April 9, 2019

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/057/2019]

On March 12, 2019, the Department of Health and Community Services (the Department) received your request for access to the following records:

“Following briefing notes: Supplemental Air Ambulance Services Jan 2019; Inuit Tuberculosis (TB) Elimination Framework; Decision of the Transitioning of Hospital-Based Services Committee on a Proposed Private Cataract Surgery Facility; Delayed Delivery of Electronic Medical Record (EMR) Results - Quality Review and Technical Update; Labrador Grenfell request for funding for air conditioning and patient washroom - Jan 2019; Labrador Grenfell Request for Funding For Air Conditioning and Patient Washroom; Letter of Support for Federal Narcotic Exemption; Long Term Care and Community Support Services System: Financial Assessment Policies to Support Implementation of Income Testing; Canadian Institute for Health Information (CIHI) release on Trends on Hospital Expenditures, 2005-2006 to 2017-2018; Electronic Medical Record Issue; Public health staffing and school attendance challenges in Natuashish; Review of Automobile Insurance in N.L.; Emergency Room Visits by Residents of the Botwood Catchment Area; Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Review of Provincial and Territorial Policies; Update on Measles Outbreak in Canada.”

I am pleased to inform you that a decision has been made by the Department to provide access to some 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):

Cabinet confidences

27. (1) In this section, "cabinet record" means

(i) that portion of a record which contains information about the contents of a record within a class of information referred to in paragraphs (a) to (h).

(2) The head of a public body shall refuse to disclose to an applicant

(a) a cabinet record; or

(b) information in a record other than a cabinet record that would reveal the substance of deliberations of Cabinet.
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)(b) The head of a public body may refuse to disclose to an applicant information 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:
(d) information, the disclosure of which could reasonably be expected to result in the premature disclosure of a proposal or project or in significant loss or gain to a third party;
(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 business interests of a third party
39. (1)(a)(ii)(b)(c)(i) The head of a public body shall refuse to disclose to an applicant information that would reveal commercial, financial, labour relations, scientific or technical information of a third party; that is supplied, implicitly or explicitly, in confidence; and the disclosure of which could reasonably be expected to harm significantly the competitive position or interfere significantly with the negotiating position of the third party.

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 page 8 has been withheld under s. 35(1)(d) and s. 39(1)(a)(ii)(b)(c)(i).

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
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
ATIPP Coordinator
/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: Supplemental air ambulance service.

Issue: Update on current status of contracted supplemental air ambulance services.

Background and Current Status:
- Current HCS direction is to have two air ambulance capable aircraft available 24/7. One aircraft is to be stationed in Happy Valley-Goose Bay (HV-GB) and one in St. John's.
- Transportation and Works (TW) through Government Air Services (GAS) operate two King Air 350s as the primary assets of the air ambulance program.
- In order to ensure aircraft availability, HCS has entered into contractual agreements with two supplemental air ambulance providers. Current agreements in place include:
  o Provincial Airlines Limited (PAL) contracted until January 31, 2019; and,
  o Exploits Valley Air Services (EVAS) contracted until February 28, 2019.

Analysis:

- The Public Procurement Regulations, Section 6 (a) (iv), permits the Department Head to approve the acquisition of a service without an open call for bids in the event that: an emergency or a situation of urgency exists and the acquisition of the commodity cannot reasonably be made in time by an open call for bids.
- An exception to an open call for bids must be reported to the Chief Procurement Officer within 15 days of entering into a contract and will be posted to the Public Procurement Agency's website within 15 days of receipt of the reported exception. Reporting to the House of Assembly is not required.

Action Being Taken:
- HCS is in the process of requesting quotes for a supplemental air ambulance service based out of Happy Valley-Goose Bay in accordance with Section 6(a)(iv) of the Public Procurement Regulations as noted above. Upon receipt of quotes, approval will be sought to contract the service as an interim measure while longer term direction on air services is considered.

Prepared/Approved by: J. Letto/C. Campbell/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

January 21, 2019
Title: Inuit Tuberculosis (TB) Elimination Framework

Issue: Summary and analysis of the recently released Inuit TB Elimination Framework:

Background and Current Status:
- The Inuit TB Elimination Framework was released by the Inuit Tapiriit Kanatami (ITK) on December 10, 2018.

- ITK is the national organization that represents 65,000 Inuit in Canada who live mostly in Inuit Nunangat, the collective term for the four regional homelands including Nunatsiavut in northern Labrador.

- ITK has been working in partnership with Inuit regions and the Federal and Provincial Governments toward elimination of TB in Inuit. Elimination means the reduction to zero in the incidence of a specified disease in a defined geographical area as a result of deliberate efforts. Continued intervention measures are required. Efforts to eliminate TB are occurring at the international, national, regional and local levels.

- The rate of Tuberculosis among Inuit living in Inuit Nunangat for 2016 was 38 times the rate for Canada as a whole and more than 300 times the rate for Canadian-born non-Indigenous people. Nunatsiavut communities on the north Labrador coast had the highest incidence rate of TB (averaged over 2006 to 2016) of all Inuit regions.

- Milestones to date:
  - September 2017 – Discussion at the Indigenous Inuit-Crown Partnership Committee regarding the development of a TB Elimination Task Force
  - October 2017 – Establishment of the Inuit TB Committee and Task Force after a large meeting of stakeholders hosted by ITK and Nunavut.
  - March 2017 – Joint announcement by ITK and Indigenous Services Canada of TB Elimination targets in Inuit Nunangat which are the reduction in the rate of active TB by at least 50% by 2025 and the elimination of TB by 2030.
  - December 2018 - Release of the Inuit Tuberculosis Elimination Framework which builds on all of the previous work.

- The Inuit TB Elimination Framework has two purposes:
  - To provide strategic direction for Inuit regions and their partners as they develop and implement region-specific TB elimination action plans; and
  - To provide an evidence-based, transparent tool for ensuring accountability and measuring progress TB elimination.

- The Framework identifies the following priority actions:
  - Enhance TB care and prevention programming;
  - Reduce poverty, improve social determinants of health and create social equity;
  - Empower and mobilize communities;
  - Strengthen TB care and prevention capacity;
  - Develop and implement Inuit specific solutions; and
  - Ensure accountability for TB elimination.
• Under each priority action, the Framework identifies key elements for the Regional TB Elimination Action Plans. In addition to health program related activities, examples of key elements include political commitment from all levels of government, collaboration and partnership, addressing the social determinants of health, Inuit led research, data management systems and processes, community engagement, monitoring and evaluation etc.

• The Federal Government budget of 2018 included $27.5 million toward eliminating Inuit TB over five years. The funds will flow through ITK.

• The End TB Regional Action Plan (RAP) will include a budget. ITK will review the RAP from each of the Inuit regions and allocate funds according to criteria under discussion.

Analysis:
• The Inuit Tuberculosis Elimination Framework along with the Inuit-Specific Tuberculosis (TB) Strategy provides helpful guidance to Inuit regions to develop region specific action plans to eliminate TB in every Inuit community in Canada. It will be used in conjunction with the WHO document entitled “Toolkit to develop a national strategic plan for TB prevention, care and control”.

• The RAPs will receive funding although the details are not yet known.

Action Being Taken:
• Nunatsiavut Health and Social Development are currently working on the RAP in conjunction with Labrador-Grenfell Health, HCS and First Nations and Inuit Health Atlantic of Indigenous Services Canada.

• The Tripartite Steering Committee (NHSD, HCS and FNIHB Atlantic) are guiding this work.

• The current work related to the Nain outbreak is contributing a great deal to the development of the action plan. Responding to the current outbreak has led to an examination of TB data base, an increase in diagnostic equipment and use of new treatment drugs. For the first time action, is being taken to initiate community wide screening and treatment for latent TB – an action that is critical in decreasing the high rate of disease in Inuit communities.

Prepared/Approved by: M. Baikie/B. Earles/C. Sarbu/M. Harvey/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

January 15, 2019
Information Note
Department of Health and Community Services

Title: Decision of the Transitioning of Hospital-Based Services Committee on a Proposed Private Cataract Surgery Facility.

Issue: The Transitioning of Hospital-Based Services Committee has not recommended approval of the proposal by Dr. Justin French to transition the provision of cataract surgeries from the Western Regional Health Authority to his private facility. The Minister intends to accept the recommendation but will be allowing all ophthalmologists to perform cataract surgery, as an insured service, in designated non-hospital facilities.

Background and Current Status:
- Cataract surgeries in Newfoundland and Labrador have been limited to the hospital setting where ophthalmologists are provided Operating Room (OR) time and bill the Medical Care Program (MCP) per case. The restriction of cataract surgeries to the hospital setting had been based on an interpretation of the Medical Care and Hospital Insurance Act and regulations made thereunder. In June 2018, government amended the regulations to state explicitly that “the medically necessary removal and replacement of a cataractous lens is an insured service covered by MCP and the surgery must be performed in a hospital or a facility designated by the Lieutenant-Governor in Council.”

- The Transitioning of Hospital-Based Services Committee (the Committee) was created in the 2014-2017 MOA between government and the NLMA to consider the potential to have fee-for-service (FFS) physicians provide services currently only provided in hospitals in their clinics. The Committee’s sole responsibility is to make recommendations to the Minister of HCS.

- Dr. Justin French, a Corner Brook ophthalmologist, has been advocating for permission to perform cataract surgeries in his private clinic. In the media, he has claimed that he can perform these surgeries more efficiently in a private setting than in Western Health facilities. He operates in both Western Regional Memorial Hospital in Corner Brook (WRMH) and Sir Thomas Roddick Hospital in Stephenville (STRH).

- In early 2018, HCS reviewed and rejected an initial proposal from Dr. French because it would not provide cost savings. It was agreed, following consultation with the NLMA, that Dr. French would be invited to submit a comprehensive proposal to the Committee which could contract an independent consultant to assess Dr. French’s proposal against data collected from Western Health to determine the financial viability of the proposal.

- Grant Thornton (GT) was engaged by Western Health to conduct the independent review. Dr. French submitted an Expression of Interest to GT to establish the “Humber Valley Surgical Centre” (HVSC) on May 12, 2018. This proposal expanded substantially from the concept originally discussed with government officials in February 2018. GT subsequently collected data from Western Health, and met with Dr. French and Western Health on numerous
occasions. It submitted its first report on July 3, 2018 and, based on further direction from the Committee, submitted supplementary analysis on October 30.

- For the sake of comparison, GT attempted to determine the cost of a cataract surgery at WRMH and compare it to the HVSC proposal. In July, GT reported that, based on the data available, the HVSC proposal compared favourably to WRMH on a direct cost analysis. However, overhead and wastage data is not available from WRMH and, therefore, the Committee requested additional analysis using a proxy measure of overhead derived from data available from relatively comparable hospitals in other jurisdictions.

- Grant Thornton did not consider the impact on STRH. Cataract surgeries represent the majority of all surgeries performed at STRH. In 2016-17, of 1193 surgeries performed at STRH, 840 (70.4%) were cataract surgeries; in 2017-18, of 962 surgeries, 572 (59.5%) were cataract surgeries.

- Considering the wait time to have the procedure after having seen the ophthalmologist (not the wait for the initial visit) WH’s cataract benchmark performance has been one of the best in the province, consistently performing more than 90 per cent of first eye cataract cases within the 112 day benchmark (see Annex C). Some Committee members expressed doubt regarding the
regarding the wait time measurement methodology and results, however; these figures follow national CIHI guidelines and are regularly published by HCS.

**Analysis:**
- The Committee met on November 29, 2018 and came to a consensus. It decided not to recommend approval of Dr. French’s proposal to the Minister. The Minister received the Committee’s report late on January 15, 2019. The NLMA has advised that the report will be sent to Dr. French on January 16, 2019.

- The primary concern of the Committee was that, while GT’s analysis suggests that the HVSC proposal compares favourably with an estimate of the costs faced by WRMH, the ability to transition cataract surgeries out of the hospital and capture savings is limited. Of the elements of the costs faced by WRMH, the Committee agreed that only the cost of consumables could actually reduce WH’s expenses. Some costs could potentially be reduced via the reduced demand on human resources, but as the non-physician staff that support cataract surgeries (nursing, administration, housekeeping, etc.) support other WRMH operations, any savings that could be captured would be delayed and partial, given that WRMH will continue to offer some cataract surgeries. Overhead costs would be impossible to capture.

- The Committee agreed that the proposed HVSC fee would not provide any opportunity for cost savings but instead would increase overall net costs to the system. As illustrated in Annex A, the net increased cost per case to WHRA of the HVSC proposal would be in the order of

In the five year period from 2013/14 to 2017/18, the volume of cataract surgeries in Western region has only exceeded 2,000 once, in 2016/17. The volume in 2017/18 was 1,324. Moreover, it was also observed that, over the five year period, the incidence of cataract surgeries in every age cohort was significantly higher in Western Health than in any other region - almost double the rate of Eastern Health (see Annex B). Dr. French projects that the demand for cataracts will continue to grow over the next 20 years as the population ages, and projections done by NLCHI support his projections; however, the Committee was not convinced that there was evidence that Western Health could not respond to this increased demand within their hospitals sufficient to justify supporting the HVSC proposal.

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The Committee noted that if the decision was made to transition cataract surgeries to private settings, the transition would have to be done so that all ophthalmologists would be permitted to perform cataract surgeries in their clinics, subject to criteria (patient safety, accreditation etc.).

- The Committee is also in receipt of a proposal by Dr. Jackman. Dr. Jackman’s proposal is much less detailed than Dr. French’s and proposes a fee that is broadly comparable. The Committee has not assessed this proposal or communicated further with Dr. Jackman about it. A decision on the court application brought by Dr. Jackman against HCS is still pending.

- The minister has decided to allow all ophthalmologists to perform cataract surgeries in their private clinics, so long as they meet criteria which will be developed to address patient safety and appropriateness of care concerns. The regulatory changes made in July 2018 are compatible with this approach, though further regulatory changes regarding approval of such clinics will likely be necessary.

- Prior to setting the fee for the provision of cataract surgeries outside a hospital, consultation with the NLMA will be required. Considerations will include: the costs incurred by the ophthalmologist to perform the service in their clinic; anticipated uptake; potential effect on recruitment; the net fiscal impact for government; and patient access, assessed as projected demand held against existing capacity.

**Action to be Taken:**

- The Minister will contact Dr. French immediately before Dr. French receives the Committee’s report from the NLMA and discuss with him the recommendation and government’s response. He will suggest that Dr. French meet with him and/or senior officials as soon as possible to discuss next steps.

- The Department will issue a press release on January 16, 2019 which will indicate the acceptance of the Committee’s recommendation and the minister’s intention to allow cataract surgeries to be performed in non-hospital facilities, as an insured service, subject to development of patient safety and appropriateness of care criteria.

**Prepared by/Approved by:** M. Harvey/K. Stone  
**Ministerial Approval:** Received from Hon. John Haggie, MD  
**January 16, 2019**
Annex B

Incidence Rate of Cataract Surgery by Age Cohort by RHA 2016.

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Cataract Surgeries per 100 Population in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eastern Health</td>
</tr>
<tr>
<td>0-64</td>
<td>0.3</td>
</tr>
<tr>
<td>65-69</td>
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<td>70-74</td>
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<td>85-89</td>
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<td>90+</td>
<td>2.6</td>
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</table>

Source: Newfoundland and Labrador Centre for Health Information.
Annex C

Cataract Surgery (First Eye) Benchmark Wait Time Data Western Health 2013-2018

<table>
<thead>
<tr>
<th></th>
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<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q1</td>
<td>Q2</td>
<td>Q1</td>
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<tr>
<td>Number of first-eye cataract procedures completed</td>
<td>149</td>
<td>183</td>
<td>219</td>
<td>220</td>
<td>279</td>
</tr>
<tr>
<td>5 out of 10 patients had surgery within this number of days (50th Percentile)</td>
<td>16d</td>
<td>30d</td>
<td>20d</td>
<td>14d</td>
<td>13d</td>
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<tr>
<td>9 out of 10 patients had surgery within this number of days (90th Percentile)</td>
<td>55d</td>
<td>70d</td>
<td>85d</td>
<td>66d</td>
<td>44d</td>
</tr>
<tr>
<td>Percentage of patients who had surgery within 112 days (% at benchmark)</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Source: Western Regional Health Authority, Newfoundland and Labrador

Notes:
1. In Q1 2018/19, WH reports 65 First Eye (FE) cataract procedures were performed in Q1 2018/19, which represents a 66% decrease compared to Q1 2017/18.
2. At the Western Memorial Regional Hospital (WMRH) 94 cataract procedures (42 FE) were performed during fourteen days with the majority (n89/94) performed by one Ophthalmologist.
3. At the Sir Thomas Roddick Hospital (STRH) 43 cataract procedures (23 FE) were performed during three days by one Ophthalmologist.
Title: Delayed Delivery of Electronic Medical Record (EMR) Results – Quality Review and Technical Update

Issue: The Regional Health Authorities (RHAs) and the Newfoundland Centre for Health Information (NLCHI) have completed a review of all cases where information, including medical tests ordered by physicians, was not delivered to EMRs in the expected timeframe.

