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COMMITTEE

ON

HEALTH

Thursday, March 14, 2019

LEGISLATIVE CHAMBER

Systemic Challenges to Our Emergency Care System

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In Attendance:

Ms. Judy Kavanagh
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Chief Legislative Counsel

Ms. Karen Kinley
Legislative Counsel

WITNESSES

Ms. Denise Perret, Deputy Minister, Department of Health and Wellness
Dr. Andrew Travers, Provincial Medical Director, Emergency Health Services
Mr. Larry Crewson, Director, Emergency Health Services
Mr. Tim Guest, Vice-President, Integrated Services
Mr. Jeff Fraser, Director, Provincial Operations, Emergency Health Services, EMC
Ms. Paula Poirier, Chief Operating Officer, EMC
Mr. Terry Chapman, Business Manager, IUOE Local 727
Mr. Mike Nickerson, Business Agent, IUOE Local 727

House of Assembly
Nova Scotia

HALIFAX, THURSDAY, MARCH 14, 2019

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

THE CHAIR: Good morning everybody. I'd like to call the Standing Committee on Health to order this Thursday, March 14th. This is the Standing Committee on Health and I would like to ask that the committee members and witnesses introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: Today we're here to hear from witnesses regarding systematic changes to our emergency care system. I would like to remind everybody to please turn off their phones or put them on vibrate. Just a reminder that when the red light comes on, that's when Hansard will record you.

We'll start with opening statements from our witnesses, beginning with Deputy Minister Perret.

DENISE PERRET: Good morning. We appreciate the opportunity to be here and speak on the issues of the systemic challenges to our emergency care system. As you all know, as we all know, the issues are complex and they're long-standing. These are issues that are challenging health systems across the country. What we have in Nova Scotia is a very strong foundation to build on, and some very good work on the issue that's gone before us.

You have four key organizations here today. We're all working together for positive change on this issue, and I want to briefly touch on each group.

IUOE, the union representing paramedics, are here and it's good to see them. I'm a come-from-away and I know that where I come from, we've all looked to Nova Scotia and its organization of community paramedicine and paramedic program - it's internationally recognized. It is a system of excellence.

In working with health professions over the years, it's my experience that paramedics are one of the most progressive and collaborative health professions. I've had wonderful experiences with them and they are often at the forefront of addressing some of the complex issues in the health system, and we have many examples of how they have done that in Nova Scotia. I think it is really excellent that we have Terry Chapman and Mike Nickerson here on behalf of their members to provide us with important information that informs the path forward and prompts us to action.

We also have EMCI here and I'm glad to see them here. They're one of our partners in the health care system and they have responsibility for managing and operating ground and air ambulance, TeleHealth, and the medical communications centre in Nova Scotia. EMCI delivers important emergency health programs to Nova Scotia through their staff of paramedics, nurses, medical communications officers, and support staff.

As well as ensuring that we have an emergency response system that never sleeps, they are leaders in helping to advance community paramedicine; important programs that ensure our health care system is adaptable and agile.

Community paramedicine programs see paramedics function outside their traditional emergency response and transport roles, to help facilitate more appropriate use of emergency care resources and to enhance access to primary health care.

I'm also glad that Tim Guest could join us from the Nova Scotia Health Authority. I know he's an extremely busy person. NSHA, as everyone knows, is our primary service delivery partner. It operates the province's emergency departments. With the consolidation of the health regions we benefit from NSHA's ability to draw upon province- wide resources and experience to provide and inform care, and NSHA has been very active and proactive on advancing the provincial system of emergency care.

The Department of Health and Wellness is the fourth organization here. We are the policy arm of the system and we benefit from the leadership and advice of people like Dr. Travers, our Emergency Health Services Director, and Larry Crewson, our EHS Director.

The Minister of Health and Wellness is charged under the Health Authorities Act with providing leadership for the health system in setting strategic policy direction and priorities. I can tell you that he has been focusing all of us on the needs of the emergency care system and the current need to address the ambulance off-load issue.

Over the past number of months, the minister has facilitated a very collaborative effort that I think has us all well informed, energetic, and very focused on the work that needs to be done.

We know there are significant pressure points in the emergency care system, but we also know we have the benefit of dedicated and skilled health professionals and managers, as represented here, who recognize the need for systemic change, who continue to step up every day to address the challenges facing the system and are truly leading change. It is a true privilege to be able to work with these people and organizations.

I look forward to the discussion this morning.

THE CHAIR: Thank you very much, Deputy Minister Perret. Next, we have Paula Poirier.

PAULA POIRIER: I would like to thank the members of the committee for the invitation to attend today and for the opportunity to speak to the important role that EHS and our team plays in emergency care and the overall health system. We proudly employ over 1,300 paramedics, nurses, communications officers, leadership, and support staff. These highly trained professionals work in the EHS system: the medical communications centre, the LifeFlight program, ground ambulance services and, as well, in several innovative community paramedicine integrated health programs. In all of these roles, EHS clinicians deliver quality, safe care to Nova Scotians each and every day.

EMC, which I'll refer to as EHS operations, is a Nova Scotia company that has been a proud partner of the Province of Nova Scotia since 1997, when we assumed the role of managing and operating Nova Scotia's ambulance service under a new, standardized provincial emergency response system. Since then, we have continued to grow and expand our role in the health care system.

The EHS system is highly integrated and streamlined. We work closely with the Department of Health and Wellness and are partners at the Nova Scotia Health Authority, the IWK, medical first response agencies, and others, to continuously improve the services we provide. The EHS system is designed to be responsive to ebbs and flows in pressures on the EHS and the health care system. It expands, and contracts, based on call demand. Paramedic units fluidly move across communities, based on this demand.

By design, the EHS ambulance deployment plan is dynamic in nature and is continually moving. Our licensed paramedics, nurses, and communications officers are leaders in their communities and play a vital and evolving role in the health care system. They work closely with EHS medical first responders who respond to emergencies, in communities all across the province, to deliver initial pre-hospital care. Paramedics and nurses respond to emergency calls, providing high-quality resuscitation, critical care, and supportive care. They are there for people when they are most in need.

The EHS system is patient-centric, collaborative, and strives to be innovative. The following programs implemented have goals of providing excellent patient care and reducing patient volume in the health system. Paramedics work in collaborative emergency centres providing care to patients in rural communities, working in collaboration with the Nova Scotia Health Authority, nurses, and EHS physicians.

Extended care paramedics in Halifax are caring for seniors in nursing homes, in collaboration with long-term care staff, to safely treat patients in their homes, reducing unnecessary EHS transports to emergency departments, which in turn reduces pressure on the system.

Through our evidence-based paramedics providing palliative care at home, paramedics have been trained to provide palliative care in the comfort of the patient's own home, if that is their wish. Most recently, a community-based paramedic program launched in Cape Breton - here paramedics provide follow-up, non-emergency visits in partnership with other health care providers, nurses, and physicians.

EHS has been internationally recognized for its commitment to pre-hospital care and novel approaches to service delivery. EHS ground, critical care, and medical communications programs have all been accredited and re-accredited for many years. These independent accreditations provide external validation of the high-quality care provided by our EHS clinicians and how well-designed Nova Scotia's integrated provincial EHS system is.

Our clinicians, support staff, and leadership teams are highly committed to providing Nova Scotians with high-quality and safe emergency, critical, and supportive care.

As we know, there is a definite strain on the health care system and on emergency care, including extensive emergency department off-load delays. Our leadership team is adjusting and fine-tuning the EHS deployment whenever possible to ensure emergency coverage. EHS clinicians are working very hard to provide care, respond to calls, and provide coverage in this demanding setting.

Due to off-load challenges, paramedics are at times spending their entire shift waiting in the emergency departments with limited breaks, increased overtime, and provider fatigue. EHS operations have implemented a number of initiatives to help alleviate some of these challenges: adding unit hours within the system, increasing the paramedic staffing numbers, collaborating with the Health Authority for policy that directs low-acuity patients to be transferred to triage staff - we refer to that as "direct to chairs" policy - adding a dedicated transfer coordinator to the EHS medical communications centre to improve efficiency of patient flow and EHS transfers, redesigning the operations leadership model to ensure more support is available for staff, and putting an internal hours-of-work policy into play to help ensure patient safety and staff well-being.

