions:

1. How long did you wait to have your call answered by a Department Client Service Officer to discuss your claim?
   - Less than 5 minutes.
   - 6 to 10 minutes.
   - 11-15 minutes.
   - 16-20 minutes.
   - More than 20 minutes.

2. Please rate your level of agreement with the following statements:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with how quickly my call was answered by a Department Client Service Officer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Client Service Officer processing my claim was helpful and understanding.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, I am satisfied with the phone service I received through IS MTAP.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Please provide the city or town you currently live in?

4. Please provide the city or town you travelled to or will be travelling to for your specialized medical appointment/service?

5. How often have you used IS MTAP support in the last six months?
   - Once.
   - Less than 5 times.
   - 6-10 times.
   - Greater than 10 times.

6. Do you have any suggestions of how to improve IS MTAP phone service or anything else you would like to share about your experience?

Thank you!
Information Note
Department of Health and Community Services

Title: Eastern Health Regional Dialysis Program Plan

Issue:
- To provide a summary of Eastern Health’s plan to address concerns brought forward by dialysis patients who reside in Placentia and Carbonar, and concerns raised on behalf of Bonavista dialysis patients.

- To provide an update on the current status of home based dialysis therapy (HBT) training and Eastern Health’s plan to increase access and manage the HBT waitlist. s. 29(1)(a)

Background and Current Status:
- Dialysis patients from the Placentia area are advocating for establishment of a satellite dialysis unit within the Placentia hospital site. Most of the patients currently travel to St. John’s for treatment; one relocated to access services in closer proximity.

- Dialysis patients and family members from the Carbonar area are requesting an increase in capacity at the Carbonar satellite dialysis unit to accommodate patients who currently travel to St. John’s for treatments.

- An advocate is requesting an increase in the capacity at the Bonavista satellite site to accommodate three patients who currently travel from Bonavista to Clarenville for treatments.

- Training for home based hemo-dialysis has been paused, with the exception of training of two patients, since July 2018 due to unresolvable issues with the previous home hemo-dialysis equipment vendor. A new tender for home hemo-dialysis machines was issued in June 2019 and is in the final stages of evaluation. The tender was to be finalized November 8, 2019.

- Training for home-based hemo-dialysis therapies requires six to eight weeks per patient. The patient educator is currently one registered nurse (RN) full time equivalent (FTE) position. Through-put for one RN is currently approximately six patients per year.

- Training of patients to carry out home peritoneal dialysis is unaffected and is proceeding as per normal routine and schedule.

- Eastern Health, on October 8, 2019, was directed to develop solutions to the issues above, to develop a plan to communicate with the Placentia patients, and to implement tangible steps to achieve resolution of the issues within timelines provided. Eastern Health provided the plan to HCS on October 30, 2019 and the communication guideline on November 1, 2019 (see Annex 1 and Annex 2 respectively).

Analysis:

- s. 29(1)(a)
Prior to issue of the home hemo-dialysis equipment tender, and during the 'pause' in training since 2018, patients were trained to carry out home hemo-dialysis therapy in 2019 using existing older technology. The older devices will be replaced with new technology when the tender is awarded.

Recruitment is underway for four FTE positions in total to increase capacity at Carbonear and Bonavista satellite units, and to reduce the wait-time for HBT training. Milestones in the timeline from RN position posting to completion of applicable orientation include:

- Posting – 10 days
- Applicant review and offer – seven to 14 days
- Release of success applicant from current position – up to 60 days
- Orientation – six weeks (42 days)

The total combined costs for 4.0 FTE RN positions is $532,198.

**Action Being Taken:**

- Eastern Health is increasing capacity at Carbonear satellite dialysis unit by extending operating hours. Evening shifts are being added three times per week. RN position recruitment commenced October 28, 2019 for 1.8 FTE positions to staff the additional hours.

- Capacity at Bonavista satellite dialysis unit is being increased to accommodate patients who currently travel to Clareville to receive dialysis treatments. RN position recruitment commenced October 28, 2019 for 1.2 FTE positions.