Background and Current Status:

- NLCHI manages the provincial EMR program, branded as eDOCSNL. Program oversight is provided by HCS and the Newfoundland and Labrador Medical Association (NLMA) through a Management Committee created under a memorandum of agreement. TELUS Health is the provider (vendor) of the EMR software. TELUS Health is contracted to maintain the software, ensure integration with other provincial e-health systems, and host all EMR data.

- The EMR is used by 264 clinicians in the province including Fee for Service and salaried physicians, Nurse Practitioners, and other health Regional Health Authority providers. Clinical information including patient demographics, medical and drug history, clinical documents, laboratory results, and diagnostic imaging reports are delivered to EMR users via TELUS.

- On Nov 14, 2018, NLCHI was made aware by TELUS of a technical issue which resulted in a delay in the delivery of 708 unique clinical results to EMRs. It was subsequently determined that 406 laboratory, 88 medical imaging, and 212 clinical documents, impacting 615 unique patients, 163 providers, and 72 clinics were not delivered to clinicians via their EMRs. A total of 134 delayed laboratory results were considered to be abnormal (example: diabetic blood sugar levels outside of normal range). A total of 7 patients had abnormal results that were critical. This included 2 out-patients (2 results) and 5 in-patients (9 test results). All critical results were communicated to the appropriate clinician over the phone without any delay.

- Paper results were unaffected by the technical issue and continued to be delivered to all, but 2 clinics (these clinics requested not to receive paper results). As is practice across the province, critical results are communicated to ordering clinicians via telephone, regardless if they were delivered through the EMR. All results continued to be available in the Electronic Health Record (a separate e-health system accessible to clinicians via an online portal).

- TELUS originally reported the issue was contained to a 3-4 month period. Further investigation revealed the delays covered a period from November 2017 to November 2018. The majority of impacted results were from testing and medical encounters in the Fall of 2018.

- NLCHI has completed an independent verification of all information provided by TELUS and confirmed that all affected patients, providers, and clinics have been identified.

- During the week of December 3, 2018 all affected patients were contacted via registered mail and courier. While some patient letters were returned to sender all cases have been subject to a patient safety investigation led by EH and the three other RHAs. This process is now complete and there have been no reports or indications of patient harm related to the delayed results and no additional follow-up is required.
### Patient Safety Audits by RHA

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Number of patient audits*</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHA: Eastern Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td>215</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>DI</td>
<td>52</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>Clinical Reports</td>
<td>118</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td><strong>RHA: Western Health</strong></td>
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<td></td>
</tr>
<tr>
<td>Lab</td>
<td>77</td>
<td>Complete. No harm identified.</td>
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<tr>
<td>DI</td>
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<td>Complete. No harm identified.</td>
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<tr>
<td>Clinical Documents</td>
<td>84</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td><strong>RHA: Central Health</strong></td>
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<td></td>
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<tr>
<td>Lab</td>
<td>36</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>DI</td>
<td>6</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>Clinical Reports</td>
<td>7</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td><strong>RHA: Labrador – Grenfell Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td>1</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>DI</td>
<td>1</td>
<td>Complete. No harm identified.</td>
</tr>
<tr>
<td>Total</td>
<td>623</td>
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</tbody>
</table>

*In cases where a patient was impacted by delayed results (Lab, DI, or Clinical Documents) in more than one category, separate audits were initiated. In cases where a patient was impacted by multiple delayed results in one category only one investigation took place. Therefore, the number of investigations is larger than the number of impacted patients, but smaller than the total number of delayed results.*

### Action Being Taken:
- NLCHI has completed a data quality review (non-clinical) to ensure the integrity of e-health systems. NLCHI has also implemented an internal quality assurance process to validate that the results delivery issue is resolved and messages are being received on schedule. This process will remain in place for the foreseeable future.

- NLCHI and TELUS’s held meetings the week of December 3, 2018 with TELUS officials and technical staff on site in St. John’s. Both parties agreed upon several issues and actions related to technical problems that resulted in the recent EMR incident. Work to address underlying technical issues is ongoing and NLCHI is withholding full payments to TELUS until all uses are addressed. TELUS and NLCHI continue to work on finalizing a Scope of Work.
(SOW) detailing future mitigation action items. The draft SOW contains a work plan that is scheduled to conclude by April 2019.

- [s. 29(1)(a)]

Prepared/Approved by: C. Campbell/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

January 28, 2019
Decision Note
Department of Health and Community Services

Title: Upgrades to the air conditioning system servicing the laboratory, as well as the development of an additional patient washroom in the inpatient unit area, at the Labrador Health Centre (LHC) in Happy Valley-Goose Bay (HV-GB).

Decision Required:
- Whether or not to provide $273,300 in funding from the Department’s 2018-19 repairs and renovations (current) account funding to Labrador-Grenfell Health (LGH) to facilitate upgrades to the air conditioning system servicing the laboratory, as well as the development of a patient washroom in the inpatient area, at the LHC in HV-GB.

Background and Current Status:
- The Department previously approved $150,000 in funding for two projects at the LHC in HV-GB: 1) upgrades to the air conditioning system within the laboratory ($100,000), and 2) the development of a patient washroom in the inpatient unit area to assist with meeting over capacity demands ($50,000).
- LGH advises that it has proceeded to advance these projects as a single tender with three bids being received as follows:
  - Mealy Mountain Construction $394,446.50
  - Churchill Construction $618,000.00
  - Moss Development Corp. $631,727.20
- The lowest compliant bid has resulted in a project shortfall of $273,300, inclusive of design fees. To facilitate awarding of the tender, LGH has requested funding to cover this shortfall.
- LGH advises that the benefits from advancing these projects include:
  1) Patient samples and expensive reagents in the laboratory will be protected from damage caused by excessive heat. LGH advises that there have been instances in the past where they have had to throw out reagents and blood products due to excessive high heat.
  2) The new washroom will allow LGH to accommodate 2 – 3 additional patients during frequent periods of overcapacity at the LHC. LGH advises that a former nurses' area can be better utilized to accommodate additional inpatients in times of overcapacity, however the space currently does not have a washroom.
- In 2018-19, the Department of Health and Community Services was provided with $23M in repair and renovation ($13M) and Building Improvements ($10M) funding combined. To date $22,205,000 in funding has been allocated thereby leaving $795,000 in funding remaining.

Recommendation:
- Provide $273,300 in funding from the Department’s 2018-19 repairs and renovations (current) account funding to Labrador-Grenfell Health to facilitate upgrades to the air conditioning system servicing the laboratory, as well as the development of a patient washroom in the inpatient area, at the Labrador Health Centre in Happy Valley-Goose Bay.

Prepared/Approved by: P. Greene/ H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

February 4, 2019
Decision Note
Health and Community Services

Title: Letter of Support for Federal Narcotic Exemption

Decision Required:
- Whether or not to provide a letter of support to Health Canada, in support of an application by Eastern Health’s Provincial Medical Oversight (PMO), for an increased narcotic exemption under the Controlled Drugs and Substances Act (CDSA).

Background and Current Status:
- Opioid medications and their administration are regulated by Health Canada through the CDSA. Under the Act, an exemption is required from Health Canada to grant paramedics the authority to possess, transport and administer controlled substances.
- In 2010, an exemption from Health Canada granted advanced care paramedics in the province the authority to administer fentanyl, ketamine, pethidine morphine, diazepam, lorazepam and midazolam (See Annex 1).
- Eastern Health is currently working with the Canadian Partnership Against Cancer (CPAC) to develop and implement a Paramedicine Palliative Care Program which will provide 24/7 support by paramedics for patients and families currently receiving palliative care at home.
- To provide palliative care services consistent with medical best practices, this new program requires the addition of hydromorphone to the current CDSA exemption. This is required to provide longer lasting pain and symptom management for patients and is in keeping with best medical practices for palliative patient management.

Analysis:
- CPAC is providing the funding for development and implementation of this program as part of a national initiative. Similar programs exist in PEI and Nova Scotia and have been successful.
- Health and Community Services supports this program. This exemption is a formality necessary to move forward. Failure to obtain the exemption will prevent the development of this program.
- Advanced care paramedics are already competent with opioid management and administration. Additionally, policies for safe storage and opioid administration already exist.
- A draft letter of support was prepared by Dr. Brian Metcalfe, the Provincial Medical Director for PMO and reviewed by department officials (See COR-2019-077357).
- This program supports a Way Forward commitment to establish community programs for community paramedicine.

Alternatives:
Alternative 1: Provide a letter of support to Health Canada supporting PMO’s request to seek an expanded exemption for hydromorphone under the Controlled Drugs and Substances Act.

Pros:
- Supports implementation of the Paramedicine Palliative Care Program.
- Allows Eastern Health to leverage funding from the CPAC.
- Supports a Way Forward commitment.
- Supports patients and families availing of the program.
Cons:
  o There are no cons identified

**Alternative 2:** Do not provide a letter of support to Health Canada supporting PMO’s request to seek an expanded exemption for hydromorphone under the *Controlled Drugs and Substances Act* s. 29(1)(a)

Pros:
  o There are no pros identified.

Cons:
  o Development of the Paramedicine Palliative Care Program will cease.
  o Missed opportunity to provide patients and families with palliative care support at home
  o Fails to leverage funding from the CPAC.
  o The *Way Forward* commitment will not be fulfilled.

**Prepared/Approved by:** R. Kelly/T. Power/C. Campbell/H. Hanrahan/K. Stone
**Ministerial Approval:** Received from Hon. John Haggie, MD

**February 20, 2019**

[Signature]

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SECTION 56 CLASS EXEMPTION FOR ADVANCED CARE PARAMEDICS AND CRITICAL CARE PARAMEDICS IN NEWFOUNDLAND AND LABRADOR

Pursuant to section 56 of the Controlled Drugs and Substances Act (CDSA), paramedics with the title of Advanced Care Paramedics or Critical Care Paramedics in the province of Newfoundland and Labrador employed by regulated ambulance service operators are exempted for medical purposes from the application of the following provisions of the CDSA and its regulations:

- Subsection 4(1) of the CDSA with respect to fentanyl, ketamine, morphine and pethidine
- Subsections 5(1) and 5(2) of the CDSA with respect to diazepam, fentanyl, ketamine, lorazepam, midazolam, morphine and pethidine
- Subsection 8(1) of the Narcotic Control Regulations (NCR) with respect to fentanyl, ketamine, morphine and pethidine

In respect of this exemption,

**Controlled substance** means one of the following substances: diazepam, fentanyl, ketamine, lorazepam, midazolam, morphine and pethidine

**Designated Administrator** means a person who is in a managerial position and is ultimately responsible for ordering, transporting, storing and providing controlled substances to paramedics for an ambulance service operator governed under the Motor Carrier Act and the Motor Carrier Regulations (Newfoundland and Labrador), the relevant policies established by the Department of Health and Community Services of Newfoundland and Labrador and its Provincial Medical Oversight Program.

**Paramedic** means a person who is registered and entitled under the Provincial Medical Oversight Program in accordance with the Health and Community Services Act (Newfoundland and Labrador) and Regional Health Authorities Act (Newfoundland and Labrador) to practice as an Advanced Care Paramedic or Critical Care Paramedic in that province and to administer controlled substances as part of the practice of paramedicine, and who is employed by ambulance service operators governed under the Motor Carrier Act and the Motor Carrier Regulations (Newfoundland and Labrador), the relevant policies established by the Newfoundland and Labrador Department of Health and Community Services and its Provincial Medical Oversight Program.

**Unserviceable controlled substance** means a drug product containing a controlled substance that is expired, contaminated or damaged, or any residual controlled substance remaining in a multi-dose vial.

This exemption provides the aforementioned paramedics with the authority to possess, transport and administer controlled substances when providing pre-hospital care to patients within their scope of practice as set out in relevant protocols established by the Eastern Health Authority on Canada.
SECTION 56 CLASS EXEMPTION FOR DESIGNATED ADMINISTRATORS OF AMBULANCE SERVICE OPERATORS IN NEWFOUNDLAND AND LABRADOR

Pursuant to section 56 of the Controlled Drugs and Substances Act (CDSA), Designated Administrators of regulated ambulance service operators in the province of Newfoundland and Labrador are exempted for medical purposes from the application of the following provisions of the CDSA and its regulations:

- Subsection 4(1) of the CDSA with respect to fentanyl, ketamine, morphine and pethidine
- Subsections 5(1) and 5(2) of the CDSA with respect to diazepam, fentanyl, ketamine, lorazepam, midazolam, morphine and pethidine
- Subsection 8(1) of the Narcotic Control Regulations (NCR) with respect to fentanyl, ketamine, morphine and pethidine

In respect of this exemption,

**Controlled substance** means one of the following substances: diazepam, fentanyl, ketamine, lorazepam, midazolam, morphine and pethidine

**Designated Administrator** means a person who is in a managerial position and is ultimately responsible for ordering, transporting, storing and providing controlled substances to paramedics for an ambulance service operator governed under the Motor Carrier Act and the Motor Carrier Regulations (Newfoundland and Labrador), the relevant policies established by the Department of Health and Community Services of Newfoundland and Labrador and its Provincial Medical Oversight Program.

**Paramedic** means a person who is registered and entitled under the Provincial Medical Oversight Program in accordance with the Health and Community Services Act (Newfoundland and Labrador) and Regional Health Authorities Act (Newfoundland and Labrador) to practice as an Advanced Care Paramedic or Critical Care Paramedic in that province and to administer controlled substances as part of the practice of paramedicine, and who is employed by ambulance service operators governed under the Motor Carrier Act and the Motor Carrier Regulations (Newfoundland and Labrador), the relevant policies established by the Newfoundland and Labrador Department of Health and Community Services and its Provincial Medical Oversight Program.

**Unserviceable controlled substance** means a drug product containing a controlled substance that is expired, contaminated or damaged, or any residual controlled substance remaining in a multi-dose vial.

This exemption provides the aforementioned Designated Administrators with the authority to possess, transport and provide controlled substances required by the aforementioned paramedics employed by regulated ambulance service operators with which Designated Administrators are affiliated.
Decision/Direction Note
Department of Health and Community Services

Title: Long Term Care and Community Support Services System: Financial Assessment Policies to Support Implementation of Income Testing

Decision/Direction Required: s. 27(2)(b)

Background and Current Status: s. 29(1)(a)

- All clients of the Long Term Care and Community Support Services (LTC CSS) system who seek assistance with the cost of services are financially assessed to determine:
  1. Eligibility for subsidy; and
  2. Client contribution amount. s. 27(2)(a) s. 27(1)(i)

- The liquid asset elimination was effective November 1, 2018, and income testing came into effect on February 1, 2019.

- Prior to November 1, 2018, the financial assessment was a two-step process. Individuals had to first demonstrate they were within the allowable liquid asset threshold. When this criteria was met, they would then be assessed with either an income test, based on Line 236 of the CRA Notice of Assessment, or a needs test, based on their income and expenses. The needs test allowed a very wide range of expenses, including payments of past debts relating to home/property, credit card balances, car payments and pre-arranged funeral premiums. s. 27(2)(b)

- The Grand Parenting Policy is designed to ensure that clients who are currently needs tested, will not have their financial contribution increase when they are reassessed with the income test. The lower contribution is to remain in place until the client moves to a different program area within the LTC CSS system (such as moving from services received in the community to a personal care home placement). See Annex A for the recommended Grand Parenting Policy.
The proposed Financial Hardship Consideration Policy is attached as Annex B. This policy was developed, with RHA consultation, following a review of policies in other Canadian jurisdictions, where consideration is given to exceptions to income testing when financial hardship can be demonstrated. A "Frequently Asked Questions" fact sheet (Annex C) has also been developed to support the proposed policy.

The Financial Hardship Consideration Policy is complex. The intention of the direction provided to HCS was that special consideration/exceptions should be available to consider higher than ordinary expenses which are frequently experienced by LTC CSS clients with disabilities, and spouses who live in the community and maintain a residence while the other spouse lives in residential care.

In developing the proposed policy, consideration also had to be given to seniors in receipt of home support; a group that has been income tested since 2009 but have not had a "financial hardship consideration" policy available.

The *Income Based Financial Assessment Policy Manual For The Home Support & Special Assistance Programs* was issued to the RHAs in 2009 and is on the HCS website. This manual has been updated to reflect the expansion of income testing across the LTC CSS system. The two proposed policies, when approved, will be incorporated into the manual. This manual will also be renamed to *Income Based Financial Assessment Policy Manual For Long Term Care and Community Support Services System*. (Annex D)

**Analysis:**

**Grand Parenting Policy**

- Grand parenting approaches have previously been used in the financial assessment process. The 2016 policy will be replaced by the policy proposed in Annex A.

- The proposed policy will apply to all clients actively in receipt of services as of January 31, 2019, and remain available to the client until either:
  - The client moves to another program for services; or
  - The client contribution calculated under the income test is lower than the contribution that had been calculated under the needs test.

- Additionally, it is proposed that the pre-February 1, 2019 needs test client contribution be adjusted to reflect debt retirement/pay-off.
  - The needs test included payment of outstanding debts as an allowable expense, (ie. the client retained income to pay down on their debts). As these debts are paid off, the needs test contribution should be adjusted to reflect that change in the client's financial situation, and their ability to contribute a higher amount towards the cost of their subsidized services.

- The proposed policy is favorable to the client and is anticipated to be well received by the public. It is recommended that the policy be approved for immediate implementation.