I'd like to re-emphasize that EHS operations is fully committed to working with our partners at the Department of Health and Wellness, the Nova Scotia Health Authority, the IWK, and as well, obviously, IUOE to help implement solutions to help improve emergency care and patient flow.

We will work closely and collaboratively with the Health Authority in the coming weeks to implement strategies to transition the care of our patients from our paramedics to receiving emergency department clinicians and other health staff. These strategies will improve patient care and safety for transporting EHS patients, and it will enable paramedics to clear from emergency departments more quickly and return to service in order to provide emergency coverage and response.

We are confident these solutions will bring immediate relief to the EHS system. We look forward to working with our partners to help position the health care system for success.

On behalf of our team, I want Nova Scotians to understand that even with the high pressure and demands on the EHS system and the health care system, they're covered. When help is needed and people call 911, an EHS paramedic crew is dispatched immediately. EHS communications officers provide directions and support to callers on the phone while paramedics are responding. Those who require the EHS system for emergencies will receive an EHS response.

EHS paramedics, nurses, communications officers, leadership, and support staff work very hard each day within this busy and complex system to provide excellent pre-hospital and critical care to Nova Scotians. We would like to sincerely thank all our staff for the continued support, commitment, and dedication to the EHS system and the patients we serve.

Thank you for your time.

THE CHAIR: Thank you, Ms. Poirier. Next is Mr. Chapman.

TERRY CHAPMAN: Good morning. My name is Terry Chapman, and I'm the CEO and Business Manager of the union that represents ground and air ambulance paramedics and registered nurses.

Ms. Poirier's opening comment doesn't leave a lot to the imagination, but I would first of all thank everyone for the day, for the opportunity to be heard, and for the opportunity for our members, who are the paramedics who turn the wheels and help unwell people in their daily issues and ongoing through their life issues with their families.

Since this program started in 1995 and 1997 with EMC, Emergency Medical Care Inc., our issue has always been that we need to understand that safety and wellness is the driver for all of the people every day. It's not simply something that we can go to work and

be unwell and unsafe on one day, and then say it's okay to be unwell and unsafe on Wednesday because Thursday is going to be better.

Since the issue as we understand it with off-load delay and all of the fallout from that - the overtime, the missed meals - and by overtime, when Paula spoke to spending an entire shift in a hospital, that also leads to four to six hours overtime after release and getting home to where you started the day. Paramedics are missing their meals. They're routinely not at home when they should be. They have family commitments. Our position on this with fellow and sister stakeholders is that we all recognize that we, as a group and this body in this House, need to fix this.

[9:15 a.m.]

It's nice that we can have standing forums, and we do appreciate this very much. Recently with the Health and Wellness Minister committing to work with us and showing us that by inviting us several times, it gives us some hope that there will be a remedy to this, but the remedy needs to be driven and it needs to not be delayed. Our members, on a daily basis, are fatigued to the point where they just go home, and some of them don't want to go to work again, when some of the members being the ones who have more of a committed history with the employer as a paramedic, I realize it's their job to be a paramedic, and it's their job to sometimes have inherent overtime, and they realize that sometimes they won't be home to pick their children up from daycare now and then, but this isn't what they signed on for.

This isn't a program like others where there's a guaranteed point of wellness at the end of the day. Most people - and no disrespect to those who can - go to work, they get a break, they get a lunch break, they eat their food, they go back to work, and they go home. They're not hungry and malnourished for the day and overtired from the day before.

Mr. Nickerson and I are here to hopefully answer any questions we can and impress upon your committee the need for this and the need for wellness. Within the total scope of the four combined units that are stakeholders in this within the province, our position and our responsibility to some people seems small. We have the position to represent not just the day-to-day union "give us money, give us time off, give us vacation" issue.

This for us is not only a program that causes unwellness as it's run now, but publicly we've also stated that, in our opinion, it's also a public safety issue. When you can't get an ambulance to a person who needs one in the amount of time that in 1997 was directed at being approximately eight minutes and 59 seconds, and now it's hours in some cases, that's a public safety issue. It needs to be addressed.

Again, Mr. Nickerson's and my position, and it's the union position, is that seems small in the grand scheme of things, if you look at the numbers and the values of all the components of the stakeholders, because we only have a concern for the wellness component and for the public issue.

The other concern, while we do have the off-load delays - specifically, how it's not functioning very well - is not our forte. That's what we rely upon all these other people for. That's what we hope you people will help direct. Even though our number is small, and we look after about 1,000 people as members - what I meant by our issue is small, sometimes it's looked at as, well, you're not the big fish in the pond. If you're looking at off-load delays across the province and the hospitals and the systemic issues that cause off-load delays, then out of 1,000 people who turn the wheels and pick up sick and injured people, that's a small number, but to us it's not small. It's no smaller than any other of the components that cause the issue.

Having said that, I'm hopeful that somehow through the event today and working in the future with government, other stakeholders, Dr. Travers' programs, the employer, EMC Medical Care Inc., we can all become one fix to a problem that is critical. It's systemic. It cannot continue, and it's going to reach a critical mass, and people are going to suffer from it.

Having said that, thank you. I'm appreciative of being here.

THE CHAIR: Thank you very much, Mr. Chapman. Mr. Nickerson.

MIKE NICKERSON: Thank you, Mr. Chairman, committee members, fellow witnesses. My name is Michael Nickerson and I'm the President of IUOE Local 727, the union that represents Nova Scotia paramedics and LifeFlight RNs. Before that, I was a paramedic for 18 years. I know what our paramedics are facing, and it's time we worked together to find a solution.

Paramedics in Nova Scotia are some of the most highly-trained and skilled paramedics in North America, as we heard from Ms. Poirier. They should not have to wake up in the morning and face the constant risk of missed meals, back injuries, shift overruns, and off-load delays. Our paramedics are incredibly adaptable and they're doing the best they can in a broken system, but enough is enough. Paramedics are tired, they're hungry, they're feeling the pressure of a busier and busier system that they work in day and night to keep our communities safe, and they aren't getting the respect that they deserve.

We don't pretend to have all the answers, and we know that there is no quick fix to this problem, but we also know that something needs to be done and it needs to be done now. We have asked over and over again for a meeting with everyone involved to try to find a solution, and that still hasn't happened until now.

Thank you for having me here today. I hope that what I have said really resonates with you, because something desperately needs to be done and the solution won't be found behind closed doors and in hushed meetings. Thank you.

THE CHAIR: Thank you all very much for your opening statements. We'll start with 20 minutes per caucus and we will try to wrap up at about 11:50 a.m., if we can.

So opening up with the Progressive Conservatives, Ms. Karla MacFarlane.

KARLA MACFARLANE: Around 11:50 a.m. or 10:50 a.m.?

THE CHAIR: I'm sorry - 10:50 a.m.

KARLA MACFARLANE: I would love to have 11:50 a.m.

THE CHAIR: I don't want to get you guys going - couldn't sneak that one by, could I?

KARLA MACFARLANE: Welcome, and thank you for your comments. We are listening. They are meaningful.

There are good things happening in our health care system. We don't deny that, but we definitely are here today because there is a crisis happening in our emergency rooms. I think there is one common denominator, though, that we can all agree on, and that is that we want to fix it and that we are concerned for public safety. We can't delay this any further. We really, really can't.

Going forward with questions, I would like to start with Mr. Chapman or Mike Nickerson. Either one of you, feel free to answer.

We have been paying close attention to what's been happening with Code Critical, the campaign that's on social media. I'd just like to know a little bit more. When did this start, what were the reasons the campaign was initiated, what are you actually trying to highlight, and more importantly, what would it take to end this campaign?

MIKE NICKERSON: Thanks for the question. Code Critical started a year ago this past February. It was to highlight the lack of available ambulances in certain areas throughout the province, just to make the public aware, because like we say, we view it as a public safety issue. Our hope was that the public would go to their elected representatives and have the discussion with them to bring it to the floor of the Legislature and try to find some remedies.