- To increase through-put and reduce the wait time for patients on the wait list for home-based dialysis training, RN recruitment for 2.0 FTE nurse educator positions commenced October
- The addition of two RN educator positions will result in increased capacity to train patients in home based modalities each year. Currently 25 patients are awaiting training.

- Eastern Health is implementing a chronic kidney disease list to monitor future system requirements.

Prepared/Approved by: D. Osborne/A. Bridgeman/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

November 13, 2019
ANNEX 1

Briefing Note
Regional Dialysis Program
Oct 30, 2019

Issue: The Minister of Health and Community Services has given the direction to develop operational plans to address patient wait lists for dialysis services in; Carbonear General Hospital (CGH) and Bonavista Health Centre Hemodialysis services, Home Hemodialysis teaching, as well as a communication plan for dialysis patients living within the Placentia area.

1. Carbonear Hemodialysis Unit

Current State: There are 43 patients receiving dialysis in the Carbonear satellite unit. Eight patients currently receiving some hemodialysis treatments within the city who are from the Carbonear area, who are/will be requesting access to dialysis services in CGH. Patients who are on the waitlist for the CGH Dialysis Unit receive notification of the waitlist process at the referring center through a conversation with the team. Once they arrive for the initial treatment at CGH site the wait list is again addressed. The process of attaining transient treatments as space permits is explained as well. Communication is ongoing from this point. The program recognizes a gap as conversations are not always documented, however the date of first HD at CGH which is documented correlates with the initial conversation, outside the information that they would have received from the referring city dialysis unit.

Plan: To extend operating hours to include an evening shift 3-evenings per week. 1.8 FTE (3-0.6 FTE) RN -NS29 staff are required at a cost of $198,906. This plan would accommodate up to nine additional patients which would meet current demand. The development of standardized processes regarding documentation of patient communication within the patient’s health record in such areas as: treatment options, initiation, discussion of home hemodialysis, treatments in satellite dialysis centers etc. Standardized communication processes will include minimal communication follow up and timelines of biannually. Capital renovation discussions are currently underway to explore additional space opportunities within the Carbonear site to support and sustain future dialysis growth for this area.

Challenges: Registered Nurse recruitment and retention has been an ongoing challenge for CGH. The RN Float Pool has declined from 18 to seven for the entire hospital. Leadership have met to explore strategies to address staffing shortages for the site.

Upon position start, the new staff would require a minimum of six weeks training.

Next Steps: Position recruitment commenced on October 28, 2019 for 1.8 FTE (3-0.6 FTE) RN at NS29 (10 day posting required). Analysis of site impact with movement of internal employees will be assessed to determine feasibility of plan. Extended hours of operation to begin when RN is secured, and orientation is completed (See Appendix A). Communication strategy to be
developed with anticipated timelines to ensure current patients awaiting access are aware of operational plan to address (See Appendix B).

2. **Bonavista Health Centre Dialysis Unit**

**Plan:** To add additional operational days opening the Bonavista dialysis unit in addition to the current 12-hour Monday-Wednesday-Friday operations an 8-hour Tuesday-Thursday-Saturday shift will be added.

1.2 FTE RN-NS29 are required at a cost of $132,604. This plan would accommodate up to six additional patients which would meet current demand with some capacity.

**Challenges:** Registered Nurse recruitment and retention has been an ongoing challenge for Bonavista Hospital. There is no float pool within the hospital to utilize/recruit staff from. Leadership met on October 21, 2019 to explore strategies to address staffing shortages for the site. Upon position start, the new staff would require a minimum of six weeks training.

**Next Steps:** Position recruitment commenced on October 28, 2019 for 1.2 FTE RN at NS29 (10 day posting required). Analysis of site impact with movement of internal employees will be assessed to determine feasibility of plan. Extended hours of operation to begin when RN secured, and orientation completed (See Appendix A). Communication strategy to be developed with anticipated timelines to ensure current patients awaiting access are aware of operational plan to address (See Appendix B).