**Financial Hardship Consideration Policy**

- Financial hardship consideration is new to HCS. When the income test was introduced in 2009 for Home Support only and/or Special Assistance Program only clients, there was no exception policy created. In the nine years since income testing was introduced, the RHAs advise that exceptions were rarely made, and clients were expected to, and did, contribute...
the amount determined through the income test. These income tested clients are primarily seniors and a small number of adult with disabilities.

- With the expansion of income testing to all populations of the LTC CSS, variations to the formulas introduced in 2009 have been added to reflect additional considerations for family composition and income source/employment status of the client. Schedule IV, Client Contribution Calculations, Annex D details the formulas which will be used according to client group.  

  s. 29(1)(a)

- The intent of the Financial Hardship Consideration Policy is to identify and assist clients who are experiencing true financial hardship. Development of the proposed policy (Annex B), used the basic premise that the targeted clients are those who would be unable to obtain the basic necessities of life, i.e. food, shelter and medical needs, if they pay the required contribution.

- The definition proposed is that significant financial hardship is when the payment of the client contribution would result in the client or client's spouse being unable to pay for monthly food; mortgage/rent; home heat; prescribed medication; other required prescribed health care; or transportation.  

  s. 29(1)(a)

-
• The full list of proposed allowable expenses is included in Annex B.

• The following expenses had been included in the needs test but will no longer be considered as allowable expenses in the proposed Financial Hardship Consideration Policy:
  o outstanding credit card debt for personal expenses, (eg. entertainment, restaurants, etc.);
  o outstanding debt related to household maintenance which was non-emergency in nature; and
  o life insurance premiums.

• A basic living allowance of $463 a month for a single individual to meet basic needs such as food, clothing, personal care items, and general household maintenance will be included in the client contribution adjustment calculation. Additionally, the November 2018 change regarding liquid asset consideration, means that clients also have access to their liquid assets, if any, to offset their community expenses. \( s. 29(1)(a) \)

Alternatives:
Option 1: Approve the Grand Parenting and Financial Hardship Consideration Policies as presented in Annex A and B. \( s. 29(1)(a) \)

Pros:
  o Grand Parenting Policy will be well received by public.
  o Financial Hardship Consideration Policy clearly defines when an exception will be considered and how the client contribution adjustment will be calculated, ensuring consistent and equitable treatment of clients.
  o The definition of significant financial hardship and identification of allowable expenses will be less subjective and easier to explain to the public than the previously used needs test financial assessment.
  o It is a fiscally responsible policy direction that will limit the potential financial impact on the RHAs.

Cons:
  o Public will likely object to the restrictiveness of the Financial Hardship Consideration policy.
  o The financial impact of the Financial Hardship Consideration Policy cannot be determined as the number of people who may avail and their financial position (expenses, income and assets) is unknown.
Option 2: Do not approve the Grand Parenting and Financial Hardship Consideration Policies as presented in Annex A and B.

Pros:
- Expanding the proposed allowable expenses identified in the Financial Hardship Consideration Policy would be positively received by the public.

Cons:
- Failure to implement policy will be negatively received by the public.
- Some clients may experience significant hardship without a provincial policy in place.
- A more generous Financial Hardship Consideration Policy than that proposed would likely see more clients requesting exceptions to income testing. These requests would result in clients being both needs and income tested, creating more work for RHA staff and may impact staff efficiencies and equitable treatment of clients.

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

February 28, 2019
Annex A

GRAND PARENTING - Proposed
To replace section 6.4 in the Income Based Financial Assessment Policy Manual

6.4 Grand Parenting of Client Contribution
With the use of income testing for all services in the LTC CSS system, there will be some active clients who will have a higher client contribution towards their subsidized services calculated with the income test. These clients will be grand parented and continue to pay their pre-February 1, 2019 client contribution, as detailed in this policy.

Clients will not be eligible for grand parenting if:
- They were not actively receiving subsidized services January 31, 2019.
- The client contribution calculated with the income test is lower than the contribution that was being paid prior to February 1, 2019.
- The client has an adjustment to the client contribution amount approved by the RHA as per policy (Section 6.6 Financial Hardship Consideration).

6.4.1 Eligibility for Grand Parenting
To be eligible for grand parenting a client must be:
- actively in receipt of subsidized services on January 31, 2019, and
- assessed for those subsidized services with the needs test or the LTC/PCH/CCH financial assessment.

6.4.2 Client Contribution Adjustments
There will be clients who are grand parented who had allowable expenses/outstanding debts, such as funeral policy premiums or credit card payments, included in their most recent financial assessment (needs test or LTC/PCH/CCH assessment). As the allowable expenses/outstanding debts are retired or paid off, the RHA will increase the client contribution by the same amount of the expense/debt that is retired/paid off.

When the adjusted client contribution amount is higher than the client contribution calculated with income test, the client will move to income testing for all future financial assessments.

6.4.3 Termination of Grand Parenting
Grand parenting of a pre-February 1, 2019 client contribution will be terminated when:
- The client moves from one service program to another, for example from community support services to a personal care home placement.
- A lower client contribution is calculated with the income test due to a change to the annual income of the client.
- The income test contribution is lower than a grand parented contribution adjusted to reflect reduced expenses, as per Section 6.4.2.

When grand parenting is terminated, it cannot be re-instated for a client. All future client contributions will then be calculated with the income test, in accordance with policy.
Annex B

Financial Hardship Consideration - Proposed

To be inserted as Section 6.6 in the Income Based Financial Assessment Policy Manual

6.6 Financial Hardship Consideration
Eligible clients who can demonstrate that they will experience significant financial hardship if they pay the calculated client contribution towards their subsidized services, may have a time limited adjustment to the client contribution approved by the RHA.

Financial hardship consideration is available to subsidized clients in the community and subsidized residents of long term care, personal care or community care homes who have a spouse/dependant(s) in the community, to ensure the spouse/dependant(s) have sufficient income to meet basic reasonable community expenses.

6.6.1 Eligibility for Financial Hardship Consideration
To be eligible for an adjustment to their client contribution, a client must meet the following criteria:

- The client is maintaining a residence in the community, either as a single individual or with a spouse/dependant child, and they will experience significant financial hardship if the client contribution as calculated is paid; or
- A client is a resident of a long term care, personal care or community care home, and the client's spouse and/or dependant children, who are living in the community, would experience significant financial hardship if the client contribution as calculated is paid.

6.6.2 Significant Financial Hardship
Significant financial hardship is when the payment of the client contribution, as calculated with the income test, would result in the client or the client's spouse and/or dependant children being unable to pay for the following each month:

- Food;
- Mortgage/rent;
- Home energy (Heat and light);
- Telecommunications (basic telephone, cable, and internet)
- Prescribed medication (must be medication which is on the NLPDP benefits listing) and other required prescribed health care; or
- Transportation – Automobile and/or medical transportation.

The amount of the adjustment to the client contribution will be determined based on what the family can afford, after meeting reasonable expenditures and expenses for basic needs. Expenses that are excessive or unreasonable will not be considered in determining the amount of the adjustment. RHAs will use comparable market rates in the clients local area in its determination of reasonable expenses.
6.6.3 Client Contribution Adjustment
The adjustment to the client contribution will be determined by the RHA financial assessor and approved by RHA management.

Procedure
The client must provide documentation, satisfactory to the RHA financial assessor, that will allow the assessor to verify:
- Current income; and
- Allowable expenses.

Allowable Expenses
When a client is approved by the RHA for financial hardship consideration, the client contribution will be adjusted to ensure that sufficient income is kept by the client to offset the allowable expenses.

The client must provide documentation satisfactory to the RHA to support consideration of the following expenses as allowable:
- Mortgage/rent
- Property taxes/condo fees
- Home energy (heat and light)
- Telecommunications (basic telephone, cable, and internet)
- Property/renter’s insurance
- Automobile expenses (car payment, insurance and significant repairs beyond general maintenance. Individual claiming expenses must have valid drivers license)
- Medical transportation *
- Extended health insurance premiums
- Co-payments under the Newfoundland Labrador Prescription Drug Program
- Dental care *
- Medical equipment/supplies *
- Prescribed special food and dietary supplements *
- Emergency household repairs or necessary retrofitting to accommodate disabilities can be included, calculated at the monthly cost with receipts and quotes
- Pre-arranged funeral expenses
- Mandatory/statutory deductions against income, eg. Canada Pension Plan, income tax, employment insurance, etc.
- Court mandated payments, eg. child support, wage garnishment
- Newfoundland and Labrador Housing Corporation loan repayments

* only non-reimbursable portion when dental/health insurance is in place

Expenses will only be considered for the principal residence of the client and/or spouse. Expenses related to maintaining a secondary residence, cabin or a camper/trailer, will not be considered in the client contribution adjustment calculation.
Basic Living Allowance
In addition to the allowable expenses approved by the RHA, the client will also retain a basic living allowance from their income. An amount of $463 per month for a single client and $685 per month for a couple/family, will be included in the calculation for the adjusted client contribution. This basic living allowance is included to ensure the client has funds to meet their basic needs including food, clothing, personal care items and general expenses.

6.6.4 Approval of Client Contribution Adjustment
Client contribution adjustments resulting from financial hardship consideration will be effective for a maximum of one-year from the date the adjustment is approved.

A client may reapply for an exception to income testing at the end of the approved adjustment period, if they can demonstrate that their financial situation has not improved.
Annex C

Financial Hardship Policy – Frequently Asked Questions

What is the financial hardship policy?
The financial hardship policy allows regional health authorities to approve a time-limited adjustment to the income test client contribution for clients of the Long Term Care and Community Support Services (LTC CSS) System. This policy can be applied to clients who can demonstrate that they will experience significant financial hardship if they have to pay a client contribution towards their subsidized services.

What is significant financial hardship?
Significant financial hardship can occur when the payment of your client contribution would result in you or your spouse (if applicable) being unable to pay for monthly expenses for:
- Food;
- Mortgage/rent;
- Home energy (Heat and light);
- Telecommunications (basic telephone, cable, and internet);
- Prescribed medication (must be medication which is on the NLPDP benefits listing) and other required prescribed health care; or
- Transportation – Automobile and/or medical transportation.

Who is eligible for financial hardship consideration?
If you and/or your spouse are living in the community you may be eligible for a client contribution adjustment if you can demonstrate that paying your full client contribution would result in significant financial hardship. You may also be eligible if you are residing in a long term care home, personal care home or community care home and your spouse is still in the community and will experience significant financial hardship and may not be able to maintain the community home if the full client contribution is paid.

Who is not eligible for financial hardship consideration?
You will not be eligible for hardship consideration if you are:
- single and residing in a long term care home, personal care home or community care home;
- married and you and your spouse are both residing in a long term care home, personal care home or community care home; or
- are eligible for grand parenting and continue to pay your pre-February 1, 2019 client contribution.

How do I apply for financial hardship consideration?
Contact your regional health authority and a financial assessor will work with you to determine if you meet the significant financial hardship definition. If you do, they will identify the documents that you must submit for your request to be processed. This documentation will include confirmation of your income and verification of your expenses.
How will I be notified of the outcome of my application?
Once your financial assessor has all of the required documents to process your request for financial hardship consideration, your request will be processed within 30 days. You will be notified in writing of the outcome of the review.

When will the client contribution adjustment come into effect and how long will it last?
If a client contribution adjustment has been approved, the effective date will be identified in your notification letter. Adjustments to your client contribution will be approved for the shortest period of time necessary for you to address your significant financial hardship. Adjustments will be approved for up to twelve months.

What if I need a client contribution adjustment for longer than was approved by the regional health authority?
If you can demonstrate that you still meet the significant financial hardship criteria, you should re-apply for financial hardship consideration at least one month prior to the end of the approved period. You will need to provide updated information on your current expenses. Health authority staff will re-assess and advise if a new adjustment to your client contribution is approved.

Are there other programs I can access for financial assistance?
Financial assistance may be available from other government programs or departments such as the Income Support Program; Department of Children, Seniors and Social Development; Medical Transportation Assistance Program; Special Assistance Program; or the Newfoundland and Labrador Prescription Drug Program.
Income Based Financial Assessment Policy Manual For Long Term Care & Community Support Services

Issued: February 2019
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II Calculation of Net Income as per Line 236 of the Income Tax Assessment
III Income Exemption Thresholds
IV Client Contribution Calculations
VI Examples of Calculating Client Contribution Using the Income Test
1.0 INTRODUCTION
The Income Based Financial Assessment Manual is a reference for the Regional Health Authorities (RHAs) and individuals. The Manual outlines the provincial policies related to the Income Based Financial Assessment (Income Test) that is to be used in the programs of the Long Term Care and Community Support Services System (LTC CSS).

The RHAs are the:
• Eastern Regional Health Authority;
• Central Regional Health Authority;
• Western Regional Health Authority; and
• Labrador-Grenfell Regional Health Authority.

1.1 Structure and Numbering
Policies are grouped into sections as indicated in the Table of Contents. The first Arabic number corresponds to the section. The second set of numbers corresponds to the subsection and the last set of numbers indicates the specific policy. Policies can be added by continuing the sequential numbering. The number of pages for each policy is indicated as “page 1 of 2”, for example, if a policy extends beyond one page.

The Effective Date will change to Revised date when there has been a revision. Old policies will be stored for five years.

1.2 Approval
Policies in this manual are approved by the Department of Health and Community Services (DHCS).

1.3 Responsibility for Reviews, Revisions and Additions
New policies are added and existing policies are revised whenever the need is identified by DHCS or the RHAs. All policies are regularly reviewed by program and financial staff of DHCS.
It is the responsibility of the RHAs to write procedures to implement policies contained in this Manual. Individuals and staff should forward questions or suggestions to their RHA.

The RHA will:
- review the request;
- determine if the request is policy related;
- write recommendations; and
- forward requested edits or additions to provincial program and financial staff.

DHCS Program and financial staff will:
- review, revise or edit material for appropriateness to the manual;
- research proposed material as necessary;
- obtain approval for policies;
- incorporate approved policies in the manual; and,
- distribute copies of the approved policies and revised table of content, if applicable.

DHCS will maintain the electronic version of this manual which can be accessed by RHA staff and the general public at: [https://www.health.gov.nl.ca/health/publications/policy_manual_income_test.pdf](https://www.health.gov.nl.ca/health/publications/policy_manual_income_test.pdf)

### 1.4 Purpose
The Income Based Financial Assessment Policy Manual for the LTC CSS System is intended to:
- provide information, direction and support to RHAs and individuals;
- ensure consistent application of financial policies in LTC CSS Programs;
- identify RHA responsibility and promote accountability by providing clearly written, accessible policies;
- identify stakeholder responsibilities; and
- ensure RHA compliance with applicable legislation.

### 1.5 Authority
The provision of LTC CSS are set out in the Health and Community Services Act and the Executive Council Act. The eligibility for LTC CSS is established based on criteria set out in policy.
2.0 LTC CSS Overview

The Long Term Care and Community Support Service (LTC CSS) system in Newfoundland and Labrador, funded through the Department of Health and Community Services and delivered by the Regional Health Authorities (RHAs), is comprised of services to adults and children with disabilities and seniors. LTC CSS includes professional care and supportive services provided to individuals in their own homes, Personal Care Homes, Community Care Homes, Long Term Care Facilities and residential options for persons with disabilities such as Alternate Family Care Homes. Care and support services are provided to individuals who qualify and need long term support in order to help them perform the activities of daily living and maintain maximum independence.

A client of the LTC CSS system is an individual who requires support in order to address the unmet needs which impact their ability to perform the activities of daily living that enable them to participate in the community. Access to publicly funded service subsidies requires:
- Professional assessment of need;
- Financial assessment; and
- Meeting of service eligibility criteria as established by the Department of Health and Community Services.

Individuals may enter the LTC CSS system in a number of ways, depending on their support needs and circumstances. RHA staff, in collaboration with the individual, will identify their service and support requirements.

Home/Community Living, Residential Living, and Long Term Care Options are foundational components of the LTC CSS system. These options are divided into a variety of Programs which offer a range of services and benefits. The resulting framework supports the individual in either the community or an appropriate care setting to meet their needs.

The following table identifies the options available and the related Programs.
<table>
<thead>
<tr>
<th>Options</th>
<th>PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Community Living</td>
<td>Home Support</td>
</tr>
<tr>
<td></td>
<td>Special Assistance Program</td>
</tr>
<tr>
<td></td>
<td>Special Child Welfare Allowance</td>
</tr>
<tr>
<td></td>
<td>Allowances/Supplementary Benefits</td>
</tr>
<tr>
<td></td>
<td>Board &amp; Lodging Relative Supplement</td>
</tr>
<tr>
<td></td>
<td>Board &amp; Lodging Non Relative Supplement</td>
</tr>
<tr>
<td>Residential Living</td>
<td>Alternate Family Care</td>
</tr>
<tr>
<td></td>
<td>Cooperative Apartments</td>
</tr>
<tr>
<td></td>
<td>Individualized Living Arrangements</td>
</tr>
<tr>
<td></td>
<td>Right Futures</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Long Term Care Facilities</td>
</tr>
<tr>
<td></td>
<td>Personal Care Homes/Community Care Homes</td>
</tr>
<tr>
<td></td>
<td>Protective Community Residences</td>
</tr>
</tbody>
</table>

Within the Programs a variety of allowances/supplementary benefits are available, and may be approved for the client, depending on their assessed need.
3.0 LTC CSS PROGRAM DESCRIPTION

Individuals entering the system, who have been assessed by RHA staff, have access to a number of home/community living, residential living and long term care options and sub-programs.