To end it, I guess we need to start having discussions, as we have been saying all along, so today is a good start. We are going to keep Code Critical going, though. If we can see some definitive results or action being taken by the government that will fix some of these issues - off-load delays and the inherent shift overruns of our members - then Code Critical may cease, but it's not going to anytime in the near future.

KARLA MACFARLANE: What would those conditions be in order to ensure that Code Critical would end?

MIKE NICKERSON: I think as long as the public safety is looked after and that there are available ambulances where they're supposed to be throughout the province, that would be when we would cease Code Critical.

KARLA MACFARLANE: Are you indicating that we need more ambulances and more paramedics?

MIKE NICKERSON: In the interim, absolutely, we do. I don't think that's a long-term fix, I think that's a short-term, but we do need that for our members because of everything that my colleague had said earlier. Our medics are just, they're run off their feet. They're missing meals; they're getting inherent overtime; shift overruns, anywhere from an hour to six hours, and it's just not safe.

KARLA MACFARLANE: I know that for the last few months, daily, I have heard from paramedics across this province. I actually apologize to your members because I can't keep up with responding, and I feel very guilty about that. I usually get back to people within 24 to 48 hours. Now, it's taking a few days because the requests and calls and emails from your members are very concerning, and I feel deeply for them.

I can't imagine being a paramedic in a situation where you're standing in a lineup of 15 ambulances waiting to off-load, because I know they deeply care, and they're there to fix situations; they're there to help and that's how the public views them. They're standing there, and they know there's other calls coming in that they can't get to, that actually may be more critical. We all know there have been situations like that.

With you having the opportunity though to speak to paramedics daily and to many of them, what are they telling you is the actual root cause of this crisis?

MIKE NICKERSON: That's a multi-faceted situation - I guess, the lack of acute care beds in the emergency departments. The off-load delays are probably the number-one issue that is causing all these other issues. I honestly think, if we can fix the off-load delays somewhat, then a lot of these other issues that our members are facing will fix themselves.

KARLA MACFARLANE: Acute care beds, long-term care beds as well, would you say, plays a part in that?

MIKE NICKERSON: I would think so. I'm not an expert in that by any means. Somebody else might be able to answer that, but I think long-term care beds would help, because then you could move patients out of the emergency department up to those floors that have patients that are waiting for long-term care.

KARLA MACFARLANE: We know we have a shortage of doctors. I know in Pictou West we have a big shortage. I don't have a doctor, my children, my father, there are many of us that don't - thousands actually, in Pictou County, that don't have a doctor. We hear quite often, too, that this could be a solution.

Do the paramedics feel that that would be a solution, more doctors as well in emergency?

MIKE NICKERSON: Yes, absolutely. I think any access to primary health care would definitely help the system, for sure. If people could get into a family doctor or a nurse practitioner, then they're not going to the emergency room. I think there's a lot of people that go to the emergency room that probably do not need to be there, but like you say, have no access to primary care.

KARLA MACFARLANE: As well, we recently heard that perhaps, we need to ensure that there are nurse practitioners in our emergency departments. Would that be something that would also alleviate some of the struggle within the emergency departments right now?

MIKE NICKERSON: I would think so. I'm not really familiar with the nurse practitioners.

KARLA MACFARLANE: Thank you. What kind of burden do you see is the lack of a fall prevention strategy putting on paramedics? I often hear from paramedics with regard to fall prevention.

MIKE NICKERSON: That might be a question for Mr. Fraser or Dr. Travers.

KARLA MACFARLANE: Sure.

DR. ANDREW TRAVERS: With respect to patients and falls, or providers and falls?

KARLA MACFARLANE: Patients.

[9:30 a.m.]

ANDREW TRAVERS: I think one of the examples, one of the innovations that we have in Nova Scotia is the falls referral program. We applaud the communities and the Health Authority for enabling paramedics to make referrals to a local Falls Clinic that occurs in the Truro and Bridgewater areas. That's the illustration of some of the innovations that we're trying to create for seniors and those patients at risk of falls. I think those types of examples could be applied in other areas of the province.

KARLA MACFARLANE: That situation in the accreditation report was seen as a failure, so what are we doing to improve that? It's actually "major high priority" in the accreditation report, so what improvements are we making with that?

ANDREW TRAVERS: I'm sorry, I'm not familiar with the accreditation report?

KARLA MACFARLANE: The Standards Set: Emergency Department - actually, I can table it if you would like a copy of it.

MS. BARBARA ADAMS: I've got a copy right here.

KARLA MACFARLANE: Okay, great. It's with regard to increasing a coordinated approach for fall prevention and ensuring that it's implemented. Have we made improvements with that?

ANDREW TRAVERS: Respectfully, you should probably direct that question towards the NSHA as it's sort of a reflection of the ED accreditation standards.

KARLA MACFARLANE: Okay. Could someone answer? What changes and improvements are we making with that? Mr. Guest.

TIM GUEST: Certainly, we've made a lot of effort to deal with any of the recommendations that came out of the accreditation process, when we were surveyed last time. We've reported significant data back to Accreditation Canada on our achievement.

I think it's worth noting that any of the activities that we do related to falls, and our survey, wouldn't have any implication related to the ambulance service. They would only be reflected on any fall-related activity that would happen within one of our facilities.

KARLA MACFARLANE: I'd like to go back actually to Mr. Nickerson and Mr. Chapman. I'm curious, are we seeing a gain in paramedics over the last few years, or a decrease?

MIKE NICKERSON: I believe we're seeing an increase. Again, that's probably a question for the employer, but I think we're seeing an increase in paramedics.

KARLA MACFARLANE: I understand paramedics do not have coverage for the same benefits as a lot of other health care workers. Can you explain the difference and the difference compared to other provinces?

TERRY CHAPMAN: Could you be more clear with the question, in that they don't have benefits equal to?

KARLA MACFARLANE: I understand that they have to pay quite a large sum out of their pays to have coverage for their own health care and long-term disability, short-term disability.

TERRY CHAPMAN: Through a Manulife program, yes, it's an employee-pay program.

KARLA MACFARLANE: Others co-share. Are there concerns from your members with making changes to that?

TERRY CHAPMAN: Yes. More recently than in the past. They have, to us, posed the question: What can we do about this and what can we do with this? I guess the question more recently reflects a decrease in their pay or in what they assume should be their pay, and, in part, the reason is that with the cost of working and the cost of the Manulife program, which would be any other program, $270 to $300 a month for some people.

When Michael and I worked out statistical value to one paramedic's pay over a two week period, and then bridge it over several other periods, and it turns out that if you actually make a comparison into the cost of health care, the cost of that program where it increases on its own annual basis up to 21 per cent each time, that if you want to look at it like we do now, paramedics are paying to go to work.

The question is more prevalent now and to ask if we actually have plans to approach that, it hasn't been tabled with anyone yet, but because of the need for it and also the need for wellness, and there has to be some bridge program, we - I've committed actually, to our members in general, and Michael and I have had discussions on perhaps in the very near future that we'll look at what programs are available as bridge programs that are equal to or sufficient and don't cost as much money or can be funded otherwise.

KARLA MACFARLANE: Okay, thank you. With regard to the availability of ambulances, I've also heard that there are concerns that sometimes they feel that they're a taxi service, that they're transporting individuals who are going from perhaps a long-term care facility to the hospital for dialysis, for a checkup. I'm just wondering: Do you believe that there's an opportunity for us to change that immediately and create a system where we find - you know, we don't want to say a taxi service - but perhaps we find another means to transport them so that we allow the availability of ambulances to be there for obviously those critical calls that are coming in?

TERRY CHAPMAN: I think any time that you can allocate an ambulance to a more proper service - and to be fair, Mr. Fraser and I way back in the early 1990s worked together. I am a career paramedic and have been one for a very long time, and actually, Mr. Fraser and I worked at the same ambulance service. So, we both understand that, on any given day, there will be what people assume to be perhaps the taxi service component of ambulance work but if, for those persons who are not critical or who are not emergent for any other reason, if they had a service that didn't impact the system status of emergency services vehicles, I would have to say that would take the load off. I would be, I guess, compelled to also make the comment that that does not mean that I support privatizing ambulance taxi ware.