3. **Home Dialysis**

**Current State:** Communication regarding access is ongoing with patients at each visit. Eastern Health is currently awaiting the finalization of a new equipment tender anticipated to be awarded on Nov 1st, 2019. Upon determination and awarding of successful tender, staff may require education and training (a minimum of two weeks) if new technology will be used within the program (See Appendix C).

**Plan:** Hire two FTE -additional RN resources at NS-29. This will provide capacity to teach two patients simultaneously and 8 home hemodialysis patients each per year. This plan would have approximately 20 patients on a home dialysis therapy in a year, both PD and Hemodialysis.
Patients will be prioritized based on criteria met, geographic location and patient specific educational requirements. Cost for staff is $200,688 and for ancillary supplies for the machines is $550,000.

**Challenges:** Recruitment and retention. Depending on the outcome of identification and awarding of tender, staff may require additional training.

**Next Steps:** Position recruitment commenced on October 28, 2019 for 2 FTE RN staff (10 day posting required). Communication strategy to be developed with anticipated timelines to ensure current patients awaiting access are aware of operational plan to address. Explore future opportunities with WH and LGH for the establishment of home hemodialysis teaching and case management for patients within those RHAs. Through consultation with the Provincial Kidney Program and the Eastern Health Dialysis Networking Committee, engagement sessions with RHA leadership regarding promotion of home hemodialysis in other RHAs in early 2020.

---

4. **Placentia Area Dialysis Patients**

**Current State:** All patients from this area have recently been assessed for home dialysis suitability. Those who meet stability criteria will be offered a home based therapy.

**Next Steps:** The distance from Placentia to Carbonear is 30 km less than Placentia to St. John’s. Patients from the Placentia area are identified at the onset of hemodialysis therapy and currently documented in demographics section in Meditech charting module. There are monthly meetings between Provincial Kidney Program and Eastern Health with Placentia as a standing agenda item.
Future Opportunities

Development of standardized operational practices (SOP) and/or policies regarding dialysis service waitlists will be important to establish in the future, ensuring a standardized prioritization process is followed for all patients awaiting access. This will be in collaboration with the Provincial Kidney Program Advisory Committee and RHAs.

The development of a dialysis waitlist data base to house all client information that are actively/non-actively waiting for services will be used for sustainability planning and reporting. The data base will house patient/program data for: hemodialysis, home hemodialysis, peritoneal dialysis and transplant services.
# Appendix A

## Hemodialysis Nursing Recruitment Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Details</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Position Posting</td>
<td>Open October 28 – November 7, 2019</td>
<td>10 days</td>
</tr>
<tr>
<td>HR Applicant Review and Offering</td>
<td>November 15, 2019</td>
<td>Estimated 5-7 days</td>
</tr>
<tr>
<td>Applicant Release Dates</td>
<td>Requires discussion with applicant’s manager with possibility of back filling applicants’ current position</td>
<td>To be determined – potential up to 60-day release</td>
</tr>
<tr>
<td>s. 29(1)(A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Orientation</td>
<td>To be determined</td>
<td>6 Weeks post release</td>
</tr>
</tbody>
</table>
## Appendix B

### Waitlist Communication Strategy Timeline

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date Range</th>
<th>Communication Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal change discussion with staff and physicians</td>
<td>October 24 – November 1, 2019</td>
<td>Meetings</td>
</tr>
<tr>
<td>Initial patient and community notification of expansion plans to address service waitlists</td>
<td>November 5 – November 18, 2019</td>
<td>Memorandum and onsite visits</td>
</tr>
<tr>
<td>Patient and community implementation updates</td>
<td>Monthly</td>
<td>Memorandum and onsite visits when applicable</td>
</tr>
</tbody>
</table>
### Appendix C