Eligibility for a financial subsidy is determined through a financial assessment that is based on the individual/family income. An Income Test assessment will be applied to determine the amount the client is required to contribute towards the cost of the approved service(s)/benefit(s).

Section 6.0 Income Test provides details of Income Testing and how it is applied to each program under the LTC CSS System.

3.1 Home/Community Living Options

Home/Community Living options are a variety of benefits which allow the client to remain in the community with appropriate supports in place to assist the client in safely maintaining their daily routine. A clinical assessment by RHA staff will determine the supports that are required. Following the clinical assessment, the financial assessment will be completed to determine the level of financial subsidization that will be available to the client.

3.1.1 Home Support

Home Support services are available to individuals who require assistance with activities of daily living. These services are delivered in the individual’s home as defined in the Provincial Operational Manual Governing Home Support 2005 (http://www.health.gov.nl.ca/health/publications/pdffiles/Home%20Support%20Manual%202005.pdf), and may include assistance with personal care, behavioral support, household management, and/or respite services. Home support services are provided by non professional staff employed by a private home support agency or through a self-managed care arrangement whereby the client is the employer. Home Support subsidies are available at a Provincially set hourly subsidy rate, to a monthly maximum ceiling (see Schedule I Rates and Maximums).
3.1.1.1 Home Support Financial Eligibility
Clients wishing to access only Home Support services must meet program criteria as determined through a professional assessment by the RHA. The individual will then be financially assessed with the "Income Test" to determine their client contribution to the services which they require. (see Section 6.0 Income Test)

3.1.1.2 Bookkeeper Fees
Private Bookkeepers may be engaged by Home Support clients to manage the payroll activities, including Federal remittances, for the home support workers hired by the client.

The fee paid is based on the number of workers a subsidized client employs and is in addition to the subsidy paid for Home Support hours. Bi-weekly fee guidelines are in Schedule I Rates & Maximums.

3.1.2 Allowances/Supplementary Benefits
Allowances-supplementary benefits are provided to community support services clients who are approved for services available under the home/community options. The allowances-supplementary benefits covers a wide array of services designed to assist an individual to remain supported in their environment, such as rent supplements and community access funding.

3.1.2.1 Allowances/Supplementary Benefits Financial Eligibility
Clients wishing to access allowances-supplementary benefits must meet program criteria as determined through a clinical assessment by RHA staff. The individual will then be financially assessed with the "Income Test" to determine their client contribution to the services which they require. (see Section 6.0 Income Test)
3.3 **Special Assistance Program**

The Special Assistance Program (SAP) provides basic supportive health products to individuals who meet program criteria to assist them with activities of daily living.

The SAP is managed by the RHAs with an approved listing of available supplies, equipment and orthotics maintained by the Province.

Benefits of the program include access to Health Supplies such as dressings, catheters and incontinence supplies; oxygen and related equipment and supplies; orthotics such as braces and burn garments; and equipment such as wheelchairs, commodes or walkers.

3.3.1 **SAP Program Eligibility**

To access products/benefits through the SAP the client must:

- Meet the SAP program eligibility criteria;
- Request an item that is on the Provincially approved benefit listing; and
- Meet both clinical and financial eligibility criteria.

There is no requirement for an individual to be in receipt of a service from the RHA as a condition of eligibility for the SAP. These individuals may apply directly to the appropriate RHA. Private paying Long Term Care and PCH residents may apply directly to the SAP to determine if they meet financial and program eligibility for requested products.

3.3.2 **SAP Financial Eligibility**

Individuals are financially eligible when:

- They are currently in receipt of subsidized services through either the LTC CSS system or the Income Support Program of the Department of Advanced Education, Skills and Labour; or
- The client contribution determined through the income test financial assessment is less than the cost of the product(s) requested.

The SAP may be a stand-alone benefit or a supplementary benefit to other programs within the LTC CSS system. Eligibility for this program does not automatically qualify an individual for other LTC CSS benefits without a further clinical assessment to determine the individuals need for supportive services.
Clients who are currently in receipt of subsidized LTC CSS services are automatically financially eligible for SAP benefits. The client contribution collected, if any, would be first applied against the LTC/PCH or Community Support services approved.

3.3.3 One-Time Requests

Individuals presenting with a one-time request for a product/benefit through the SAP would have their total client contribution assessed as "3 X the monthly contribution" calculated by the Income Test. The product cost must be more than the three month contribution for the individual to be financially eligible.

The following provides an example of how this is to be calculated:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of equipment requested</td>
<td>$150</td>
</tr>
<tr>
<td>Line 236 of Client</td>
<td>$15,050</td>
</tr>
<tr>
<td>Monthly contribution</td>
<td>$30</td>
</tr>
<tr>
<td>Client contribution for product is 3 x monthly</td>
<td>$90</td>
</tr>
<tr>
<td>Client is eligible for subsidization:</td>
<td></td>
</tr>
<tr>
<td>RHA Pays to Vendor</td>
<td>$60</td>
</tr>
<tr>
<td>Client Pays to Vendor</td>
<td>$90</td>
</tr>
</tbody>
</table>

If multiple one-time requests or a combination of one-time and then a new on-going request is approved during the fiscal year, the individual's contribution is not to exceed their annual contribution toward the cost of the products/benefits.

3.4 Residential Living Options

Residential living options include client placements in the community under programs such as alternative family care and individualized living arrangements. Clinical staff of the RHAs will assess clients and approve the appropriate benefits to support the clients in the residential living option.

3.4.1 Residential Living Options Financial Eligibility

Clients wishing to access a residential living option must meet program eligibility criteria as determined through a clinical assessment by RHA staff. The individual will then be financially assessed with the "Income Test" to determine their client contribution to the approved benefits which they require. (see Section 6.0 Income Test)
3.5 Long Term Care Options

Long term care options include client placements in a long term care facility, personal care home (PCH), community care home (CCH), or protective community residence. Clinical staff of the RHAs will assess the client and identify the appropriate long term care placement option.

3.5.1 Long Term Care Options Financial Eligibility

Clients wishing to avail of a long term care option must meet program eligibility criteria as determined through a clinical assessment by RHA staff. The individual will then be financially assessed with the “Income Test” to determine their client contribution to the approved benefits which they require. (see Section 6.0 Income Test)
4.0 FINANCIAL ASSESSMENT OVERVIEW

A financial assessment process is in place which enables a RHA to complete an assessment for any individual who requests financial subsidization for a service/benefit in the LTC CSS system.

4.1 Guiding Principles

The LTC CSS system financial assessment policy is based on the following principles:

1. All individuals will be financially assessed to determine their financial contribution towards the approved programs and services being accessed.
2. The approved programs and services are those that have been authorized by the RHA clinical staff to meet the client's assessed needs.
3. An individual's financial contribution is only made towards one program or service.
4. The client contribution amount will be determined through an income test unless:
   a. The individual is eligible for grand parenting, or
   b. The RHA has approved the application of the Financial Hardship Consideration policy for the individual.
5. Financial reasseessments will be completed for clients on a regular basis to ensure continued financial eligibility and current client contribution.

4.2 Individual/Client Responsibility

Individuals who can afford the full cost of their services do not require a financial assessment.

Individuals who cannot afford to pay the full cost of their services/benefits may request a financial assessment to determine their eligibility for financial subsidization and client contribution.

Individuals requesting financial subsidization must:

- Complete the appropriate application form;
- Provide the required financial information and/or documentation to complete the financial assessment;
- Agree to pay the amount calculated as the monthly client contribution in order to receive the subsidized services;
- Agree to follow program policies; and
• Provide any additional information that may be requested by the RHA in relation to the subsidized service.

If the individual does not provide all information requested by the RHA to complete a financial assessment, the application will not be processed.

The full monthly client contribution towards the approved service must first be paid to the service provider/bookkeeper before the RHA subsidy is paid, regardless of the start date within the initial month.

If the monthly contribution is greater than the cost of the approved service for a given month, then the client is responsible for the full cost of that month’s service.

4.3 Financial Assessment Process Timelines
Within five (5) working days of receiving all required information from the individual requesting a financial subsidy, the financial assessment will be completed and the clinical assessor notified of the results. It is the responsibility of the individual to provide the necessary information to complete the assessment. Any service received by the individual prior to the completion of the financial assessment and approval of subsidized funding is the responsibility of the individual.
5.0 DETERMINATION OF NET INCOME

The financial assessments in the LTC CSS system are income tests and each test uses the uses the same income assessment base, Line 236 Net Income as determined by the Canada Revenue Agency (CRA). This section provides a general description of net income and how net income will be determined in the absence of a CRA Notice of Assessment.

5.1 Net Income as Calculated by Canada Revenue Agency

For the purposes of the Income Test, the RHAs will be referring to the net income calculated by CRA as identified in Line 236 of the Notice of Assessment. Schedule II includes a listing of the income and deductions which CRA considers in the calculation of Line 236.

The Canada Revenue Agency requires an individual to file a tax return for the prior calendar year if any of the following situations apply:

- Taxes have to be paid for the prior calendar year.
- CRA had sent a request to file a return.
- If the individual and spouse or common-law partner elected to split pension income for the prior calendar year.
- The individual received Working Income Tax Benefit (WITB) advance payments in the prior calendar year and they wish to apply for WITB advance payments for the current calendar year.
- The individual disposed of capital property in the prior calendar year (for example, the sale of real estate or shares) or the individual realized a taxable capital gain (for example, if a mutual fund or trust attributed amounts to the individual, or the individual is reporting a capital gains reserve claimed on the a previous return)
- The individual has to repay any Old Age Security or Employment Insurance benefits.
- The individual has not repaid all of the amounts withdrawn from their Registered Retirement Savings Plan (RRSP) under the Home Buyers’ Plan or the Lifelong Learning Plan.
- The individual has to contribute to the Canada Pension Plan (CPP).

Even if none of these requirements apply, the individual may still want to file a return to receive certain benefits and credits.
The Canada Revenue Agency identifies the following benefits of filing a return:

You may want to file a return if any of the following applies to you:

- You want to claim a refund.
- You received Working Income Tax Benefit (WITB) advance payments in prior year and you want to apply for WITB advance payments.
- You want to apply for the GST/HST credit.
- You or your spouse or common-law partner want to begin or continue receiving your Canada Child Tax Benefit payments.
- You have incurred a non-capital loss in the previous year that you want to be able to apply in other years.
- You want to carry forward or transfer the unused portion of your tuition, education and textbook amounts.
- You want to report income for which you could contribute to an RRSP, in order to keep your RRSP deduction limit for future years up to date.
- You want to carry forward the unused investment tax credit on expenditures you incurred during the current year.
- You receive the Guaranteed Income Supplement or Allowance benefits under the Old Age Security Program. You can usually renew your benefit simply by filing your return by April 30th. If you choose not to file a return, you will have to complete a renewal application form.

5.2 Individuals Presenting with No Notice of Assessment

When an individual under 65 presents at the initial application of the income test without a Notice of Assessment, the assessor will assume there is no income and proceed with the assessment as detailed in the section 6.1.5 Individuals with Income below the Income Exemption Threshold.

When an individual who is over 65 presents at the initial application of the income test without a Notice of Assessment, the assessor will assume that the individual has an income equivalent to the basic OAS/GIS rates.

In either case, the individual must be advised that they will have six months to file a return and present the RHA with a Notice of Assessment. The client file should be flagged for a reassessment in 6 months.

One Time Only Special Assistance Program Benefits

Individuals requesting a one-time only item from the Special Assistance Program are required to provide their Notice of Assessment at the time of application. When an individual meets the SAP eligibility criteria as outlined in Section 3.3.1, but does not have a Notice of Assessment, they will not normally be eligible for financial subsidization of the requested item, as there will be no automatic assumption of a level of income.
If the individual would experience hardship (e.g., risk of physical harm) by not having the item provided immediately, the RHA has the discretion to contact the Department to obtain approval for the request without the Notice of Assessment.

Individuals who had filed their Income Tax return but misplaced their Notice of Assessment can contact CRA at 1-800-959-8281 to request a duplicate copy.

The RHA may also accept any official documentation from CRA that identifies the most recent Net Income reported on Line 236, if the Notice of Assessment is not available.

### 5.3 Assessment of Veteran’s Allowance

Line 236 of the Notice of Assessment does not reflect income received by Veterans as it is not a taxable income, however when an individual applies for subsidized programs it is to be assessed as income by the RHA.

Individuals applying for Home Support only and/or the Special Assistance Program will be asked if they are in receipt of Veterans Allowance, and if so, will be required to provide verification of the amount received. This income is to be added to the amount stated in Line 236 for a total assessment of the client’s income.

### 5.4 Individuals with Employment Income

There may be instances when the most recent Notice of Assessment is not reflective of the current financial circumstances of individuals who have employment income. In such cases, the assessor may use actual pay cheque statements to calculate monthly income rather than the Notice of Assessment. When using the actual pay cheque statements, voluntary deductions are to be added back to the net pay to determine the amount of income to be entered into CRMS Pay System. Voluntary deductions may include, but are not limited to:

- Optional Life Insurance
- Optional Health Plans (Basic coverage or Accidental Death/ Dismemberment)
- Optional Dental Plans
- Top-up to Employer Mandated Health/Dental plans
5.5 Converting Bi-Weekly/Semi-Monthly Income
When the income of an individual is determined using actual pay cheque statements the following methods are to be used to convert to monthly income.
- Bi-weekly payment x 26 pay periods = Annual income
- (Bi-weekly payment x 26 pay periods) / 12 months = Monthly income
- Semi-monthly payment x 24 = Annual income
- Semi-monthly payment x 2 = Monthly income

5.6 Treatment of Severance Packages Due to Layoff
There may be situations where an individual has received a significant severance package as a result of a layoff. The following guideline identifies the process to follow in such situations:
1. Clients impacted by layoff will be re-assessed, as per program policy, to determine:
   a. their continued need for supportive services or supplementary benefits; and
   b. client contribution toward services or subsidy due to their changed circumstances.
2. In the event the client/family member returns to work, a financial reassessment would be completed which must consider income from employment.
6.0 INCOME TEST

The income based financial assessment process applies to all individuals who apply for services in the LTC CSS system and have been deemed eligible for service by RHA staff.

The income test is based on the income reported on Line 236 of the Canada Revenue Agency Notice of Assessment from the previous Income Tax Assessment year, subject to Section 6.6. Expenses of the individual are not considered.

6.1 Application of Income Test

6.1.1 Income Exemption Threshold
The income exemption threshold is a Provincially set level of income which is exempt from the financial assessment process in the application of the Income Test. The threshold will differ depending on whether or not the assessment is being completed for a single individual or a couple. In the event there are dependent(s) residing with the individual, an additional annual exemption may be added to the basic exemption threshold (also refer to Section 6.1.3 Dependent Income).

See Schedule III Income Exemption Thresholds, for the current income exemption thresholds.

6.1.2 Outstanding Debt of Individual
The Income Test does not take into consideration expenses or debts of the individual. It is based solely on the individual’s reported net income, and permits the individual to manage their financial affairs with the income that is retained after the client contribution is made.

6.1.3 Dependent Income
When the client chooses to claim the additional exemption amount for a dependent, any income earned by that dependent would be considered as income for the family and their Notice Of Assessment Line 236 Net Income must be used in determining the client contribution.
6.1.4 Client Contribution Calculation

A formula will be applied to the assessable income base to determine the client contribution that must be paid towards the cost of the approved service. The assessable income base is consistent for all clients, and is Line 236 Net Income as determined by the Canada Revenue Agency. The formula applied to the assessable income base will differ depending on a number of factors:

- LTC CSS service requested
- Martial Status
- Number of Dependents
- Source of Income

Schedule IV Client Contribution Calculations identifies the formula that is to be used for each Program from which services are being requested.

For individuals with non-employment income, typically approved for Home Support Only and/or Special Assistance Program Benefits only, the bands of income above the income exemption thresholds will be assessed using the percentages identified in Schedule V Income Test Bands and Assessment Percentages. Also refer to Schedule VI Examples of Calculating Client Contribution Using the Income Test. The details of how to manually calculate the client contribution has been included in these schedules, however RHA staff will have access to either CRMS Pay or a Client Contribution Calculator which will be used to automatically calculate the contribution amount. Client contributions under a pre-determined level (see Schedule I Rates and Maximums) will not be collected.

If the monthly contribution calculated is greater than the cost of the approved service, the client is not eligible for financial subsidization.

6.1.5 Adjustment to Client Contribution Calculation

There will be instances where an adjustment can be made to the client contribution calculated with the income test that does not have to be processed as an exception to income testing (Section 6.6). The following details the situations where the financial assessor can make an adjustment without prior approval of RHA management.
DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Income Based Financial Assessment for
Long Term Care and Community Support Services

Section: 6.0 Income Test                                      Page: 3 of
Effective Date: December 1, 2009                             Revised: February 2019

6.1.5.1 New LTC/PCH Single Resident with Community Home
At the time of admission to a LTC or PCH, a single subsidized resident with a home in the
community may be permitted to retain sufficient income for the expenses to maintain the
home in the community for a three month period. Verification of the basic household
expenses, such as mortgage/utilities/insurance will have to be provided to the RHA. An
adjustment to the client contribution to allow for community home expenses is not to
exceed three months.