KARLA MACFARLANE: Absolutely. Okay, thank you. I realize there is a pilot project happening in Cape Breton. I'm just wondering if perhaps, Paula - I remember your

first name, not your last name, sorry - if you could maybe give us an update on that, how it's working, and when do we plan to implement that across our province?

PAULA POIRIER: Actually, I'm going to pass that over to Jeff. From the operations perspective, he'll be able to articulate that for sure.

JEFF FRASER: Thank you for the question. We began our program in Cape Breton in around December 11th and, often, as we do with new programs, we do them as a phased approach. These programs have to be patient-centred. There's not a lot of books you can take off the shelf that tell you how to design them and they have to be built in partnership. So, we're in phase one where we're taking referrals from the emergency department in Cape Breton Regional Hospital and we've just re-engaged with our partner at the Health Authority this week. They're ready to begin the discussions about moving the program into the next phase.

All the specialized programs that we've put together, the history has been, we've built these in phased approaches. You put them in place. You look at them to make sure they're hitting the mark, make the adjustments you need to make, and then you build on putting in the next one. Although sometimes we certainly like to do things faster, but to be patient-centred, it's important that we take our time as we move through these cycles.

KARLA MACFARLANE: With the implementation of that program, did you have to hire more paramedics for this to be initiated?

JEFF FRASER: Yes, we did. We hired existing paramedics in Cape Breton and it's one of the nice things about doing programs like this because it provides paramedics options that they didn't have before. As Mr. Chapman alluded to, when he and I started many years ago, there were very few options for paramedic programs to get into, so we hired from our existing ranks and then obviously we'll be backfilling those positions.

KARLA MACFARLANE: Okay, thank you. I'm wondering if someone could answer, probably with EHS or DHW: What is the status of the Fitch report with regard to sustainable emergency care? I believe it was supposed to be due to be released this winter and we haven't seen that report yet so we're getting a few calls with regard to that?

DENISE PERRET: Thank you for the question. The Fitch and Associates report is an important part of how the minister is responding to this issue. He wants a very detailed analysis of how the system is working and recommendations from the experts in the field. That report, I think you'll see it in the Spring of this year and the work is ongoing. We've seen them very active in both the interviewing and the reviewing of data in the system. I think it will be an important initiative for the people of Nova Scotia.

KARLA MACFARLANE: Who is actually working on the report? As you indicated earlier, you have four organizations here today - who is actually working on that report?

DENISE PERRET: The report is commissioned by the Department of Health and Wellness, but Fitch & Associates in compiling it then works with all our associations to do interviews and collect the data to do a thorough analysis of that.

KARLA MACFARLANE: I know my time is running short, but I feel I have time for one more question. I'm just wondering if you can give us some background on the ECP - the Emergency Care Practitioner - program, where is it currently based?

ANDREW TRAVERS: I am very excited about the Extended Care Paramedic Program. It's an initiative which saw over 920 patients in the calendar year last year, and in 90 per cent of the patient context kept those seniors safely at home in their long-term care facilities.

At present it is mainly structured out of the HRM and in partnership with the Infirmary, the Dartmouth General, and the Cobequid in the long-term care facilities that feed into those areas, but it is only in the Central Zone of the province.

KARLA MACFARLANE: So, when are we planning to expand beyond the Central Zone?

ANDREW TRAVERS: An excellent question, again following Mr. Fraser's recommendations that we build things in pieces, and as we develop those partnerships and networks of care we can begin to roll out those types of programs, so we're keen to continue those conversations with the Health Authority as to where those hot pockets are, to enable programs like that to exist.

KARLA MACFARLANE: Will we see any extension of this program within this year elsewhere in rural Nova Scotia?

ANDREW TRAVERS: As a physician, I always hope so. I would like to start tomorrow but the example being it is a phased approach, it does work well.

THE CHAIR: Thank you very much for the questions. We'll now move to the New Democratic Party, and Ms. Tammy Martin.

TAMMY MARTIN: Thank you so much and thank you everyone for being here. I'll start with my questions to Mike and Terry. From one union leader to another, I'm so happy that you are getting a voice to your concerns, so thank you for being here.

A few things I'd like to clarify from your last remarks, and I believe it was you, Terry, who said paramedics pay 100 per cent of your medical, so as a former NSHA employee, we paid 65/35. Are you saying there is no co-pay from your employer?

TERRY CHAPMAN: Not right now, but as I may comment, we do intend to - when it becomes an official comment to the employer - inform the employer that we will be looking perhaps for some bridge program or other program where that's no longer the case.

THE CHAIR: Mr. Nickerson.

MIKE NICKERSON: Just to add to that, the 100 per cent pay is for short-term and long-term; the medical plan is paid for by the employer.

TAMMY MARTIN: Okay, thanks for clarifying that.

Terry, I believe you also talked about - and I completely agree that we don't want to privatize any service, but in my years in the Cape Breton District Health Authority we had PTUs, patient transfer units, are they still out there for the non-emergent transfers?

TERRY CHAPMAN: Yes.

TAMMY MARTIN: Do they ever get used - or my understanding is that sometimes when we are at a Code Critical point, they are used for other than just transfers.

TERRY CHAPMAN: I think if you want the details or the specifics of that and how they are allocated when there is the requirement, I think that Mr. Fraser would best answer that.

THE CHAIR: Mr. Fraser.

JEFF FRASER: Thanks for the question. In our two cities in the province we have what I would refer to as a split production model, that is we have emergency ambulances in the Halifax region and we have emergency ambulances obviously in Cape Breton, but we also have these transfer units that you suggested.

For the most part, the transfer work we do is very predictable. We usually know by four o'clock today what our volumes are going to look like tomorrow. Allocating those crews to those vehicles which were not part of our emergency deployment plan allows us to move those patients freely between the hospitals.

There are occasions, because some of the units we have are multi-patient transfer units and they have the ability to transport two patients at one time, so we like to use those units if we have a major event where we are able to move the ambulances too. For the most part, we have a split production model and it is separate, and we do that on purpose, so we can take some pressure off the emergency system.

[9:45 a.m.]

TAMMY MARTIN: Back to Terry and/or Mike, do you see this Code Critical as just one result or one systemic issue as a result of the overall health care crisis in this province?

TERRY CHAPMAN: I think we understand it as everyone else sees it. Everyone who speaks with us, the people who see the Code Critical issue see it as the issue that might affect them. Perhaps it could be a fair statement to say that not everyone understands the intricacy of the models that need to be refined to cure it. It's easy to stand outside of the fence and look in and see all of the animals, but it's different than going in and being one of the animals. We are but one of the animals in the farmyard with all of the other ones - no disrespect - that all need to play together and play nicely and think and learn the program together, and then come to a solution to it.

TAMMY MARTIN: To that end, I would suggest, then, that on one of my last tours of the Regional Hospital ER in Sydney when there were 27 admits and numerous patients waiting for transfer to a long-term care bed and five ambulances lined up in the bay, had we had a significant investment in long-term care beds, then that would move the process through. When there is a stall, and you can't get patients moving, we can't get our ambulances in and out of the system.

TERRY CHAPMAN: On that the question of long-term care beds and whatever facilities might be constructed to put those in, any way that you can take the load from the ER and get it out of there so that there are available beds in the ER for our members to leave a patient behind and get back to the street, I think anything that would fix that would be at least a partial cure, whether it's long-term care beds or not. If long-term care beds - and again, Michael and I not being the authority or the principal for that - is a way to fix it, and it will be fixed, then I'm good for anything that anybody can come up with to fix it.

TAMMY MARTIN: How long typically does it take to get an ambulance?

TERRY CHAPMAN: That depends on the day. We don't see the daily CAD stats - we don't actually get that printed at the end of the day - that shows where they're muddled. We have a different procedure.

In 1997, when the performance-based contract was devised, there was a township requirement of 8 minutes 59 seconds from the time you pick up the phone and actually talk to someone until the ambulance is knocking at your door. Now that could be - we have actually seen one case that I witnessed in this city that was 58 minutes.

TAMMY MARTIN: Is that acceptable?

TERRY CHAPMAN: To me, it's not.