<table>
<thead>
<tr>
<th>Home Hemodialysis Expansion Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final Tender Review</strong></td>
</tr>
<tr>
<td><strong>Tender closing</strong></td>
</tr>
<tr>
<td><strong>Equipment acquisition and implementation plan with vendor</strong></td>
</tr>
<tr>
<td><strong>Nursing Position Posting</strong></td>
</tr>
<tr>
<td><strong>HR Applicant Review and Offering</strong></td>
</tr>
<tr>
<td><strong>Applicant Release Dates</strong></td>
</tr>
<tr>
<td><strong>Vendor equipment training with staff</strong></td>
</tr>
<tr>
<td><strong>Patient Preparation</strong></td>
</tr>
</tbody>
</table>
## Appendix D

<table>
<thead>
<tr>
<th>Waitlist Site</th>
<th>Type of Service</th>
<th>Identifiers</th>
<th>Home Town</th>
<th>Treatment Location</th>
<th>Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carbonear HD Unit</strong></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Temp accommodated at CG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>CG and 2 MPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>CG and 2 MPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>HSC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>SCWH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Inpatient SCWH - Not actively waiting, anticipated future request</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Newly added to list Oct 18</td>
<td></td>
</tr>
<tr>
<td><strong>Bonavista HD Unit</strong></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>1 RV (every second week) and remaining in Clareville (Init in RV)</td>
<td>36 Oct</td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>1 RV (every second week) and remaining in Clareville</td>
<td>36 Oct</td>
</tr>
<tr>
<td><strong>Placentia Dialysis</strong></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: candidate for HHD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis Clareville: not interested in HBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis HSC: too frail for HBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: query medically unstable at this time for HBD but possible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: too frail for HBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: candidate for HBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: no PD could do HHD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>Active dialysis MPS: too frail HBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Active dialysis HSC: on transplant list</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Dialysis Waitlist</strong></td>
<td>Hemodialysis</td>
<td></td>
<td></td>
<td>May 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Jun 16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Aug 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Jan 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Jan 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Feb 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Feb 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Apr 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Apr 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Dec 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Dec 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Sep 19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Sep 19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Mar 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Mar 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>May 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>May 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Hemodialysis</td>
<td></td>
<td></td>
<td>Nov 17</td>
<td></td>
</tr>
</tbody>
</table>
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Information Note
Department of Health and Community Services

Title: Health and Community Services' Interactions with the Teamsters Union

Issue: To provide information on Health and Community Services' (HCS) interactions with the Teamsters Union.

Background and Current Status:
- The Transport and Allied Workers Local Union 855 (Teamsters) has signed collective agreements to represent ambulance staff with the following companies:
  - Fewer’s Ambulance Service Limited and five of Fewer’s subsidiary companies including Mercer’s, Ferryland, Ryan’s, Tremblett’s, and 13190 NL;
  - Freake’s Ambulance Service Limited; and,
  - Smith’s Ambulance Service Limited.

- The President of Teamsters Local 855, Mr. Rick Gill, has requested meetings with HCS ambulance staff on several occasions to discuss ambulance program issues which, in the Teamsters’ opinion, directly affect their membership.

- HCS has declined the meeting requests stating that Teamsters have collective agreements with ambulance operators and the union should bring their concerns to their memberships' employers. Government contracts with operators for the provision of services. Government does not contract with the Teamsters. [s. 29(1)(a)]

Analysis:
- [s. 30(1)(a), s. 30(1)(b)]

- [s. 38(1)(b)(i)]

- [s. 29(1)(A)]
- Paramedics are represented by the Paramedics Association of NL and can provide HCS with any information required to inform paramedic concerns.

Action to be Taken:
- [Redacted]

Prepared/Approved by: W. Young/T. Power/H. Hanrahan/K. Stone
Ministers Approval: Received from Hon. John Haggie, MD.

November 13, 2019
Information Note
Department of Health and Community Services

Title: Update on a multi-regional outbreak of Shiga Toxin-producing Escherichia coli (STEC)

Issue: To update the Minister on the multi-regional outbreak of STEC and actions being taken to address the outbreak. See related BN-2019-00548 and BN-2019-00563.