The client is to advise the RHA if they sell or otherwise dispose of the community home
prior to the end of the three month period. The client contribution is then to be reviewed
and the adjustment removed from the calculation of the client contribution.

6.1.5.2 Pre-Arranged Funeral/Burial Insurance Premiums
Subsidized clients who have a pre-arranged funeral/burial insurance in place at time of
initial subsidization by the RHA will be permitted to retain sufficient income to pay the
premium through an adjustment to their client contribution. Appropriate verification of the
pre-arranged funeral contract/burial insurance plan must be provided to the RHA.

The premium payment allowed is to be within the provincially set monthly maximum, to
be paid towards a funeral with the maximum value identified in Schedule II, Rates and
Maximums, providing the beneficiary is either the "The Estate of" of the individual
(preferred) or the funeral home.

The premium payment can be carried forward as an allowable adjustment to the monthly
contribution in the event the client moves from the personal care home program to the
long term care home program.

The Financial Assessor is to KIV the end date of the funeral/burial plan, and adjust the
client contribution calculation when the term of the plan ends.

6.1.6 Individuals with Income below the Income Exemption Threshold
In the event the individual reports income below the exemption threshold, as per the
Notice of Assessment, the individual will be eligible for a subsidy with no client
contribution. All approved benefits would be set up in CRMS Pay Module or the client
payment system utilized by the RHA.
6.2 Use of Multiple Financial Assessments

It is possible that the situation will arise where more than one assessment may be used to determine an individual's eligibility for financial subsidization.

There will be cases present where a community spouse of a LTC/PCH subsidized resident requests a financial subsidy for services/benefits under the Home or Residential Living Models. The LTC Income Test Assessment would first be applied to the couple to determine the client contribution of the LTC/PCH resident. If the community spouse requires Community Support Services, including SAP benefits, the appropriate Community Support Income Test would then be applied. In the application of the Individual in the Community or Special Assistance Only Income Test, the Line 236 of only the community spouse would be used to determine the client contribution. The income of the LTC resident, is not to be considered in the financial assessment.

6.3 Financial Reassessment

Financial reassessments may be requested by the client at any point in time when there are substantial changes in their income. The normal cost of living indexing to the Old Age Security/Guaranteed Income Supplement is not considered a significant change in income, and need only to be considered in the annual review process. A variation in income due to changes in employment status would be considered significant and should result in a review.

The client is financially reassessed by the RHA annually, at a minimum. A financial reassessment may also be undertaken by the RHA at any time information is received that there is a change to client's income that may affect the calculated client contribution.

6.3.1 Reassessment Process

To reassess the client contribution when there has been a substantial change in the income of the client that is not reflected in the Notice of Assessment, the RHA will have to estimate the average monthly income based on the information more recent than the Notice of Assessment.
In estimating the revised income, the income of the client includes, but is not limited to:

- Employment income;
- Public and private domestic and foreign pensions;
- Income provided from RRSP’s and RRIF’s, as well as withdrawal of funds from these plans;
- Transfer payments for any level of government (e.g. OAS, GIS, CPP, WHSC, Veteran’s Allowance);
- Business revenues;
- Investment income (e.g. interest and dividends);
- Loan repayments from family members;
- Income from a trust fund;
- Social Assistance Payments;
- Lump sum payments received from any source;
- Rental income; and
- Any other form of monies received as income.

6.4 Grand Parenting

Insert new policy here

6.5 Administrative Financial Review Process

Each RHA has a protocol in place to review decisions. Clients who have had a financial assessment completed using the Income Test have the ability to request a financial review by using the established protocol process.

6.6 Financial Hardship Consideration

Insert new policy here
7.0 DEFINITIONS

Client – for the purpose of this policy, refers to the person in receipt of the services.

Cohabitating partner – means either of 2 persons who are cohabiting and:
- Have cohabitated continuously in a conjugal relationship outside marriage for not less than one year; or
- Have entered into a written agreement in respect of their cohabitation, in which they agree on their respective rights and obligations during cohabitation, upon ceasing to cohabit or upon the death of either of them.

Dependent – for the purposes of this policy, refers to a child of, or a person under the guardianship of, the client or the client’s spouse who depends financially on either and who is either under 19; over 18 and enrolled full time in a post-secondary institution; or over 18 and disabled.

Family – the purposes of this policy, refers to a single person; a single person with dependents; a husband and wife, or cohabitating partners, with or without dependents.

Family Income – for the purposes of this policy, refers to the amount reported in the Canada Revenue Agency Income Tax Assessment, Line 236 “Net Income” for both the client and their spouse/cohabitating partner. If separate Income Tax Assessments are filed, the amount in Line 236 on each assessment will be combined to calculate the client contribution.

Income – for the purposes of this policy, refers to the amount reported in the Canada Revenue Agency Income Tax Assessment, Line 236 “Net Income”.

Spouse – refers to a person to whom you are legally married; or to a cohabitating partner.
### Schedule I

#### Rates and Maximums

<table>
<thead>
<tr>
<th>Private Paying Rates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCF</td>
<td>$2,990/mth</td>
</tr>
<tr>
<td>Medically Discharged</td>
<td>$1,132.50/mth</td>
</tr>
<tr>
<td>Protective Community Residence</td>
<td>$2,800/mth</td>
</tr>
</tbody>
</table>

#### Transportation Rates

<table>
<thead>
<tr>
<th>Transportation Rates:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Access</td>
<td>$0.30/km</td>
</tr>
<tr>
<td>PCHs (when provided by operator)</td>
<td>$0.55/km</td>
</tr>
<tr>
<td>PCHs (when provided by family)</td>
<td>$0.30/km</td>
</tr>
<tr>
<td>PCHs (when provided by Licensed Taxi carrier)</td>
<td>Actual</td>
</tr>
</tbody>
</table>

#### Residential Respite

<table>
<thead>
<tr>
<th>Residential Respite Rates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>$55</td>
</tr>
<tr>
<td>Weekend (Friday to Sunday)</td>
<td>$190</td>
</tr>
<tr>
<td>Extended Weekend (Friday to Monday)</td>
<td>$251</td>
</tr>
<tr>
<td>Weekly</td>
<td>$365</td>
</tr>
<tr>
<td>Monthly</td>
<td>$1,380</td>
</tr>
<tr>
<td>Respite Provided in a PCH</td>
<td>$64/day</td>
</tr>
<tr>
<td>Respite Provided in a LTCF</td>
<td>$20/day</td>
</tr>
</tbody>
</table>

#### Home Support Hourly Subsidy Rates

**Effective July 1, 2017:**

<table>
<thead>
<tr>
<th>Self-Managed:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite/Homemaker/Attendant Care (base rate)</td>
<td>$15.55</td>
</tr>
<tr>
<td>Behavioural Aides (base rate)</td>
<td>$17.13</td>
</tr>
<tr>
<td>Home Therapist (base rate)</td>
<td>$17.13</td>
</tr>
<tr>
<td>Agency</td>
<td>$23.43</td>
</tr>
</tbody>
</table>

#### Maximum Subsidies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PCH</td>
<td>$2,375/mth</td>
</tr>
<tr>
<td>Home Support – Under 65</td>
<td>$5,220/mth</td>
</tr>
<tr>
<td>Home Support – Over 65</td>
<td>$3,650/mth</td>
</tr>
<tr>
<td>AFC</td>
<td>$1,380/mth</td>
</tr>
</tbody>
</table>

#### Client Contribution

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No collection of client contributions below:</td>
<td>$5.00/mth</td>
</tr>
</tbody>
</table>

#### Bookkeeper Rates

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 2 Workers</td>
<td>$25.00 bi-wkly + HST</td>
</tr>
<tr>
<td>3 Workers</td>
<td>$30.00 bi-wkly + HST</td>
</tr>
<tr>
<td>4 Workers</td>
<td>$35.00 bi-wkly + HST</td>
</tr>
<tr>
<td>5 + Workers</td>
<td>$40.00 bi-wkly + HST</td>
</tr>
</tbody>
</table>

#### Pre-Arranged Funeral/Burial Insurance

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum monthly premium</td>
<td>$120</td>
</tr>
<tr>
<td>Maximum value of arrangement</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Updated: February 2019
### Calculation of Net Income as per Line 236 of the Income Tax Assessment

#### Income included in Line 236:

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 101</td>
<td>Employment Income</td>
</tr>
<tr>
<td>Line 102</td>
<td>Commissions</td>
</tr>
</tbody>
</table>
| Line 104 | Other employment income:  
- Employment income not reported on a T4  
- Net research grants  
- Clergy's housing allowance  
- Foreign employment income  
- Income maintenance insurance plans (wage loss replacement plans)  
- Veteran's benefits  
- Certain GST/HST rebates  
- Royalties  
- Amounts received under a supplementary unemployment benefit plan (a guaranteed annual wage plan)  
- Taxable benefit for premiums paid to cover you under a group term life-insurance plan  
- Employee profit sharing plan  
- Medical premium benefits  
- Wage earners protection plan |
| Line 113 | Old Age Security pension |
| Line 114 | CPP benefits |
| Line 115 | Other pensions or superannuation (includes foreign pensions, annuity and RRIF) |
| Line 116 | Elected split-pension amount |
| Line 117 | Universal Child Care Benefit |
| Line 119 | Employment Insurance and other benefits |
| Line 120 | Taxable amount of dividends from taxable Canadian corporations |
| Line 121 | Interest and other investment income (includes foreign dividends, bank accounts, term deposits, GICs, Canada Savings Bonds, T-Bills, earnings on life insurance policies, etc.) |
| Line 122 | Net partnership income: limited or non-active partners only |
| Line 125 | Registered disability savings plan income |
| Line 126 | Rental income |
| Line 127 | Taxable Capital Gains |
| Line 128 | Support Payments received |
| Line 129 | RRSP income |
| Line 130 | Other Income (scholarships, fellowships, bursaries, artists' project grants; apprenticeship incentive grant; lump-sum payments; retiring allowances; death benefits; other) |
| Lines 130 to 143 | Self-employment income |
| Line 144 | Workers' compensation benefits |
| Line 145 | Social Assistance payments |
| Line 146 | Net Federal Supplements |

#### Deductions to Income:

<p>| Line 206 | Pension adjustment |
| Line 207 | Registered Pension Plan deduction |
| Line 208 | RRSP deduction |
| Line 209 | Saskatchewan Pension Plan deduction |
| Line 210 | Deduction for elected split-pension amount |
| Line 212 | Annual union, professional or like dues |
| Line 213 | Universal Child Care Benefit repayment |
| Line 214 | Child Care expenses |
| Line 215 | Disability supports deduction |
| Line 217 | Business investment loss |
| Line 219 | Moving expenses |
| Line 220 | Support payments made |</p>
<table>
<thead>
<tr>
<th>Line 221</th>
<th>Carrying charges and interest expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 222</td>
<td>Deduction for CPP or QPP contributions on self-employment and other earnings</td>
</tr>
<tr>
<td>Line 223</td>
<td>Deduction for provincial parental insurance plan premium on self-employment income</td>
</tr>
<tr>
<td>Line 224</td>
<td>Exploration and development expenses</td>
</tr>
<tr>
<td>Line 229</td>
<td>Other employment expenses</td>
</tr>
<tr>
<td>Line 231</td>
<td>Clergy residence deduction</td>
</tr>
<tr>
<td>Line 232</td>
<td>Other deductions</td>
</tr>
<tr>
<td>Line 235</td>
<td>Social Benefits repayment (EI or OAS)</td>
</tr>
<tr>
<td><strong>Line 236</strong></td>
<td><strong>Net income</strong></td>
</tr>
</tbody>
</table>
Schedule III

Income Exemption Thresholds

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with Non-Employment Income</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$13,000</td>
</tr>
<tr>
<td>Couple</td>
<td>$21,000</td>
</tr>
<tr>
<td>Dependent Exemption (per Dependent)</td>
<td>$2,000</td>
</tr>
<tr>
<td>Individuals with Non-Employment Income</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$27,150</td>
</tr>
<tr>
<td>Single with one-dependent</td>
<td>$30,009</td>
</tr>
<tr>
<td>Single with more than one dependent</td>
<td>$42,870</td>
</tr>
<tr>
<td>Married with no dependents</td>
<td>$30,009</td>
</tr>
<tr>
<td>Married with dependents</td>
<td>$42,870</td>
</tr>
</tbody>
</table>

Updated: February 2019
## Schedule IV

### Client Contribution Calculations

<table>
<thead>
<tr>
<th>Service/Client Group</th>
<th>Assessed Income Base</th>
<th>Client Contribution Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long Term Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>Line 236</td>
<td>87% of assessed income base</td>
</tr>
<tr>
<td>Couple: Spouse in Community</td>
<td>Line 236</td>
<td>23% of assessed income base</td>
</tr>
<tr>
<td>Couple: Spouse and dependent in community</td>
<td>Line 236 adjusted by $2,000 per dependant</td>
<td>23% of assessed income base</td>
</tr>
<tr>
<td>Couple: Spouse in LTC/PCH</td>
<td>Line 236</td>
<td>87% of assessed income base (each resident assessed as a single)</td>
</tr>
<tr>
<td><strong>Personal Care Home/Community Care Home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>Line 236</td>
<td>87% of assessed income base</td>
</tr>
<tr>
<td>Single: Employment Income</td>
<td>Line 236 adjusted for $150 personal allowance and</td>
<td>100% of adjusted assessed income base</td>
</tr>
<tr>
<td></td>
<td>employment exemption (20%)</td>
<td></td>
</tr>
<tr>
<td>Couple: Spouse in community</td>
<td>Line 236</td>
<td>23% of assessed income base</td>
</tr>
<tr>
<td>Couple: Spouse and dependent in community</td>
<td>Line 236 adjusted by $2,000 per dependant</td>
<td>23% of assessed income base</td>
</tr>
<tr>
<td>Couple: Spouse in LTC/PCH</td>
<td>Line 236</td>
<td>87% of assessed income base (each resident assessed as a single)</td>
</tr>
<tr>
<td><strong>Community Support Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single: AESL Client, with or without Dependents no income</td>
<td>Not Applicable</td>
<td>No contribution, automatic financial eligibility</td>
</tr>
<tr>
<td>Single: Non-employment Income(^1), with or without</td>
<td>Line 236</td>
<td>Maximum contribution of 18% of Line 236.</td>
</tr>
<tr>
<td>dependant</td>
<td></td>
<td>See Schedule V for details</td>
</tr>
<tr>
<td>Single: Employment Income</td>
<td>Line 236</td>
<td>$27,150 exempt (same as NLPDP Access Plan - Single), assess 10% of income above exemption as contribution</td>
</tr>
<tr>
<td>Single: Employment Income with one dependant</td>
<td>Line 236</td>
<td>$30,009 exempt (same as NLPDP Access Plan - Couple), assess 10% of income above exemption as contribution</td>
</tr>
<tr>
<td>Single: Employment Income with more than one dependant</td>
<td>Line 236</td>
<td>$42,870 exempt (same as NLPDP Access Plan - Family), assess 10% of income above exemption as contribution</td>
</tr>
<tr>
<td>Couple: AESL Clients no income</td>
<td>Not Applicable</td>
<td>No contribution, automatic financial eligibility</td>
</tr>
<tr>
<td>Couple: Non-employment Income(^1)</td>
<td>Line 236</td>
<td>Maximum contribution of 18% of Line 236.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Schedule V for details</td>
</tr>
<tr>
<td>Couple: Employment Income, no dependants</td>
<td>Line 236</td>
<td>$30,009 exempt (same as NLPDP Access Plan - Couple), assess 10% of income above exemption as contribution</td>
</tr>
<tr>
<td>Couple: Employment Income, with dependants</td>
<td>Line 236</td>
<td>$42,870 exempt (same as NLPDP Access Plan - family), assess 10% of income above exemption as contribution</td>
</tr>
<tr>
<td><strong>Supportive Services for Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Parent: AESL Client no income</td>
<td>Not Applicable</td>
<td>No contribution, automatic financial eligibility</td>
</tr>
<tr>
<td>Service/Client Group</td>
<td>Assessed Income Base</td>
<td>Client Contribution Formula</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>----------------------------</td>
</tr>
</tbody>
</table>
| Single Parent: Non-employment Income<sup>1</sup> | Line 236 | Maximum contribution of 18% of Line 236.  
**See Schedule V for details** |
| Single Parent: Employment Income | Line 236 | $30,009 exempt (same as NLPDP Access Plan - Couple), assess 10% of income above exemption as contribution |
| Single Parent with more than one dependant: Employment Income | Line 236 | $42,870 exempt (same as NLPDP Access Plan - Family), assess 10% of income above exemption as contribution |
| Couple: AESL Client, no income | Not Applicable | No contribution, automatic financial eligibility |
| Couple: Non-employment Income<sup>1</sup> | Line 236 | Maximum contribution of 18% of Line 236.  
**See Schedule V for details** |
| Couple: Employment Income | Line 236 | $42,870 exempt (same as NLPDP Access Plan - Family), assess 10% of income above exemption as contribution |

<sup>1</sup> Non-employment income would include such payments as pensions and Employment Insurance (EI).
Schedule V

Income Test Bands and Assessment Percentages for Individuals with Non-Employment Income

<table>
<thead>
<tr>
<th>Application of the income test for a single:</th>
<th>Total % of income assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Exemption Threshold for a Single</td>
<td>$13,000</td>
</tr>
<tr>
<td>Portion of Income Between $13,001 to $18,000</td>
<td>Assess at 24.0% Up to 6.7%</td>
</tr>
<tr>
<td>Portion of Income Between $18,001 to $23,000</td>
<td>Assess at 34.0% Up to 12.6%</td>
</tr>
<tr>
<td>Portion of Income Between $23,001 to $28,000</td>
<td>Assess at 42.8% Up to 18%</td>
</tr>
<tr>
<td>Income Between $28,001 to $150,000 Assess Full Income At</td>
<td>18.0% 18%</td>
</tr>
<tr>
<td>If Income Exceeds $150,000</td>
<td>Not Eligible for Subsidy</td>
</tr>
</tbody>
</table>

Effective July 1, 2016

<table>
<thead>
<tr>
<th>Application of the income test for a couple:</th>
<th>Total % of income assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Exemption Threshold for a Couple</td>
<td>$21,000</td>
</tr>
<tr>
<td>Portion of Income Between $21,001 to $25,000</td>
<td>Assess at 38.5% Up to 6.2%</td>
</tr>
<tr>
<td>Portion of Income Between $25,001 to $32,000</td>
<td>Assess at 32.3% Up to 11.9%</td>
</tr>
<tr>
<td>Portion of Income Between $32,001 to $40,000</td>
<td>Assess at 42.5% Up to 18%</td>
</tr>
<tr>
<td>Between $40,001 to $150,000 – Assess Full income at</td>
<td>18.0% 18%</td>
</tr>
<tr>
<td>If Income Exceeds $150,000</td>
<td>Not Eligible for Subsidy</td>
</tr>
</tbody>
</table>

Effective July 1, 2016

In the event there is a dependant(s) in the household. An additional $2,000 per dependent would be added to the annual exemption threshold.