TAMMY MARTIN: Being from Cape Breton, I have known many instances where there have been zero ambulances available in CBRM. I also know that sometimes the nearest ambulance is in Baddeck or Antigonish. If that was my family member who needed an ambulance, let me tell you, you would hear me screaming from the rooftops. What happens when I call an ambulance - God forbid - in New Waterford, and the nearest ambulance is in Baddeck?

TERRY CHAPMAN: You wait.

TAMMY MARTIN: My loved one has just had a cardiac arrest.

TERRY CHAPMAN: You wait with a person who will probably be non-living when they arrive.

TAMMY MARTIN: How that doesn't infuriate the people of this House boggles my mind each and every day.

TERRY CHAPMAN: I agree with you.

TAMMY MARTIN: Do you see any other statistics that would be beneficial to post or publish as with the Code Critical?

TERRY CHAPMAN: One thing that we're very cautious of is, we fully intended to make the public aware every time that we can be aware of that there is what we call a Code Critical issue. Just to go back a little bit, one of the reasons is, we met with Minister Delorey a little over a year ago, when this was becoming the issue. We shared with him that we would like to see something started - we would like to see some movement to somehow alleviate this problem. Failing that, we would have to have the public help us do that - people who pay taxes - help us do that.

That's actually what started the Code Critical, is to make the people who pay taxes aware of the probability that there may not be an ambulance when they need one. And by the way, 1,000 of our members pay taxes.

TAMMY MARTIN: Absolutely. I'm sorry, I'm still upset by your previous answer.

The John Ross report in 2010 said that the average, or the standard, a patient should wait is 20 minutes. How often is this happening?

TERRY CHAPMAN: I can't give you a brass number on how often it happens, because again, we don't see the CAD minute by minute. But based on the fact that on any given day in this city there is one available ambulance, I would bet dollars to doughnuts that it's not very often.

TAMMY MARTIN: Are the off-load times different at different facilities, different hospitals across the province?

TERRY CHAPMAN: Yes.

TAMMY MARTIN: Why would that be? Is there a reason why certain places are having a more difficult time meeting that standard, or even showing up within a reasonable amount of time?

TERRY CHAPMAN: Well, one of the things I became aware of at a meeting with the minister - I believe it was on the 8th - I wasn't actually aware until that meeting, because there were other stakeholders - actually, people from the Dartmouth General Hospital were there. They made me aware of the differences between taking from core staff to facilitate a program and having to otherwise administrate staff - similar to us moving trucks around - inside of the hospital.

So I can't answer what would fix it, or what the reason in each place is, but each hospital that experiences this, to my knowledge - our experience is that it's never a schedule. You can't say that at 9:00 a.m. this morning, it's going to be the QEII, but at 11:00 a.m., it's going to be the Colchester Regional Hospital. It's random, sporadic, but it does happen every day somewhere.

TAMMY MARTIN: You mentioned the lack of - well, one, a quick fix would be more ambulances and more paramedics, and this government tells us, or has told us in this House, that they're investing. But we believe as well that that's not the long-term fix.

I've had conversations with Mike about paramedics fleeing Nova Scotia, because like other health care workers in this province right now, they're exhausted.

TERRY CHAPMAN: That's true.

TAMMY MARTIN: I've talked to many, from a cleaner to a doctor and everybody in between, including paramedics, who are exhausted and are not being listened to.

Do you have any hope or belief that there's going to be a remedy anytime soon, so that you can get back to your families? So that the nurses who don't get to go to the bathroom on a 12-hour shift - that this will change anytime soon?

TERRY CHAPMAN: Seeing what's happening today and in the past few weeks with Minister Delorey and his folks at the Department of Health and Wellness and Emergency Medical Care Inc., I'm hopeful that this is the point where we're going to start to see what we would call a corrective resolution to that problem.

As with several years ago, I can also see people, who might otherwise have stayed, not wanting to be a paramedic anymore and going to other provinces. When it happens -

I've actually jokingly predicted it's going to be June or July of this year, without them actually saying it, because we see patterns. When it happens, it's going to happen, and when one leaves, the people who see the green grass are going to leave with them.

TAMMY MARTIN: Thank you. Perhaps going back to Mr. Fraser, do you know how many times an emergency vehicle is used as a PTU?

JEFF FRASER: Part of the current system design that is in place, some of those patient movements are utilized by our emergency ambulances. That's the system design that we've been operating on for a number of years in the province.

It's also one of the reasons that we're very thankful the department has brought Fitch and Associates in. As an operator of the system, obviously we see opportunities to make some major changes. Fitch will help articulate that and help with some of the blind spots in the way that our service operates.

We do recognize that this is a great opportunity as we go forward, but ambulances do patient transfers. That is how the system has been designed. In our busier areas, as I mentioned earlier, we do our best to split that volume out. Those hospitals are close, and that's why we have that service in place. If you're in a smaller area, you may be assigned a transfer, but it's important to understand that we are moving our system around, as Ms. Poirier stated earlier, all the time.

TAMMY MARTIN: So, in the last month, you wouldn't know how many times a PTU has been used as an emergency vehicle?

JEFF FRASER: How many times a PTU has been used as an emergency vehicle? I wouldn't have that stat here today, I'm sorry.

TAMMY MARTIN: To Ms. Poirier, if I could. In your opening remarks, you mentioned strategies and solutions are being developed for the not-too-distant future. I wonder if you could explain and give us some details on these solutions.

PAULA POIRIER: We have been having discussions with the Nova Scotia Health Authority. As you know, from us, from an emergency care perspective, by the time we get to the hospital and the paramedics are standing there, then obviously we have to collaborate on what some of the solutions could be moving forward. At the end of the day, if we can move our paramedics out of there in 20 minutes or less, it certainly would make a huge difference for us within the system.

As far as strategies and opportunities, I'm going to pass it over to Mr. Guest because obviously they will be the ones that will be leading it; we would be helping out.

TIM GUEST: Thank you for the opportunity to provide some information on some of the work we're doing. Maybe the easier way to respond is to give you a couple of examples of some of the things that are under way.

At the Dartmouth General Hospital, as an example, we have implemented a team that takes handover of the patients when the ambulance comes in to allow them to off-load and return to the community. It was initially done as a pilot, and it has been really very successful. We are expanding that to the Valley Regional site in Kentville. It has just started to be operationalized.

We have also put in place rapid assessment zones in a couple of sites. Initially, it was put in Valley Regional. A rapid assessment zone is an area of the emergency department where you move the individual around depending on what's going on. If they are waiting for lab or diagnostic imaging results, they may wait in a waiting area, so they don't hold up a stretcher the entire time so that you can get more people through in care. We also have one of those at the Halifax Infirmary and we're expanding it to 24 hours a day to help with our off-load issue at the Halifax Infirmary. There's also a rapid assessment zone we're planning for the Truro site, as an example.

We have also implemented triage protocols where when individuals come, nurses assess them and can automatically order lab and DI tests right from triage to help with the timeline and timeliness to care, so when the physician sees them the results are already back. I think it's important to say that these strategies are very much focused on the emergency department and that they won't solve this issue on their own.

There's a need to focus on reducing the number of individuals whom we're caring for in acute care hospitals who would be better cared for in other settings. We're working closely with colleagues in long-term care and home care, and also with the Department of Health and Wellness and the Department of Community Services, to improve our processes so that we can maximize as many opportunities as we can for those individuals to be cared for in more appropriate settings. I think the reality of this is that it's going to require a systemic solution to a very complex problem that can't be solved by the ambulance provider or the emergency departments alone.

TAMMY MARTIN: Thank you for that. We know that transferring patients is an issue. Moving patients through the system is a problem, and it has been mentioned in the accreditation report. We have heard it from patients, and we have heard it from doctors. We know that the emergency rooms are backed up.

I would like to talk to Ms. Perret about how we can address this issue. Can you tell us, please, about the Home First philosophy and how it's applied in emergency rooms? Would it be fair to say that there are many individuals in ALC who would not be able to go home, who need to go to direct care or residential care facilities who cannot leave the hospital otherwise?