Background and Current Status:
- On October 30, 2019, the Medical Officer of Health informed the Outbreak Management Team (OMT) that the provincial outbreak has ended, as two incubation periods since the date of onset of symptoms in the last known case (October 7, 2019) has passed (based on the maximum incubation period of 10 days).

- The outbreak case definitions for confirmed and suspected cases of STEC have been updated to reflect new information, as follows:
  - o
  - [40(1)]
  - s. 40(1)

- As of November 4, 2019, there are 30 confirmed cases and 19 suspect cases of STEC reported from Eastern, Central and Western Health regions. Service NL (SNL) Environmental Health Officers (EHOs) continue to interview confirmed and suspect cases. Thirty-one food exposure histories have been submitted to HCS (26 from confirmed cases), and eleven of the confirmed cases are known to be unaffiliated with Memorial University.

- As of November 4, 2019, bacterial cultures from twenty-seven confirmed cases have been sent to the National Microbiology Lab (NML) in Winnipeg for genotyping. Twenty-five samples (18 cases living in Eastern Health region, [in] in Central Health region, and [in] in Western Health region) were identified as E. coli O26:H11, and were genetically related in a single provincial cluster by whole genome sequencing. Of the remaining two samples, one could not be typed and results are pending for the other.

- On October 24, 2019 the Canadian Food Inspection Agency's Office of Food Safety and Recall (OFSR) provided an update on its investigation of the suspect spinach, as follows:
OFSR does not see any potential corrective actions or risk mitigations to be taken on this issue. As such, OFSR is not considering doing any further traceback or forward work on these products.

- On October 21, the NML shared the genetic sequencing data with the US Centers for Disease Control (CDC), at the request of the CDC, for comparison.

- On October 25, 2019, the NML notified the Public Health and Microbiology Laboratory that the NL E. coli O26 cluster is highly related to a newly coded cluster of eight E. coli O26 cases in the US. The NML shared this information with the Outbreak Management Division at PHAC. As of November 1, 2019, no exposure information is available on the US cluster.

**Analysis:**
- As of November 4, 2019, the following data has been collected:
  - the age range of all cases is 4 to 62 years, with a median of 20 years;
  - sixteen (33%) of the cases are male and 33 (67%) of the cases are female; and,
  - the symptom onset date range is September 10 to October 7, 2019 (see Appendix I).

- No other province or territory has contacted HCS regarding the Public Health Alert posted on the Public Health Agency of Canada (PHAC) secure website.

**Action Being Taken:**
- HCS will work with PHAC, NML and the CFIA as part of an international investigation, if requested.

- HCS will organize an outbreak debrief session with all OMT members to identify and discuss lessons learned.

- HCS will prepare an outbreak report to summarize all actions taken, investigation findings and recommendations.

**Prepared/Approved by:**

D. Howse/J. Fitzgerald/C. Simms/K. Stone

**Ministerial Approval:**

Received from Hon. John Haggie, MD

November 5, 2019
Information Note
Department of Health and Community Services

Title: Usage of Personal Mobile Devices by Employees in the Workplace

Issue: To provide a comparison of policies related to personal mobile devices usage by employees in the four regional health authorities (RHA), Newfoundland and Labrador Centre for Health Information (NLCHI) and the Government of Newfoundland and Labrador (Government).