Income related to the dependent(s) would have to be included in the calculation of total Net Income of the family.
Schedule VI

Examples of Calculating Client Contribution Using the Income Test

The following are examples of how this test would be applied to clients with non-
employment income

**Example 1: Application for a single:**

Line 236, annual income $25,200
This equates to monthly income of $2,100
Assess Contribution:
Portion of Income Between $13,001 to $18,000 At 24% $1,200
Portion of Income Between $18,001 to $23,000 At 34% $1,700
Portion of Income Between $23,001 to $25,200 At 42.8% $941
Total Annual Contribution $3,841
Monthly Contribution $320
Monthly Retained Income $1,780

**Example 2: Application for a single:**

Line 236, annual income $29,400
This equates to monthly income of $2,450
Assess Contribution:
If Income Exceeds $28,000 Assess Full Income At 18% $5,292
Total Annual Contribution $5,292
Monthly Contribution $441
Monthly Retained Income $2,009

**Example 3: Application for a Couple:**

Line 236, annual income $32,000
This equates to monthly income of $2,583
Assess Contribution:
Portion of Income Between $21,001 to $25,000 At 38.5% $1,540
Portion of Income Between $25,001 to $32,000 At 32.3% $2,261
Total Annual Contribution $3,801
Monthly Contribution $316
Monthly Retained Income $2,267

**Example 4: Application for a Couple:**

Line 236, annual income $43,000
This equates to monthly income of $3,583
Assess Contribution:
If Income Exceeds $40,000 Assess Full Income At 18% $7,740
Total Annual Contribution $7,740
Monthly Contribution $645
Monthly Retained Income $2,938
Information Note
Department of Health and Community Services

Title: Canadian Institute for Health Information (CIHI) release on Trends in Hospital Expenditures, 2005-2006 to 2017-2018


Background and Current Status:
- Quebec and Nunavut are not included in the Hospital Spending release.

National Trends:
- Employee compensation represents 64.1 per cent of hospital spending, accounting for almost $35 billion in 2017-2018.

- While per capita spending on drugs in hospitals has generally increased year over year, its share of total spending has been slowly decreasing, from 4.7 per cent in 2005–2006 to 4.2 per cent in 2017–2018.

- Among direct patient care services, the nursing ward accounts for the largest share of hospital spending at 19.3 per cent, followed by support services at 18.0 per cent and other diagnostic and therapeutic services at 13.1 per cent.

- Since 2005, total hospital spending has grown at an average annual rate of four per cent.

- Ventricular assist device implantation is the most expensive condition to treat in a hospital setting, at an average cost of $238,274 for the duration of the stay.

- Due to the incidence and volume of patients, Canadian hospitals spend much more in total on conditions such as chronic obstructive pulmonary disease ($753 million), pneumonia ($506 million) and unilateral knee replacements ($486 million).

- While inpatient care remains an important part of hospital services, there has been a gradual shift toward increased outpatient care. Since 2005, outpatient volumes have grown almost 1.5 times as quickly as inpatient volumes, with increases of 25 per cent and 17 per cent, respectively.

- This continuing shift means that more complex cases are being treated as outpatients, leading to a slow but consistent increase in the average complexity of both outpatients and inpatients.

- Hospitals continue their shift to outpatient care: growth in ambulatory care (74 per cent) and community health services (140 per cent) has outpaced that in nursing inpatient services (60 per cent) since 2005-2006.

- While Canada is among the highest spenders on overall health care in the Organization for Economic Co-operation and Development (OECD), we spend less than most other countries on hospital services, at $1,742 per person, compared with the OECD average of $1,822.
When limited to government spending, however, Canada spends around the OECD average of $1,568. For voluntary/household out-of-pocket hospital spending, Canada ($174) spends less than the OECD average of $254.

- Of 32 selected OECD countries, 16 spent more on hospitals than Canada on a per person basis.

Newfoundland and Labrador (NL) Trends:
- Employee compensation represents 66.8 per cent of total hospital spending, accounting for almost $937 million in 2017-2018.

- While per capita spending on drugs in hospitals has generally increased year over year, its share of total spending has been slowly decreasing, from 4.2 per cent in 2005-2006 to 3.7 per cent in 2017-2018.

- Among direct patient care services, the support services accounts for the largest share of hospital spending at 24.1 per cent, followed by nursing ward at 17.5 per cent and other diagnostic and therapeutic services at 14.0 per cent.

- Since 2005, total hospital spending has grown at an average annual rate of five per cent.

- Newborn/Neonate 750-999 grams, Gestational Age <29 Weeks has the highest average cost of $235,351 per case. Certain newborn/neonate conditions (typically premature, low birth weight cases) tend to have the highest average cost per case due to very high resource utilization and low volume of cases.

- Due to the incidence and volume of patients, hospitals in Newfoundland and Labrador spend much more in total on conditions such as chronic obstructive pulmonary disease ($15.5 million), palliative care ($12.2 million), and viral/unspecified pneumonia ($9.7 million). Overall in Canada, the top five conditions for total hospital costs are similar to that of NL, however palliative care does not appear in this list.

- While inpatient care remains an important part of hospital services, there has been a gradual shift toward increased outpatient care. Since 2005, outpatient volumes have grown almost 4.7 times as quickly as inpatient volumes, with volume increases of 37 per cent and 8 per cent, respectively.

- Overall, inpatient complexity has increased over the last four years. Since NL does not submit data to the National Ambulatory Care Reporting System (NACRS), the only outpatient cases that can be reported on are the day surgery cases that are in the Discharge Abstract Database (DAD). For the day surgery cases, complexity has been relatively flat over the last four years (ranging from 0.157 to 0.160 for any given year). NL cannot report on the complexity of the cases in the emergency department or the ambulatory care clinics.

- Hospitals continue their shift to outpatient care: growth in ambulatory care (87 per cent) and community health services (396 per cent) has outpaced that in nursing inpatient services (60 per cent) since 2005-2006.
Analysis:
- In 2016-17 and 2017-18 NL was able to reduce the percentage of hospital expenditures by 1.1 per cent and 0.5 per cent respectively.

- Since 2009-10 NL's ranking on hospital expenditures per capita has been the highest among the jurisdictions. In 2009-10, NL spent $2,109 per capita versus the national average of $1,647. In 2017-18 NL spent $2,654 per capita versus the national average of $1,919. NL had the second highest hospital expenditures from 2005-06 to 2008-09, Nova Scotia was the only jurisdiction that had higher hospital expenditures in those fiscal years.

- The following table illustrates a comparison of per capita hospital spending in the provinces and territories by type of expense, functional area, and total spending for 2017-2018.

<table>
<thead>
<tr>
<th>Provincial/territorial per capita hospital expenditure by key functional area or type of expense of current dollars, 2017-2018</th>
<th>Type of Expense</th>
<th>Functional Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drugs</td>
<td>Compensation</td>
</tr>
<tr>
<td>P/T</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NL</td>
<td>97.0</td>
<td>1,773.0</td>
</tr>
<tr>
<td>PEI</td>
<td>60.7</td>
<td>1,382.6</td>
</tr>
<tr>
<td>NS</td>
<td>108.6</td>
<td>1,664.6</td>
</tr>
<tr>
<td>NB</td>
<td>98.0</td>
<td>1,479.2</td>
</tr>
<tr>
<td>ON</td>
<td>94.0</td>
<td>1,125.2</td>
</tr>
<tr>
<td>MB</td>
<td>57.3</td>
<td>1,470.9</td>
</tr>
<tr>
<td>SK</td>
<td>48.5</td>
<td>1,354.3</td>
</tr>
<tr>
<td>AB</td>
<td>57.7</td>
<td>1,395.5</td>
</tr>
<tr>
<td>BC</td>
<td>68.7</td>
<td>1,088.7</td>
</tr>
<tr>
<td>YK</td>
<td>70.8</td>
<td>1,129.6</td>
</tr>
<tr>
<td>NT</td>
<td>76.1</td>
<td>3,077.1</td>
</tr>
<tr>
<td>Canada</td>
<td>81.0</td>
<td>1,229.9</td>
</tr>
</tbody>
</table>

Source: CIHI
*there are other functional areas and types of expenses included in the Trends in Hospital Expenditure, 2005-06 to 2017-18, but for readability purposes they are not included in this table.

- The higher per capita hospital spending in NL compared to the other provinces may be due to the following factors:
  o The population has declined in NL, reducing the denominator in this ratio.
  o A reduction in population has not resulted in a proportional reduction in hospital spending in NL because of such things as minimum staffing levels in rural areas, and limited ability to change existing infrastructure.
  o In more recent years (2007 through 2012) NL’s population has remained stable and as a result of experiencing an increase in revenue from the offshore oil, more money was put into healthcare (including hospitals) thus increasing the numerator.

- NL has the highest per capita spending of all provinces in contracted-out service expenses. This expense is related to one service or a group of services performed by a contracted-out third party provider using its personnel and often its supplies, equipment and premises. The higher per capita hospital expenditure in this area may be due to a number of factors, including ambulance, food, and clinical laboratory services, which are currently contracted out. HCS has engaged the Newfoundland and Labrador Centre for Health Information to conduct further analysis into possible cost-drivers in this expense type. Interestingly, per capita expenditures in contracted-out services have been declining since 2016.
- Eastern Health (EH) issued a tender in summer 2018 seeking a vendor who could provide a tool able to produce function-specific operational benchmarking reports. Benchmarking Intelligence Group Healthcare (BIG), the successful bidder, offers its members a suite of online tools to help organizations improve operational performance. BIG online benchmarking tool had to be customized using NL's chart of accounts. Once operationalized, BIG will provide EH with benchmarking reports for: each functional centre; four-year trends of resource use and performance measures; peer performance ranges; estimates of expected resources for functional centres to operate at target performance levels; and other indicators such as sick leave, overtime and orientation hour percentages.

Prepared / Approved by: N. Kennedy/M. Power/S.Breen/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

February 27, 2019
Information Note  
Department of Health and Community Services

Title: Electronic Medical Record Issue

Issue: To provide an overview of the issue involving the incorrect linkage of patient demographic data in Electronic Medical Record (EMR) charts.

Background and Current Status:
- The Newfoundland and Labrador Centre for Health Information (NLCHI) manages the provincial EMR program, known as eDOCSNL. Program oversight is provided by Health and Community Services (HCS) and the Newfoundland and Labrador Medical Association (NLMA) through the EHR Management Committee (i.e., the committee) created under a memorandum of agreement. TELUS Health is the provider (vendor) of the EMR software. TELUS Health is contracted to maintain the software, ensure integration with other provincial e-health systems, and host all EMR data.

- The EMR is used by 355 clinicians in the province including fee-for-service and salaried physicians, nurse practitioners, and other health regional health authority (RHA) providers. Clinical information including patient demographics, medical and drug history, clinical documents, laboratory results, and diagnostic imaging reports are delivered to EMR users via TELUS.

- On February 25, 2019, HCS was made aware by NLCHI of an EMR software issue which resulted in patient demographic information (e.g., age, address, MCP number) being linked to the wrong patient charts.

- The issue is not isolated to Newfoundland and Labrador as TELUS reports it has been found in other provinces as well. TELUS reported they became aware of the issue through their routine support ticketing process. (i.e., customer support). Ninety-two EMR charts in Newfoundland and Labrador are affected. At this time, it is not known which EMR instances (i.e., clinics) contain the charts, which physicians are involved, or the timeframe surrounding the issue.

- TELUS requested permission to begin an investigation of the issue requiring direct access to the affected patient charts. This request was approved by the committee on February 26, 2019.

- There has not been any formal communication with users or the public regarding this issue. The question of when/if communication should take place was discussed by the committee on February 26. Those in attendance felt, at this time, there is very little to communicate and it is not yet clear if there are any clinical or privacy risks.

Action Being Taken:
- TELUS has been asked to proceed promptly with the investigation and report clinically significant findings as soon as the information is available. They committed to providing further information about the issue by end of day, February 28, 2019.
• It was requested that TELUS refrain from communicating with EMR users or the public on this issue without first reviewing the relevant information and intended communication with the committee.

• NLCHI will work with TELUS to understand the root cause of the issue and potential impacts. This will inform the decision on next steps. NLCHI will provide an update to HCS.

• HCS will continue to monitor the situation and provide updates as required.

• HCS will develop a communications plan and key messages in the event communication is required regarding this issue.

Prepared/Approved by: C. Chisholm/T. Power/H. Hanrahan/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

February 27, 2019
Information Note
Department of Health and Community Services

Title: Public health staffing and school attendance challenges in Natuashish

Issue: To provide information on public health challenges in Natuashish.

Background and Current Status:
- The Federal Government’s First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada supports the delivery of public health and health promotion services in the Innu First Nation community of Natuashish, including funding for public health staff employed by the Mushuau Innu First Nation (MIFN). Public health has not been devolved to MIFN, but it is directly involved in public health delivery and may choose to have law-making authority over health in the future.

- HCS purchases vaccine for Newfoundland and Labrador’s publically funded vaccination programs. HCS supplies vaccine to MIFN through the Labrador-Grenfell Regional Health Authority (LGH).

- The Newfoundland and Labrador immunization schedule follows the recommendations published in the Public Health Agency of Canada’s Canadian Immunization Guide. The immunization policy manual outlines the immunization schedule for children in this province starting at two months of age up to grade nine (Annex A).

- HCS policy, as outlined in the immunization manual, requires regional health authorities to submit annual immunization coverage rates for the following:
  - Status of two year olds;
  - Status of kindergarten students;
  - Grade four meningococcal-C-ACYW135;
  - Grade six human papillomavirus (HPV);
  - Grade six hepatitis B (HB); and,
  - Grade nine tetanus, pertussis, diphtheria (Tdap).

- HCS received the school aged immunization coverage rates for LGH in September 2018. It was at that time that LGH and HCS became aware of the low coverage rates in Natuashish:

- In addition to low school aged immunization rates, there were approximately [redacted] infants requiring vaccinations and [redacted] individuals requiring tuberculosis testing.

- In September 2018, LGH convened a working group with staff from LGH, HCS (including the Chief Medical Officer of Health, the Public Health Manager and the Communicable Disease Control Nurse Specialist), FNIHB, the Innu Round Table, and MIFN (the working
group). This working group met bi-weekly September 2018 to January 2019 and weekly after January 23, 2019.

- The working group became aware that up until January 2018, Natuashish had two full time public health nurses in the community. Between January and May 2018 there was one full time nurse and after May 2018 the only public health nursing support was a relief nurse for the month of August 2018. Natuashish was actively trying to recruit public health nurses during this time; interviews were conducted, but they were unable to secure any positions.

- Finding nurses to work in Natuashish was a priority for the community and the working group. With assistance from FNHIHB, Natuashish was able to obtain 2 nurses from a private nursing agency to work in Natuashish from November 12 to November 24, 2018 to assist with Fall 2018 scheduled and catch up vaccinations. Prior to their arrival, two FNHIHB staff went to Natuashish to assist public health staff in the community with planning, and to develop work plans for vaccinations, including childhood and influenza vaccinations, and tuberculosis contact testing and treatment.

- During the November 2018 visit, the two nurses were able to vaccinate school-aged children, infants, and provide influenza vaccinations. In addition, the nurses tested of the tuberculosis contacts from the tuberculosis cluster investigation in Nain.