DENISE PERRET: It's an important question, and I think the issue of the movement of patients throughout the system is obviously very complex. If it were simpler, we would have resolved it in this province and we would have resolved it in every other province that is wrestling with it.

[10:00 a.m.]

What we've been looking at are the factors that affect the movement of patients and what are the levers that we can pull that relieve those pressure points and facilitate the proper care?

There are a number of them. I know you've mentioned a few, but I don't want anyone to - if it were as simple as having more long-term care beds, then that would have fixed the system decades ago. This is not an issue that has risen in the last couple of years, this is an issue in health care systems that really has the focused attention of a lot of experts.

We've done a couple of things in the hospital. First, the minister, as you've heard, has called people together to really focus them on the issue of patient transfer from the off-load point and to talk about proper staffing. You'll see an increase in the funding that's gone into emergency departments and emergency health services.

The government has also made a significant – over $8 million investment – in a hospitalist program. Hospitalists looks at in-patient care and start planning for discharge the minute that patient comes into care. That discharge planning is critically important.

We have long-term care beds that are expanding. You have the announcement in Cape Breton of two new facilities that are being organized. From what we know in the continuing care system, continuing care operates in three layers – home care; care in the community; and an institutional program in long-term care. People tell us that they want to be at home and they want to be cared for in their community first and foremost. That is the focal point, so there has been an investment in home support. We are very much focused on how we support people at home, how do we support the caregivers that are caring for them.

THE CHAIR: Order. Time is up. We will now move to the Liberals with Mr. Keith Irving.

KEITH IRVING: Perhaps the deputy minister could finish her answer to the question before I proceed?

DENISE PERRET: I wanted to inform the committee that there are a number of initiatives certainly on the home support front for both people that are being cared for at home, but their caregivers. A number of interesting pilots have been done to provide equipment, provide virtual care; we want to support caregivers through mental health supports because they have anxiety and depression. We're looking at the linkages where

we support people at home through community organizations and even the linkage into long-term care. If you look at modern systems of care, they're looking at how their food services, for example, can provide a food service to people in the home.

It's one of the most interesting areas in health care and there is a lot of focus and research and planning and piloting going on there. I wouldn't want anyone to think that no one is paying attention to the issue, it's just the opposite. They're very focused on how we make this, how we facilitate these transfers.

KEITH IRVING: I'd like to thank all eight of our witnesses here today to join us and to discuss this important project. Obviously this is an issue that all Nova Scotians are aware of, concerned with, all members of the House as well and as is the minister and the department. I think this is a valuable session for Nova Scotians to hear of the work that is going on.

My first question to Deputy Minister Perret, you mentioned in your opening statements that you felt we had a strong foundation to work towards a solution here. I wonder if you would expand on that.

DENISE PERRET: It's in reference to some of the things I was just commenting on, but in particular if we're looking at emergency department pressures, if we're looking at the off-load issue, we're also looking at how we divert people from emergency care and how we have a system of really comprehensive primary health care in the community.

One of the foundations that Nova Scotia has, and I can't emphasize enough how many people around the world are watching this, is its ability to stand up community paramedicine programs: to provide care for seniors in their home as well as in long-term care; to provide for fall prevention programs. What we're piloting in Cape Breton is an example of how we can use that kind of program and talent to facilitate with early discharge. We're working with other health professional groups as we do it because we don't want to have fragmented response systems. I think that there's really a strong base and where we have seen the extended care program succeed in Halifax, the next place where we're looking at scaling and spreading that, and discussions have initiated, is in the Cape Breton community.

So, we want to take what's working here and see if we can adapt it and introduce it into Cape Breton. It's those kinds of building blocks that really facilitate good care and when you talk to patients who receive that care, the response is very positive. Again, if we can provide care that does keep people at home and keep them safe at home, that is a priority.

KEITH IRVING: Thank you very much. I want also to shout out to our paramedics. We've sat in this House with a few paramedics and got some insight from our colleagues who have worked in the profession. I know that all members of the House and all Nova Scotians recognize and thank the paramedics and all of our first responders who are there

for us. I appreciate the work that you've done to elevate the discussion on the challenges that we're dealing with right now.

Nova Scotians need to know that action is being taken because this has elevated to a position of headlines. I'm encouraged to hear Mr. Chapman feel that today's discussion and the discussions over the last few weeks have created some hope for you and your employees, and the minister reaching out to work with you and all members here. I understand the minister has really laid down a challenge to you, or an order I guess, in showing some leadership to get hold of this issue and, you know, direct action now.

My question is to Mr. Chapman. I know the minister has asked you to all work together and I think we're seeing that here in the discussion: Can you talk to us about how you're working together and how you envision going forward in tackling this problem together?

THE CHAIR: Mr. Guest.

TIM GUEST: The minister has given us direction that he would like to see this issue be dealt with as a priority. We have some fairly aggressive timelines in which we have to respond, and I would say that we have engaged our partners in discussion and our organization has placed a significant priority on this work. We have put in place some project teams that are very focused solely on this work and we are very committed to doing whatever we can to see an improvement in it.

KEITH IRVING: Thank you very much. I'll turn the microphone over to my colleague.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Thank you, Mr. Chair. I appreciate everyone's time here this morning. We certainly heard from all Nova Scotians and from all members of the House that this is something that needs to be addressed and addressed as promptly as possible. That being said, we want to make sure that we're careful in our measures and that we're doing things, I believe the words were "a phased approach" was a reasonable way to move forward.

Not that I want to have too many remarks, but I did think it was important to note the deputy mentioned in her initial comments about the positive foundation that Nova Scotia rests on in terms of the profession and EHS services.

On a personal note, I have a partner who worked as an EMT in the State of Pennsylvania and she referred to a former member of this House, Dr. Ron Stewart, who actually lent himself to the work that they're doing in that particular state and otherwise. He wrote the book, so to speak, so I think that that's relevant in terms of adding some positivity and optimism to this conversation. I know we're all here. Mr. Chapman, I did

want to validate something that you said - and I guess validate is probably not the appropriate word but let you know that I heard your comments around, you know, we want to ensure that we have a healthy, capable workforce so that all the things that we're doing from a quality improvement perspective are best facilitated by the strongest workforce that we have.

I also would like to validate because I know that all Nova Scotians have been focused on - and justifiably so - on this Code Critical campaign. It has been a good opportunity for us as members of the House to hear from people and I don't want to undermine that as an initiative. A comment was made that we're not being provoked in the House. I believe that that's why we're here today. So, I'll get off my soapbox here and I'll ask some questions.

We've talked a little bit about a report that will be forthcoming in the not-too-distant future and I'm wondering if perhaps Mr. Fraser, Mr. Chapman, and Mr. Nickerson might provide some insight as to the opportunity for engagement from a staff and ground-level employee perspective, how much opportunity has there been with your counterparts here to express that ground-level perspective and has it been meaningful?

MR. TERRY CHAPMAN: I think if the question is to validate the viability of the questions and the responses that we've been giving, like I said before and going back to the report that we hope to see apparently in the spring, Mr. Nickerson and I were invited to speak before the Fitch committee and the questions asked were systemic and operational, as you might expect, but they received our answers and anybody that has ever met me or comes to know me knows that if you don't want the answer don't ask the question. We were forthcoming, we were honest with them in everything that they asked and they were appreciative of that.

In answer to, if I understand your question correctly, on my response to how we feel the readiness or the response of the committee or the House is dealing with this, I think recently we can see that the province is looking at our concerns - and that's recently. Not to criticize, but take note that that took one year, a little over one year of poking the bear and, while we are appreciative right now of the day and what happened last week or a few weeks ago with Mr. Delorey, we are cautiously optimistic until we see something that shows us that we need to be no longer concerned.

BEN JESSOME: Mr. Fraser, maybe you can weigh in as well?

JEFF FRASER: The Fitch review, I was pleased that Fitch and Associates when they hit the ground here back in December, spent some time with Terry and Michael. I think it's a reflection of looking at the system holistically and a lot of the time that they spent was spent with our senior team going through their analysis and giving an overview of how our system functions and we did get them out into our medical communications centre as well as one of our larger centres where they had an opportunity to interact with staff. It's not a foreign concept because we have three accreditations and all the

accreditations bring accreditors from the outside who also interact with their staff to validate the process that we have in place.