Background and Current Status:
- While there are slight variations in how RHAs, NLCHI and Government reference personal mobile devices, each have related policies. However, not all policies address personal usage in the workplace.
- Policies in three of the RHAs, Central Health (CH), Western Health (WH) and Labrador-Grenfell Health (LGH), address employee use of personal mobile devices during work:
  - CH has a policy titled Employee Use of Personal Cell Phones (effective April 15, 2011) which states that personal cell phone usage should be limited during work and can be used in designated area only during lunch or break periods.
  - WHs policy is titled Use of Cellular Telephones in Acute Care and Long Term Care – Staff and External Care Providers (effective March 2008 and updated March 2013). It explicitly states that cell phones are prohibited from use in all patient/resident care areas in acute care and long-term care. Usage is allowed in cafeterias, waiting areas, office areas and corridors not included in the list of prohibited area and entrances.
  - LGH has a similar policy titled Use of Wireless Devices dated July 2009 that states that “all employees must refrain from using wireless devices for personal reasons during work hours except during break/meal breaks”. While this policy is dated, LGH circulated a memo to staff in January 2018 as a reminder of the policy requirements. Policy also discusses concerns related to proximity to medical equipment.
- Eastern Health (EH) issued a policy titled Safe Use of Cellular Telephones and other Cellular Devices in Eastern Health Facilities in May 2009 which focuses on the use of cellular devices around medical devices to avoid radio frequency interference. This policy includes employees and the public. However, another related policy titled Personal Cellular Telephone and Camera Use was issued to the paramedicine division in October 2010 which states that personal cell phone usage is only permitted when work responsibilities are not being performed and all other related responsibilities are complete. This policy appears to be specific to paramedicine staff and does not apply to all EH employees.
- NLCHI has a policy titled Mobile Devices (dated January 30, 2015) which relates to usage of personal devices in the performance of work related business. This policy does not address usage of personal devices for non-work related duties.
• Government also has policies related to accessing government networks using personal devices in the performance of work related duties but there does not appear to be a policy directly related to usage of personal devices for non-work related duties.

Social Media
• Personal mobile devices are often used to access social media. All groups have detailed policies related to social media usage and inappropriate postings (e.g. confidential information) and its potential impact on the organization and the employees employment. Each policy also addresses usage during work hours:
  o EH has a policy titled Social Media, dated October 11, 2017, that states use of social media by employees, physician, volunteers and students is limited to breaks and not in front of patients, residents, clients or visitors. It states usage must not interfere or cause a delay with the provision of care and service delivery, or with one’s ability to safely perform work-related responsibilities without distraction.
  o CH has four separate policies related to social media usage. A new policy is under development to merge these documents. One policy is titled Use at Work, dated October 9, 2012, and specifically states that use of social media during work hours for non-work related purposes is strictly prohibited.
  o WH has a Social Media Policy that came into effect August 14, 2012. Usage of social media during work must be work-related and approved by the Director of Communications.
  o LGH has a policy titled Social Media dated April 2019 which states that personal use of social media during work hours is prohibited and is only allowed during lunch or break in designated, non-clinical areas. Employees are not permitted to be affiliated with an LGH email address on social media sites.
  o Government and NLCHI policies states that personal use of social media must never interfere with work duties.

• Social media can also be accessed using corporate networks and/or IT assets. As such, all groups have policies in place to address personal usage. With the exception of EH, each group allows for some personal use provided it does not impact employee productivity.
  o CH has a policy titled Internet—Use of, dated September 28, 2011, that states that individuals should limit their personal use of the Internet.
  o WH has a policy titled Internet – Acceptable Use, effective June 2012 (revised June 2016), which states that excessive personal use is prohibited.
  o NLCHI has a policy on Acceptable Use of Centre Resources dated July 1, 2011 that states that some personal use of NLCHI resources are allowed provided that it does not negatively impact NLCHI and does not interfere with the employees workload. Usage for personal gain is not permitted.

• EH has a policy titled Appropriate Use of Computer Resources/Services (dated April 7, 2014) which states that computer resources are for the delivery of client programs and services, research and the administrative functions required to conduct the legitimate business of EH. It specifies that computer resources are not to be used for personal reasons, such as private business.

• Government allows for incidental use of the internet for personal use during lunch or approved breaks. Personal devices are prohibited from using the government network unless authorized.
• LGH has a policy titled Laptop and Mobile Data Device Policy and Agreement, dated November 2011, which provides standards for accessing the internet for business purposes on LGH issued equipment via third party wireless internet service providers. However, this policy does not address personal usage. LGH is following up to see if there is another related policy.