- The report from the nurses in fall 2018 revealed several challenges including:
  o insufficient vaccine supply;
  o insufficient medical supplies;
  o issues with school age consents, including expired consents, absent consents, inability to locate parents and/or guardians, and signed consents that conflicted with medical charts with regard to identified parents and/or legal guardians; and,
  o absenteeism from school for entire grades due to teacher shortage.

- Public health nurses completed more vaccinations during their rotations in December 2018 and January 2019. A report from January 23, 2019 reveals the current gaps:
  Immunizations
  o The total number of children behind schedule is 106 with up to 200 doses of vaccinations required. The Newfoundland and Labrador immunization schedule lists the 15 diseases against which these vaccinations protect (Annex A).

  o Unlike the 2018 data, the current 2019 vaccination rate for each age group is unknown as denominator is missing.
Tuberculosis testing

Sexually transmitted infections (STI) contact tracing

- It was reported that STI clients need follow-up.
- The number of clients requiring STI follow up is unknown.

School attendance

- The school administration informed the public health nurse that several students on the immunization list no longer attend school.
- The public health nurse was informed by school administration that children in grades kindergarten, five, seven, eight, and nine have not been attending school regularly due to inability to recruit teachers. The teachers in the school are rotating classes, for example, one teacher is covering grades seven, eight and nine and the students are doing a three-day rotation.
- The total number of children no longer attending school or the reason why they are not attending is unknown.

Children out of community.

- The public health nurse was informed by school administration that several students are not present in the community. Some have relocated to other communities, others are in treatment centres or are under the care of the Department of Children, Seniors and Social Development (CSSD).
- Presently, we do not know the total number of children relocated out of community, the circumstances for relocation, nor the vaccination status of those children.

Staffing

- Natuashish has one part time public health nurse that works a rotation of two weeks in and three weeks out. Natuashish, with assistance from FNIHB, has contracted with two private agency nurses for rotation.
- The number of rotating nurses equals one full time equivalent position.

Water treatment

- Indigenous Services Canada, Regional Operations (ISC RO) provides annual funding to MIFN for community infrastructure including capital improvements, operating and maintenance and capacity enhancement initiatives.
- FNIHB provides annual funding to MIFN to monitor drinking water quality for bacteria and chlorine residual. This monitoring includes collecting samples, shipping to the provincial public health laboratory for bacteria testing, and recording test results. The water quality throughout the community is monitored weekly for bacteria and chlorine residual and twice a year for chemicals (e.g. lead, disinfection by-products). Monitoring occurs more frequently, if required.
- The community of Natuashish has been under a boil water advisory since December 7, 2017 for ineffective water treatment. Currently there are elevated levels of sodium and chloride throughout the water distribution system.
Analysis:

- While it has been helpful to bring in temporary private agency nurses, there are limits to public health outreach when the nursing continuity is not present.

- Recruitment of public health nurses into Natuashish has been difficult. The public health nurse currently in Natuashish suggests that it would be best if the MIFN administrators considered offering the position on a rotational basis. A rotational basis could enhance the ability of attracting qualified individuals.

- Obtaining timely, accurate information has been a challenge, hampering planning efforts.

- The focus at this time in on immunizations and tuberculosis follow-up. We do not know the status of other public health programs including the prenatal, healthy beginnings or preschool health check programs.

- The immunization status is not included in the placement medical form that is completed when children are placed into the care of CSSD and relocated to other communities. CSSD cannot provide HCS with the names of the children currently in care without consent from their Children and Youth Services Division. If a child was relocated to attend a substance use treatment centre, then consent is required from the parent or guardian of the child before appropriate follow-up can be arranged.

- The working group has identified several public health priorities in Natuashish. It is a priority to bring children up to date with vaccinations, and to provide tuberculosis and STI testing, treatment, and contract tracing. The complement of public health staff needed to ensure continuity of services to the community must be identified and recruitment efforts must continue. HCS and LGH will work with MIFN to complete a broader assessment of other public health programs offered in Natuashish and the status of those programs including healthy beginnings and the preschool health checks.

Action Being Taken:

- LGH, through the working group meetings, has offered to assist Natuashish and send public health staff to the community to provide short-term surge capacity to address the vaccine gap. Assistant Deputy Minister Michael Harvey made this offer directly to MIFN Chief John Nui on February 14, 2019 at the Innu Round Table meeting, and it was accepted. The working group will now discuss how best to identify and provide that public health nursing staff. Should LGH capacity prove to be insufficient, HCS will contact other RHAs.

- LGH is assisting MIFN in obtaining medical supplies for the community.

- FNIHB is working with MIFN to continue the recruitment of public health staff for Natuashish. HCS has also offered to assist with the recruitment by circulating the job advertisement.
• The Regional Medical Officer of Health in LGH responsible for tuberculosis has been made aware of the tuberculosis contacts in Natuashish and is taking appropriate action to follow up.

• The ISC RO and FNIHB are working with MIFN and an engineering consultant to investigate the water quality in Natuashish and develop and implement a course of action to address the situation. The community is currently being provided bottled water.

• HCS has informed the Department of Education and Early Childhood Development, CSSD, the Intergovernmental and Indigenous Affairs Secretariat, and the Labrador Affairs Secretariat on the public health challenges in Natuashish. HCS has also discussed the school absenteeism problem with the ISC RO Acting Director General to ensure that he is aware of the issue.

• HCS has engaged CSSD to address confidentiality issues and explore options for identifying children in their care and referring them to public health offices in their current location (Annex B).

• HCS and FNIHB are in regular contact at the executive and official’s level.

Prepared/Approved by: A. Tucker/Dr. J. Fitzgerald/M. Harvey/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD
February 18, 2019
# Annex A: Newfoundland and Labrador Immunization Schedule for Children

## Immunization Schedule Newfoundland and Labrador
June 1, 2018

### Table 1: Routine immunization schedule for children beginning series in early infancy:

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months</td>
<td>DTaP-IPV-Hib, Pneu C-13 and Rot-5*</td>
</tr>
<tr>
<td>4 months</td>
<td>DTaP-IPV-Hib, Pneu C-13 and Rot-5*</td>
</tr>
<tr>
<td>6 months</td>
<td>DTaP-IPV-Hib *<em>, Rot-5</em></td>
</tr>
<tr>
<td>6 months and older</td>
<td>Inf (Fall/Winter only)</td>
</tr>
<tr>
<td>12 months</td>
<td>Pneu C-13, MMRV and Men-C-C</td>
</tr>
<tr>
<td>18 months</td>
<td>DTaP-IPV-Hib and MMRV</td>
</tr>
<tr>
<td>4-6 years</td>
<td>DTaP-IPV or Tdap-IPV</td>
</tr>
</tbody>
</table>

### Table 2: As part of the school health program:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 4</td>
<td>Men-C-ACYW-135</td>
</tr>
<tr>
<td>Grade 6</td>
<td>HB</td>
</tr>
<tr>
<td>Grade 9</td>
<td>HPV-9</td>
</tr>
<tr>
<td></td>
<td>Tdap</td>
</tr>
</tbody>
</table>

**Definitions:**
- DTaP-IPV-Hib: diphtheria, tetanus, acellular pertussis, polio and Haemophilus influenza b
- DTaP-IPV: diphtheria, tetanus, acellular pertussis and polio
- Tdap-IPV: tetanus, diphtheria, acellular pertussis and polio
- Pneu-C-13: 13 types of pneumococcal disease in a conjugated vaccine
- Inf: influenza
- Men-C-C: type C meningococcal disease in a conjugated vaccine
- Men-C-ACYW: type A, C, Y and W135 meningococcal disease in a conjugated vaccine
- MMRV: measles, mumps, rubella, & varicella (chickenpox)
- HB: hepatitis B (2 doses over 6 months)
- HPV-9: 9 strains of human papillomavirus (2 doses over 6 months available Sept 2018)
- Tdap: tetanus, diphtheria and acellular pertussis for adolescents
- Rot-5: Oral pentavalent rotavirus
Dana Downey  
Acting Regional Director  
Department of Children, Seniors, and Social Development  
Children and Youth Services Division  
149 Montana Drive  
First Floor  
Stephenville, NL  
A2N 2T4  

February 4, 2019  

Dear Ms. Downey,  
The Office of the Chief Medical Officer of Health is requesting your collaboration in an effort to bring the population of children 2 months -18 years of age from the community of Natuashish in Labrador up to date with the recommended immunizations.  
It has come to our attention through the annual immunization coverage report from the Labrador Grenfell Health Authority that children from Natuashish are behind in the recommended vaccines as per the Provincial Immunization Schedule.  


The goal of the Routine Childhood Immunization program is to have 95% of the population of children up to date with their immunizations. When coverage is lower than 95% there is a risk to children under-immunized and even to those immunized, of a vaccine preventable disease such as Measles or Meningococcal meningitis. These diseases are rarely seen these days due to consistent annual coverall rages of 95% or higher. Outbreaks of severe disease and deaths can occur in vulnerable populations that are not fully immunized, however. Presently there is a significant health risk to the children and adults of Natuashish.  

The local public health nurses have been diligently working in recent months to bring the children up to date, but there has been a challenge noted in that many children are not presently in the community. Routine lines of business require that the local public health nurse (PHN) be notified when a child is no longer in the community and that the public health nurse in another community be notified when a child moves into the community. Maintaining consistent human resources in Natuashish has been a challenge and there is a gap in that information sharing. We hope to rectify this with a short term plan and a long term plan going forward.  

**Short Term/Immediate Need:**  
We respectfully request that CYSD release the total number of children currently removed from Natuashish due to any reason. We also request that the social worker responsible for Natuashish inform the local public health nurse which Natuashish
children are not presently in the community. The PHN will require the name, DOB and MCP # as well as the community where the child presently resides. The Natuashish PHN will need to forward a copy to the PHN in the community where the child is currently living, as necessary. If the child requires any immunization updates, then the PHN in the host community will obtain consent from the legal guardian and make arrangements for immunization to be completed as soon as possible. When the child returns to Natuashish the PHNs in both communities should be notified.

**Long Term Need:**
Going forward, as children are removed from the community of Natuashish, we request that a copy of their immunization record go with them and be given to the PHN of the new community. The same should happen in reverse when the child returns to Natuashish and the PHN in Natuashish should be notified of the child’s return.

Each child’s interests are best served when there is a collaborative information sharing process so that no child’s immunizations are missed. Sharing the immunization record information must comply with policy and procedures of the various organizations and with Personal Health Information Act.

The Children and Youth Services Division of the Department of Children, Seniors and Social Development and the Public Health Division of the Department of Health and Community Services have the child’s health and wellbeing as their primary consideration. We hope this letter will start the process of ensuring timely immunization of these children to minimize the risk of preventable diseases.

Thank you for your attention to this matter. Looking forward to discussing further.

Sincerely,

[Signature]

Janice Fitzgerald, MD MPH
Regional Medical Officer of Health
Information Note
Department of Health and Community Services

Title: Review of Automobile Insurance in Newfoundland and Labrador

Issue: To inform the Minister of the findings of the Board of Commissioners of Public Utilities’ “Review of Automobile Insurance in Newfoundland and Labrador” released on January 31, 2019.

Background and Current Status:
- The Board of Commissioners of Public Utilities (PUB) is an independent administrative tribunal which has responsibility to regulate aspects of the NL automobile industry, such as automobile insurance rates and underwriting guidelines, through the Public Utilities Act, the Automobile Insurance Act, and the Insurance Companies Act.

- The NL automobile insurance industry operates in a tort-based system, similar to most provinces, in which an injured party may seek losses from the driver who caused the accident. This is in contrast with “no-fault” systems seen in Manitoba and Quebec, where injured parties are compensated based on their level of damages, regardless of who caused the accident.

- Automobile insurance is provided through private insurers with PUB-approved rates, including a maximum $2500 deductible for pain and suffering damages. 98% of total premiums are written by 15 insurers.

- The Facility Association is an unincorporated non-profit organization of all automobile insurers, and was established as the insurer of last resort for owners or drivers who are unable to obtain coverage elsewhere. The Facility Association insures 95% of NL taxis.

- On August 9, 2017, the Provincial Government directed the PUB to review and report on a number of issues with respect to automobile insurance in NL, including the reasons behind increasing claims costs for private passenger vehicles and taxi operators, and options to reduce these costs.

- Throughout the review period, the PUB engaged the public, organizations that participated in the 2005 Automobile Insurance Review, taxi operators, and other organizations through the PUB website, direct correspondence, personal meetings, and public hearings.

- The PUB released its report on January 31, 2019 which included the following findings:
  o NL consumers pay 35% more, on average, for private passenger automobile insurance than consumers in the Maritimes, primarily due to higher bodily injury claims costs. Bodily injury costs represent about 47% of total claims and have increased from an average of $318.57 per private passenger vehicle in 2006, to $414.48 in 2017, which is 50% higher than the next highest average cost for bodily injuries in Atlantic Canada.
  o NL has the highest rate of uninsured automobile claims in Atlantic Canada.
  o Even with higher premium levels, the total premiums paid between 2012 and 2016 were not sufficient to cover insurance industry costs.
  o The deductible implemented in NL in 2004 was less effective in controlling bodily injury costs than the minor injury caps introduced in the other Atlantic provinces at that time.
Industry generally supported the introduction of a $5000 cap on pain and suffering damages for minor injuries, while the Government-appointed Consumer Advocate for the review supported an increase in the maximum deductible from $2500 to $10000.

Neither the implementation of a cap nor an increased deductible are expected to result in rate decreases for consumers, in the absence of additional reform measures such as:
- Assigning license plates to individuals, and/or verifying automobile insurance coverage through Motor Registration, to reduce the number of uninsured drivers;
- Implementing accident prevention initiatives, such as mandatory winter tires;
- Streamlining the claims adjustment and settlement process;
- Changing the classification and definition of "mild and minor" injuries;
- Reviewing and adjusting the Facility Association’s underwriting guidelines for taxis to recognize good driving records or other taxi industry risk reduction measures;
- Taking measures to prevent fraud; and,
- Reviewing insurance taxation.

NL has the lowest Accident Benefits coverage limits in Atlantic Canada, and is the only province in Canada where this coverage is not mandatory. Implementation of such would impact premiums, but would also provide better benefits for claimants.

Implementation of minor injury diagnostic and treatment protocols would likely increase premiums for Accident Benefits but would also provide claimants with immediate access to evidence-based treatment on a pre-approved basis so they can recover quickly.

Analysis:
- Royal Newfoundland Constabulary (RNC) data shows that the number of vehicle accidents in NL decreased by over 20% between 2012 and 2017, partly as a result of the RNC’s education, awareness and enforcement efforts to improve road safety during that time.

- Injury prevention falls within the mandate of the Department of Children, Seniors and Social Development (CSSD), however, road safety is not a current focus of its work.

- Service NL and the Department of Transportation and Works (DTW) are jointly responsible for the Highway Traffic Act, which provides the legislative framework for drivers’ insurance requirements and highway safety.

- The Provincial Government has announced and implemented several legislative amendments since September 21, 2017 to deter unsafe driving, including amendments related to: impaired driving, excessive speeding, vehicle modification, and distracted driving.

- Affordable and accessible transportation is a social determinant of health, as this can impact opportunities for education and employment as well as access to programs and services. Many students, families, and people living with low incomes and/or disabilities, rely on public transportation and/or taxi services, due to the high cost of vehicles and related insurance.
• Through the new Public Health Governance Steering Committee, HCS will encourage CSSD to engage in road safety initiatives in collaboration with Service NL, DTW and the RNC.

Prepared/Approved by: D. Howse/M. Harvey/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

February 21, 2019
Information Note
Department of Health and Community Services

Title: Emergency room visits by residents of the Botwood catchment area

Issue: To provide an update on the number of visits by residents in the Botwood catchment area to the emergency rooms in the Dr. Hugh Twomey Health Centre in Botwood and the Central Newfoundland Regional Health Centre in Grand Falls-Windsor.

Background and Current Status:
- Prior to June 15, 2016, the Dr. Hugh Twomey Health Centre (DHTHC) in Botwood operated a 24 hour emergency room (ER) service. The DHTHC served a catchment area of 9,155 residents in 12 communities.
- During 2015, there were 10,051 visits to the Botwood ER, with 87 per cent of these occurring from 8 am to 8 pm. The 1,312 visits during 8 pm to 8 am averaged three or four visits each evening.
- It was acknowledged that this was an inefficient use of resources and Central Health (CH) proposed a reduction in service hours to address deficit pressures and to increase efficiency.
- On June 15, 2016 CH reduced the ER at DHTHC from a 24-hour service to an 8 am to 8 pm service with after-hours diversion of emergency clients to the ER at the Central Newfoundland Regional Health Centre (CNRHC) in Grand Falls-Windsor.
- The distance between Botwood and Grand Falls-Windsor is approximately 42 kilometers, or a 30 minute drive.
- ER registration data for the calendar year 2018 continues to support the 2016 decision to reduce the service hours at DHTHC.
- The following table summarizes the number of visits, at each ER, by community.