I am hopeful. You know, I recognize, working in our system for almost 30 years, that we're at a point where change is a good thing. Fitch will help us understand what changes need to be put in place. I think it's too early yet to say what those will look like but there are a number of opportunities and some of them came in the form of questions today about how our system is utilized.

[10:15 a.m.]

BEN JESSOME: Thank you. Through the Chair, we've kind of bounced around here a little bit and, as someone who hasn't been on the ground, I humbly say that it sounds like it's a fairly complex environment to work in and certainly there's the human component to all the processes. You are ultimately there to look after a patient and ensure that the best opportunity for health or survival is there.

I'm wondering, perhaps again directed at the two witnesses across from me here, who I just posed questions to, can you give us an idea, kind of simplified, start to finish, what goes into a call. We're talking about a bottleneck at the point of drop-off so maybe focus a little bit more on that point of drop-off, if that's helpful, in the interest of time.

THE CHAIR: We'll start with Mr. Chapman.

TERRY CHAPMAN: Our part in the bottleneck comes after the initial 911 call and the response and whatever delays are there. Assuming that there is a properly timed pickup, or not, of a patient, so if you are talking about on arrival at the ER and then the delay in getting that stretcher back into an ambulance and that ambulance back into service. Typically, it doesn't matter what hospital, it's the same issue - they arrive, there is nowhere to put them, and they stay on the stretcher. It's simple.

If you want a breakdown of the failed components internally, I can't give that to you because I'm not an expert in the hospital internal system. What we see is the paramedic team arrives at a hospital, they take the stretcher in with the patient on it; there is some form, as always, of an initial assessment by the triage person and then they wait, and they wait. If the person needs to go to CT or X-ray, there's nobody there to take them so they stay on the stretcher. Most of the time they are wheeled in and out of there on our stretcher, which quite honestly, we feel is not our position; then they wait, and they wait. That's the story.

If there is a breakdown of the internal component of the machinery that allows that wait and wait to happen, while we hope it is fixed, we're not the people who understand the integral component, that would be someone else.

BEN JESSOME: Mr. Fraser, can you jump in here as well.

JEFF FRASER: Thank you for your question. Just to back it up a little bit, one of the messages that I think is important to relay, even though our system is under significant pressure, we are confident that the changes the Health Authority is under, in line with Mr. Irving's question to Mr. Guest, it will bring significant relief to our system.

The inability to off-load patients safely at hospitals within the standard certainly has had an impact on our ability to operate. The message for the public is that even though our system is under significant pressure, our system is managed live 24 hours a day, seven days a week.

There is no doubt there will be delays when we have 10, 15, 20 per cent of our fleet tied up a hospital, it is going to have an impact. But even if the off-load issues are all removed, there are going to be challenges in delivering a provincial service.

I will tell you from my experience in the system that if you have 50 resources, there will be a time, today, when we will need 51. The prioritization and re-prioritization of those things happen in our communication centre.

What I don't want to do is lose the focus that the system is under pressure. What is being proposed, though, will bring relief because we'll be able to get our rigs back on the road.

When we look at this through the eyes of three angles here - what is best for the public; what is best for our patients; and, of course what is best for our providers. This is taxed, all of it. This is a positive change.

The bottleneck, as you suggest, does happen at the emergency department and it is a very complex issue. The Health Authority has been a good partner, has brought us in to understand how complex it is and the patients that we take and place.

From an EHS system, our focus really has to be on how we keep people out of the emergency department to begin with. Ms. MacFarlane spoke about fall prevention programs. For the most part, Emergency Medical Services are reactive; they respond to 911 calls. The difference in Nova Scotia is that it is proactive, and we do things that do keep people in their homes.

Ms. Poirier in her opening remarks talked about palliative care. Nova Scotia has become a leader in palliative care. When Terry and I worked as paramedics, we didn't have the option, people had to go to the hospital. We have created options for people, allowing our practitioners to work the full scope. We will continue to push. I know we were pressed today give an answer about when. There is a lot that goes into these things, but these are novel programs. There are people from all over the world who come here and look at what we have done. We also look at how other people have put novel solutions in place.

Our goal will not change. We will focus on keeping people healthy in their communities. Programs like the Extended Care Paramedic Program, which Dr. Travers talked about, 90 per cent of the people we see there, we don't have to take. The reason that program was implemented in 2011 was this very reason. We saw that we had an opportunity to impact the lives of people, and we put this program in place to do just that.

BEN JESSOME: I appreciate that. How am I doing for time?

THE CHAIR: One minute.

BEN JESSOME: I'll just ask a personal interest question. What is a reasonable response time in urban Nova Scotia versus rural Nova Scotia, Mr. Fraser?

JEFF FRASER: We have standards in place, and I believe Mr. Chapman alluded to those, that we have to meet with the department. There are a number of issues that complicate our ability to do that. The standards in an urban area are less than nine minutes. In suburban areas, they're less than 15 minutes. In rural areas, they're less than 30 minutes at the 90th percentile.

The reality is that, because these are people, we obviously strive to do our best to manage our deployment plan, so we're able to move those resources around to capture most of that population.

THE CHAIR: The time has expired. We'll now move to the Progressive Conservative Party, starting with Ms. Adams. We have nine minutes for the next three rounds.

BARBARA ADAMS: I have been listening to the Department of Health and Wellness and EHS saying that there is a good foundation and that they are confident that what is possibly going to be proposed in the Fitch report is giving them optimism that things will improve. As a health professional who read Dr. Ross's report from 2010 - he also wrote a report with a lot of recommendations. I think if you asked him today, he would say that we are not moving forward.

In preparation for this meeting, we were sent a 750-page document. I read it all, and I can tell you that what's missing in here are two things, the paramedic story of what happens during the input phase - this is really the flow-through phase - and then we all know about the output phase of backups in long-term care.

I want to go to what an independent person has done. We had the accreditation of the Nova Scotia Health Authority, which has been amalgamated for quite a few years now. They reviewed the emergency department, on Pages 86 to 92. They identified quite a number of unmet needs. Nobody is going to be perfect, but we're talking about off-load times, which directly impact the paramedics. We're talking about triaging for pediatric

clients. We're talking about falls prevention strategies. There is a whole slew of things here that are unmet despite all of those recommendations from Dr. Ross almost 10 years ago.

My question is to the Department of Health and Wellness. In 2013, there were over 15,000 ER closure hours - 75 per cent unplanned. In 2015, it was almost 22,000. In 2017, it was 25,000. In 2018, it was 30,000. That's almost twice as many over the last six years, despite a lot of reports that have recommended great things to happen. I'm just wondering if the Department of Health and Wellness could address this. Would you agree that the escalating numbers in ER closures around this province indicate that the government is not stemming the tide of increasing ER closures?

DENISE PERRET: It's an important question and something we keep an eye on. As you have heard in this whole discussion, on the issues about how we keep people well, how we invest in community primary health care, how we address the issue of ambulance off-loads, and what we are doing with discharge planning, there is a lot of activity going on at every level.

When we come to the emergency department closure issue, again, there's a number of factors at play. We have our eye on that. We're paying attention to it. We're looking at how we can consolidate resources in some cases, how we can have a system of care and programs of care that provide more comprehensive service without breaks in service.

I think, maybe it's important to look at it from the other side of the coin, because we're conscious of the hours that you've reported, and everyone hears the dire circumstance, but from April 1 of 2018 to the end of January of this year, 91 per cent of all emergency department scheduled hours were staffed and they were open. So, I just put that out there to provide the perspective that people are paying attention to the issue and they are putting in place programs and responses that may not be perfect, and may not have immediately solved the problem, but I hope you see the indication that people are paying attention and working to keep these departments open and services provided.

I want to also add that over the last, probably two years or so we've come to a point where we've built collaborative primary care capacity in the system, where we've gone up to 78 teams of services with allied providers. That has been a large investment in those allied supports to primary care physicians. We know we have work to do to maximize and optimize that capacity, but again it's part of the answer to your question, that we're going to reduce even the need to go into ER departments through that type of initiative, which we're very focused on.