Analysis:
• All entities discussed here have some policies on the use of personal device and, in particular, social media.

• Generally, access is restricted to specific areas at specific times.

• Patient and family interaction with front line staff is very important to a patient's overall experience with the healthcare sector. Employee usage of personal devices while with a patients is perceived negatively by patients and families.

• On times, concerns of this nature have been brought to the attention of HCS.

• Employees may use mobile devices (personal or work issued) for work related purposes (e.g. look up medication dosages).

• It is impossible for patients and families to know if a device is personal or issued by the organization; however, employees are responsible for appropriate usage and to make sure it does not impact their professional integrity with patients and families.

Action Being Taken:
• The RHAs, NLCHI and Government regularly review policies to ensure they are current and communicate to staff.

• Content of this note shared with the five health organizations asking them to review and strengthen their policies regarding use of personal mobile devices at work, particularly in the presence of patients and families.

Prepared/Approved by: K. Nolan/A. Bridgeman/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

November 29, 2019
<table>
<thead>
<tr>
<th>RHA</th>
<th>Policies</th>
<th>Policy Date</th>
<th>Does it Address Personal Usage During Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Health</td>
<td>Social Media</td>
<td>October 11, 2017</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Personal Cellular Telephone and Camera Use</td>
<td>October 20, 2010 (reviewed December 2011)</td>
<td>Yes (limited to paramedicine)</td>
</tr>
<tr>
<td></td>
<td>Safe Use of Cellular Telephones and other cellular devices in Eastern Health Facilities</td>
<td>May 27, 2009 (reviewed June 2011)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Appropriate Use of Electronic Mail (E-Mail)</td>
<td>May 5, 2011 (revised October 14, 2014)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Appropriate Use of Computer Resources/Services</td>
<td>April 7, 2014</td>
<td>Yes</td>
</tr>
<tr>
<td>Central Health</td>
<td>Employee Use of Personal Cell Phones</td>
<td>April 15, 2011</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Internet – Use of</td>
<td>September 28, 2011</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Social Media – Introduction</td>
<td>September 14, 2012</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Social Media – Official Use</td>
<td>September 14, 2012</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Social Media – Use at Work</td>
<td>October 9, 2012</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Social Media – Terms of Use for Staff</td>
<td>September 14, 2012</td>
<td>No</td>
</tr>
<tr>
<td>Western Health</td>
<td>Internet – Acceptable Use</td>
<td>June 7, 2012 (revised June 3, 2016; reviewed June 28, 2019)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Use of Cellular Telephones in Acute Care and Long Term Care – Staff and External Care Providers</td>
<td>March 12, 2008 (revised March 4, 2013; reviewed June 28, 2019)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Social Media Policy</td>
<td>August 14, 2012 (reviewed September 10, 2018)</td>
<td>Yes</td>
</tr>
<tr>
<td>Labrador-Grenfell Health</td>
<td>Use of Wireless Devices</td>
<td>July 2009 (Memo January 24, 2018)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Laptop and Mobile Data Device Policy and Agreement</td>
<td>November 2011</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Social Media</td>
<td>April 2019</td>
<td>Yes</td>
</tr>
<tr>
<td>RHA</td>
<td>Policies</td>
<td>Policy Date</td>
<td>Does it Address Personal Usage During Work</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------</td>
<td>----------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>NLCHI</td>
<td>Acceptable Use of Centre Resources</td>
<td>July 13, 2011</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mobile Devices</td>
<td>January 30, 2015</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Social Media Guidelines</td>
<td>No date</td>
<td>Yes</td>
</tr>
<tr>
<td>Government</td>
<td>Social Media Policy and Guidelines</td>
<td>No date</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Directive – Acceptable Use of the Government Network and/or Information Technology Assets</td>
<td>December 2018</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Equipment and Resources Usage Policy</td>
<td>July 25, 2011</td>
<td>Yes</td>
</tr>
</tbody>
</table>