Table 1:

<table>
<thead>
<tr>
<th>Community</th>
<th>2016 Population*</th>
<th>Dr. Hugh Twomey Health Centre (DHTHC)</th>
<th>Central Newfoundland Regional Health Centre (CNRHC)</th>
<th>Total Visits</th>
<th>% of total visits to DHTHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Travel Time to Botwood (Minutes)</td>
<td># Seen 8am - 8pm</td>
<td>% of Total Seen</td>
<td>Travel Time to GF-W (Minutes)</td>
</tr>
<tr>
<td>Botwood</td>
<td>2,875</td>
<td>0</td>
<td>4,508</td>
<td>57.9%</td>
<td>28</td>
</tr>
<tr>
<td>Bishop's Falls</td>
<td>3,156</td>
<td>19</td>
<td>206</td>
<td>2.6%</td>
<td>11</td>
</tr>
<tr>
<td>Cottrell's Cove</td>
<td>123</td>
<td>63</td>
<td>106</td>
<td>1.4%</td>
<td>85</td>
</tr>
<tr>
<td>Fortune Harbour</td>
<td>78</td>
<td>71</td>
<td>83</td>
<td>1.1%</td>
<td>93</td>
</tr>
<tr>
<td>Glover's Harbour</td>
<td>92</td>
<td>50</td>
<td>15</td>
<td>0.2%</td>
<td>72</td>
</tr>
<tr>
<td>Leading Tickles</td>
<td>292</td>
<td>54</td>
<td>216</td>
<td>2.8%</td>
<td>75</td>
</tr>
<tr>
<td>Northern Arm</td>
<td>426</td>
<td>3</td>
<td>352</td>
<td>4.5%</td>
<td>31</td>
</tr>
<tr>
<td>Peterview</td>
<td>828</td>
<td>9</td>
<td>1,076</td>
<td>13.8%</td>
<td>27</td>
</tr>
<tr>
<td>Phillips Head</td>
<td>151</td>
<td>18</td>
<td>152</td>
<td>2.0%</td>
<td>39</td>
</tr>
<tr>
<td>Pleasantview</td>
<td>43</td>
<td>37</td>
<td>17</td>
<td>0.2%</td>
<td>59</td>
</tr>
<tr>
<td>Point Leamington</td>
<td>591</td>
<td>27</td>
<td>470</td>
<td>6.0%</td>
<td>49</td>
</tr>
<tr>
<td>Point of Bay</td>
<td>154</td>
<td>25</td>
<td>125</td>
<td>1.6%</td>
<td>47</td>
</tr>
<tr>
<td>Other Communities</td>
<td></td>
<td>464</td>
<td>6.0%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Dept of Finance, 2016 Census Data
Analysis:
- The number of residents reported in the 2016 population census for the Botwood catchment area is 8,809, a decrease of 346 people from the 9,155 identified in the 2011 population census.

- The number of after hour (8 pm to 8 am) visits to CNRHC by residents of the Botwood catchment area during 2018 is 1,497, an average of four visits per evening. If the evening visits for residents of Bishop’s Falls (786) is removed from the total annual visits (1,497), this reduces to 711 annual visits, or approximately two per evening.
  - Residents of Bishop’s Falls are closer to CNRHC, and more likely to present at that facility rather than at the DHTHC.

- As can be seen in Table 1, more than 83 per cent of all ER presentations for the residents of the Botwood catchment area are made at DHTHC, with the exception of residents of Bishop’s Falls who are closer to CNRHC.

- The data from 2018 supports the 2016 CH recommendation that ER service from 8 pm to 8 am is not required at the DHTHC as residents of the Botwood catchment area are accessing ER services from CNRHC as needed.

Action Being Taken:
- HCS will continue to monitor ER services at CNRHC by residents of the Botwood catchment area during the hours of 8 pm to 8 am to ensure service needs of residents are being met.

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

February 21, 2019
Information Note  
Department of Health and Community Services

Title: Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Review of Provincial and Territorial Policies

Issue: On February 20, 2019, the Canadian Institute of Substance Use Research (CISUR), the Centre for Addiction and Mental Health (CAMH) and other public health experts released the report “Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Review of Provincial and Territorial Policies”.

Background and Current Status:

- This report provides a comparative review of the implementation of provincial and territorial policies proven to reduce the considerable health and social harms from alcohol. The intended purpose of the report is to encourage provinces and territories to establish effective alcohol control policies and programs.

- The report states that alcohol is the most popular recreational drug used in Canada. It was estimated that in 2014 there were 14,800 deaths and 88,000 hospitalizations attributed to alcohol across Canada, substantially higher than the 4,500 deaths and 21,900 hospitalizations attributed to all illicit drugs combined in that year (Canadian Substance Use Costs Harms Report, 2018).

- The estimated economic cost of alcohol in 2014 for healthcare, policing, lost productivity and other areas was $14.6 billion, substantially higher than net revenues brought in from alcohol sales ($10.9 billion) and more than the costs of any other psychoactive substance, including tobacco.

- NL’s per capita alcohol consumption (for age 15+) was 10.1L of absolute volume for total per capita sales. This was the third highest rate in the country, with Yukon Territory at 15.0L and Northwest Territory at 12.8L. The average rate for the 10 provinces was 8.9L.

- Based on an extensive international literature review, there were 11 policy domains that were reviewed and demonstrated direct or indirect impact on alcohol consumption and related harms.

<table>
<thead>
<tr>
<th>Direct Impact on Alcohol Consumption and Related Harms</th>
<th>Indirect Impact on Alcohol Consumption and Related Harms by facilitating the direct domains</th>
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</thead>
<tbody>
<tr>
<td>• Pricing and Taxation</td>
<td>• Type of Alcohol Control System</td>
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<tr>
<td>• Physical Availability</td>
<td>• Existence of a formal provincial/territorial Alcohol Strategy</td>
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<tr>
<td>• Impaired Driving Countermeasures</td>
<td>• Monitoring and Reporting of alcohol harms</td>
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<tr>
<td>• Marketing and Advertising Controls</td>
<td>• Health and Safety Messaging about alcohol.</td>
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<td>• Minimum Legal Drinking Age</td>
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<td>• Screening, Brief Intervention and Referral</td>
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<td>• Liquor Law Enforcement</td>
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Table 1: Policy Domains for Alcohol Policies
• Each jurisdiction was evaluated on each of these domains. For each domain, the score was based on two dimensions: (i) the strength of evidence for effectiveness in reducing harms from alcohol, and (ii) the scope or population reach of the domain i.e. the extent to which implementation of a policy has the potential to reach all those affected by alcohol-related harms.

• The weighted domain scores were then summed to obtain a total weighted policy implementation score for each jurisdiction. Letter grades ranging from an A+ (highest score) to an F (lowest score) were also applied to further highlight the current performance of the provinces and territories in each policy domain.

• Across all 11 policy domains, jurisdictions collectively achieved less than half (43.8%, Grade F) of their potential to reduce alcohol-related harm through the use of evidence-based policies. The national policy implementation score, assessed across all Canadian jurisdictions, was slightly lower than in 2012 (43.8% vs 47.7%) suggesting some erosion of alcohol control initiatives over the intervening years.

• Two provinces, MB and QC, achieved higher scores than in 2012, while NL, NB and ON had lower scores.

• Across each of the 11 policy domains, scores varied substantially. Minimum Legal Drinking Age achieved an average grade of Grade A (85.9%) being the highest and Health and Safety Messaging with a Grade F (34.2%) the lowest.

• NL was rated as a "best current practice leader" in the following policy domains:
  o Pricing and Taxation (minimum pricing for off-premises sales). This is one of the most influential policy levers to reduce alcohol-related harms;
  o Impaired Driving Countermeasures (zero Blood Alcohol Concentration (BAC) limits for new drivers, ignition interlock programs for re-licensing, vehicle impoundment for all drivers with 0.05% BAC, and licensing suspensions); and
  o Minimum drinking age at least 19 years.

• NL scored the lowest grade of all provinces and territories in the domain of physical availability, which includes indicators such as the number of outlets and licensed establishments, hours and days of sale, and regulating availability within the establishment. Outlet density is associated with drinking levels in the local population. There is also a positive relationship between the density of both on-premise and off-premise outlets and alcohol-related harms such as violence and injuries, including assaults, alcohol-related accidents and suicide, as well as public disturbances.

• The report also reviewed the Federal Government's policy potential regarding policies and strategies. It was found that the Federal Government was only reaching a third of its full policy potential and encouraged the Federal Government to consider their role in each of the policy domains. Examples provided included increasing alcohol excise taxes, standardizing the minimum price per standard drink, updating the CRTC advertising code, developing a national alcohol policy, and developing a national Alcohol Act.

Analysis:
• According to the report, there has been an increase in the harms and economic costs of alcohol use in Canada and a weakening of effective alcohol policies over the past decade.
The authors attributed the decline in attention to alcohol policy to the emerging issues in addressing tobacco control, the response to the opioid crisis and new cannabis legislation.

- In NL there has been significant work completed on the transformation of mental health and addictions services, however, the planning for a specific plan for alcohol (medium term Towards Recovery recommendation to be completed by March 2021) is in the beginning stages with the formation of a provincial working group.

- NL ranked 8th lowest of the 10 provinces in terms of the total weighted score across the policy dimensions. The national mean score was 47.2% and NL scored 44.2%. This report provides support for the provinces to strategically target the policy domains that have the greatest potential impact on alcohol-related harms.

- The economic cost of alcohol in Canada for 2014 was estimated to be $14.6 billion, while the net revenue from alcohol was only 75% of this amount at $10.9 billion. The overall alcohol-related harms cost (2014) for NL was $276M, while the net revenue from alcohol for NL in 2014 was $248M. Across the country, the costs of alcohol-related harms exceed the net revenues in each province and territory. This information provides substantial ammunition for the necessity of changes to alcohol-related legislation, policies and practices.

**Actions Being Taken:**

- The Promotion and Prevention Project Team under Towards Recovery is responsible for the development of a provincial action plan for alcohol. This plan will focus on promotion and prevention, as well as screening, brief intervention and referral (Recommendation #47). This plan will also include an alcohol policy. A multisectoral group has been established to lead this work. [s. 29(1)(a)]

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**Prepared/Approved by:**
D. Curtis/C. Simms/K. Stone

**Ministerial Approval:**
Received from Minister John Haggie, MD

**February 26, 2019**
Information Note
Department of Health and Community Services

Title: Update on Measles outbreak in Canada

Issue: To an update on measles outbreak in Canada and the prevention actions being taken in Newfoundland and Labrador (NL).

Background and Current Status:
- Measles is a highly communicable infectious disease. The virus is transmitted by the airborne route, respiratory droplets, or direct contact with the nasal secretions of an infected person. The incubation period is seven to 18 days. Fever usually develops ten days after exposure and a rash usually appears on day fourteen. Initial symptoms include fever, cough, runny nose, and red eyes (conjunctivitis). The rash can begin as flat red spots that appear on the face at the hairline and spread downward to the neck, trunk, arms, legs, and feet. The spots may become joined together as they spread from the head to the rest of the body.

- Complications of measles include ear infections, pneumonia, and inflammation of the brain (encephalitis). Two to three infected people out of 1000 die as a result of measles infection in developed countries.

- Measles disease can be prevented with vaccination. The NL immunization schedule offers two doses of the measles, mumps, rubella and varicella (MMRV) to all children at 12 and 18 months.

- Two doses of measles containing vaccinations have been offered to all people in NL born after 1983 (those currently 35 years old and younger). Children born 1965 to 1982 in NL have been offered one dose of measles containing vaccine. Due to prevalence of the disease prior to 1970, most people born before 1970 would have natural immunity.

- Two doses of the measles vaccine is 97 per cent effective at preventing measles.

- NL has the highest childhood vaccination rate in the county. The current vaccination rate for measles in NL is 95 per cent.

- As of February 15, 2019, the BC Centre for Disease Control (BCCDC) reported nine confirmed cases of measles. Seven of those nine cases were associated with a cluster of school outbreaks.

- The Government of Canada’s Measles and Rubella Weekly Monitoring Report showed two cases of measles in Ontario during week five (January 27 to February 2, 2019)

- Several countries in Europe have reported measles cases including nine countries involving outbreaks of 1000 or more cases.

- The United States Centers for Disease Control and Prevention have reported 127 cases of measles from January 1, 2019 to February 14, 2019 in 10 states. There is an ongoing outbreak in Washington state with 65 cases as of February 21, 2018.

- As of February 21, 2019, there are no confirmed cases of measles in NL for 2019.
There were cases reported in NL in 2017, both cases were linked to an outbreak. One of those cases was never vaccinated against measles and the other had an unknown vaccination status.

Prior to 2017, the last reported measles cases in NL was in 1997.

To protect the population if we do have a case or cases of measles, the NL communicable disease policy states that susceptible contacts to a confirmed measles case may be excluded from childcare, school or work at the direction of the MOH. Susceptible contacts can include those that are not fully immunized or do not have laboratory evidence of immunity.

While there have been no measles confirmed test results in NL since 1997, testing does routinely occur if patients present with symptoms similar to measles and after consultation with an MOH. On February 20, 2019, specimens were sent to the National Microbiology Laboratory in Winnipeg, Manitoba. Polymerase chain reaction (PCR) test results on February 26, 2019 were negative for measles.

In an interview with CBC on Wednesday February 20, 2019, a physician at Eastern Health mentioned that NL has a suspect case of measles.

Analysis:
- Vaccination is the most important way to prevent measles. NL’s high vaccination rate will help protect the population from this disease.

- Communication on the importance of vaccination is needed to protect not only individuals, but those around them who are not old enough to be vaccinated, have weakened immune systems, or have medical contradictions to the vaccine.

Action Being Taken:
- Public health staff in HCS and in the RHAs are continuing to monitor the measles cases nationally and internationally.

- A memo to physicians and nurse practitioners was sent from the Office of the Chief Medical Officer of Health on February 25, 2019 (annex A). The memo provides information on measles, measles vaccination, isolation criteria, and Public Health Laboratory guidelines for testing.

- Dr. Janice Fitzgerald, MOH, has reached out to occupational and health directors in each of the RHAs to determine vaccination status for health care workers and to remind them of exclusion criteria should someone have, or are suspected to have, measles.

- On February 20, 2019 Dr. Janice Fitzgerald, MOH, conducted a telephone interview with (CBC Here and Now) Katie Breen on measles and the importance of vaccinations. The
reporter asked about the suspected case reported earlier that day. Dr. Fitzgerald reported that we currently have no confirmed cases in the province and that we monitor and test suspect cases.

- On February 26, 2019 Dr. Janice Fitzgerald conducted a radio interview with the CBC Morning Show on measles and measles vaccination.

Prepared/Approved by: A. Tucker/Dr. J. Fitzgerald/M. Harvey/K. Stone
Ministerial Approval: Received from Hon. John Haggie, MD

February 26, 2019
Annex A: Memo to physicians and nurse practitioners

MEMORANDUM

TO: Physicians, Nurse Practitioners, CDCNs
FROM: Dr. Janice Fitzgerald, Regional Medical Officer of Health
RE: Measles Outbreak
DATE: February 22, 2019

Outbreaks of measles within Canada and United States have brought increased attention to this disease. At this time, we do not have an outbreak of measles nor any confirmed cases in our province.

Measles is a highly communicable infectious disease. The virus is transmitted by the airborne route, respiratory droplets or direct contact with the nasal secretions of an infected person. The incubation period is 7-18 days. Fever usually develops ten days after exposure and a rash usually appears on day fourteen. Some of the signs/symptoms of measles include:

- Fever
- Cough
- Coryza
- Conjunctivitis
- Koplik spots (white spots on the inner lining of the mouth)
- Macular or maculopapular rash that starts centrally including on the face, spreads to the limbs and lasts at least three days.

Complications of measles include otitis media, pneumonia, blindness, and encephalitis.

Measles during pregnancy results in a higher risk of premature labour, spontaneous abortion, and low birth weight.

Individuals at higher risk for contracting measles include:

- those with incomplete immunization against measles
- those who have travelled to an area with endemic measles or measles outbreaks (updates available on the Public Health Agency of Canada and US Center for Disease Control websites)
- health care workers
- students (especially those living in dormitory settings)

Measles is a notifiable disease. Investigation of suspected measles is important in a highly immunized population, like our province. If an individual at risk for contracting measles presents with clinical symptoms suggestive of the disease, please ensure the following actions:
- Notify the Medical Officer of Health on call (1-866-270-7437) and be prepared to discuss symptoms, immunization status, travel history, and identify contacts.
- Exclude the suspected case from school, work and group activities for 4 days after rash onset.
- Follow the Public Health Laboratory guidelines for testing. Viral PCR, through nasopharyngeal swab and urine samples, is recommended for measles diagnosis. Measles serology can be helpful; however, IgM and IgG acute and convalescent serology can be difficult to interpret for diagnosis, especially in those previously immunized.

The population of Newfoundland and Labrador has a high rate of immunization against measles. Those born in 1983 or later have been offered two doses of measles-containing vaccine. Individuals born before 1970 are considered to have acquired natural immunity, even if they were not vaccinated. Those born after 1970 are recommended to have two doses of MMR. Individuals who have received two doses of measles, mumps, and rubella (MMR) vaccine or MMR-varicella (MMRV) vaccine are considered immune.

Individuals who would like to verify their vaccination history can contact their regional public health office.

Public Health Agency of Canada website:

Center for Disease Control (US) website:
https://www.cdc.gov/measles/cases-outbreaks.html

Thank you