BARBARA ADAMS: You mentioned that there were 91 per cent that were staffed - I'm not sure which Nova Scotian wants to be in that 9 per cent where the emergency departments are not staffed.

I'm aware of all of the discussions and the strategies, but the numbers that I had read to you suggest that things are not improving; in fact, they're twice as bad as they were

for ER closures as six years ago. Again, I like numbers because we have to evaluate whether we are in fact improving, or not.

So, I want to talk about the wait times in the emergency departments though. In 2012-13, it was 28.3 hours per patient; in 2015-16, it was 29.3; in 2016-17, it was 32.6 - and I don't have any more recent numbers. Of course, older folks are waiting longer than that. Certain hours of the day, those hours can be up as long as 41 hours.

So, I guess the question I want to ask the paramedics is: Mr. Chapman, how does the impact of not being able to off-load people impact the paramedic's experience and the safety of the patient that they have in there?

THE CHAIR: So, we'll start with the paramedics? Mr. Fraser, and then Mr. Chapman.

JEFF FRASER: So, I thank you for the question. It's a complex answer to be honest with you. Some systems have made a decision at the standard to leave the patients in the hallway; the EHS system has never done that. So, we do stay with the patients until they are safely taken to the emergency department.

There is no doubt that there are adverse events that do happen, and these are unexpected things, but we do see ourselves as an extension of the emergency department. Obviously, we need to get back into our communities, which is why we are so hopeful on this new plan that's being put in place.

The reality is though, it is very uncomfortable for the patients in the hallway on those stretchers. Again, one of the reasons you put our Extended Care Paramedic Program in place is because that program deals with seniors, and we saw a lot of our seniors before we had this program in place on our stretchers in the hallway.

TERRY CHAPMAN: I would have to agree with Mr. Fraser. If you're talking specifically about patient safety in the hallway, with two highly trained paramedics and, generally, the equipment to do the job with them, they are, under those circumstances, as safe as they can be anywhere.

BARBARA ADAMS: Okay, that's fine, thank you.

So, Mr. Fraser, you referred to a new program that you're excited about. Can you tell us what that program is?

JEFF FRASER: Well, I think it links back to the question earlier to Mr. Guest, over the directive received by the department and how they're dealing with the off-load program. So, this is a change for us.

[10:30 a.m.]

BARBARA ADAMS: Great, thank you. Just with the remaining time, one of my constituents is in the hospital in Dartmouth General and got moved to Halifax, to the VG, because they had empty beds. His wife got a directive that he was going to be moved to Melville Lodge, even though Melville Lodge is shut down now because of the flu virus, so the directive in this new program you're talking about was going to move a man who is quite ill now into Melville Lodge even though he was previously blocked from going there because of the flu virus. But because of the directive that was sent out last week when the emergency backed up, they were going to move this man into a facility that previously wasn't going to accept him, so is that the type of plan you're talking about?

JEFF FRASER: I think I'll defer that to Mr. Guest to answer.

THE CHAIR: Mr. Guest for 30 seconds.

TIM GUEST: I can't speak to the specifics, because I don't know them. In the whole issue about how we move individuals to the most appropriate level of care, one of the challenges we've run into is that there are multiple interpretations from across the long-term care sector as to what the recommendations from infection prevention and control are in relation to when they can take new patients and when they cannot.

THE CHAIR: Time has expired. I'll now move to the New Democratic Party starting with Ms. Leblanc.

SUSAN LEBLANC: Thank you everyone for all of your answers so far. This is a great discussion and I have to say that I feel an amount of tension because while I understand and appreciate the complex nature of these issues, what really gets me is hearing about the fact that I may call 911 for one of my parents who are in their 80s and they may die waiting for an ambulance. The tension between those two things is very difficult and I don't think I'm the only one in Nova Scotia that's feeling that right now.

I just want to go back to Mr. Guest. You were talking about the program at the Dartmouth General that the staff actually implemented with the ambulance off-load times and then you talked about how you're implementing that in the Valley Regional and a couple of the other systems that you are implementing in different places. I'm a patient of the Dartmouth General sometimes and a resident there and I really appreciate that that's happening there. Why are you not planning to implement that across the province?

TIM GUEST: One of the factors with respect to some of those specific initiatives is they require space and some of our facilities, Sydney as an example, the way it is currently designed and the challenge that it certainly has from a volume perspective makes it very difficult for us to implement that program there, so we're looking at different strategies in different sites. I think the reality of it is, we have to do different things in order to achieve the same outcome. Where we determine a location would benefit from that type

of initiative, we're going to put it in place. We need to be looking at a number of different ways that we can achieve a solution to have ambulances off-load and return to the community in a reasonable period of time.

SUSAN LEBLANC: Thanks. We have some information that talks about the chaotic nature of emergency departments around the province right now. We know that the NEDOCS program is a universal program used to score and track the severity of overcrowding in emergency departments and a normal NEDOCS, I don't know how you refer to it, score is between zero which is not busy, and 200 which is dangerously overcrowded, and the NEDOCS score at the Halifax emergency department recently reached 420. Are you planning any of these programs at the Halifax Infirmary emergency department?

TIM GUEST: Yes. One of strategies for the Halifax Infirmary is to open our rapid assessment zone 24 hours a day. It has only been open up to 16 hours in the past and so when it's not open 24 hours a day, we have a capacity of a whole section of the department that we don't have access to. So that's one of the reasons why we believe that's a good strategy there. The design of the Halifax Infirmary doesn't lend itself really well to the handover team. The team there itself has felt that this is probably the best strategy for them. I think we need to look at a number of strategies.

The one thing I want to add is, and I think it's really important, that the EHS system is a top-notch system that provides excellent service and I think our emergency departments also do. What's happening to both is a symptom of a system that has become challenged with capacity and we really need to be focused on the outflow, trying to manage the best we can putting in place any process that we can to implement this service. But our focus needs to be on getting people out of hospitals to enable both the paramedics and the emergency staff to cope.

SUSAN LEBLANC: I agree with you, so I want to flag this. Last year the majority of the patients discharged from ALC places in our hospitals were people actively waiting for long-term care placement - not for home care or hospice or transfer to another acute care facility. The Health Authority does track those numbers and submits them to CIHI every year.

Do these numbers indicate to you that we are meeting the need for facility-based long-term care spaces in our province, speaking of outflow?

TIM GUEST: I would say that we do have areas of the province that I would maybe consider hot spots where we're challenged with access to long-term care. Two locations that come immediately to mind are HRM and the communities between North Sydney and Glace Bay. As the deputy minister said, the government has announced two new facilities that would help with the issue there.

I think, though, that some of the things we've also seen is that we are finding more and more that there are individuals who fall between needing long-term care and being able to manage in the community, and that we do need to be looking at other options between those that would be programs that we would see in some other jurisdictions.

I think we need to be careful of throwing all of our eggs in the long-term care basket, where that's not necessarily the solution that all of the citizens need.

SUSAN LEBLANC: I totally agree with you, but I'm talking about the numbers of people who had been deemed appropriate for long-term care.

Speaking of that as well, thinking of home care, then - I know there are more solutions than those two, even, but someone waiting for discharge home care with support services spends 94 days in the hospital waiting, on average.

I guess I'll direct this to Ms. Perret, does the department have a benchmark for acceptable wait times, and what is that benchmark?

DENISE PERRET: I don't know of a specific benchmark, but waiting too long is not acceptable. That's why you've heard the information that you have received this morning, that everyone is focused on this and wants it to change and improve.

We have a number of initiatives going on in the continuing care space, some of them driven by the recent report from the long-term care expert panel. Looking at staffing and looking at staffing mixes that facilitate a more responsive and a more appropriate home care service are absolutely something that we're looking at and working on.

SUSAN LEBLANC: To clarify, you don't have an actual benchmark? Is that correct? You don't have a number that is too many days to wait or the amount of time that's appropriate for waiting?

DENISE PERRET: There are benchmarks for length of stay in hospitals that are monitored nationally. Nova Scotia tends to be above some of the length-of-stay benchmarks, and that's not acceptable from our perspective. We would be looking at those CIHI - the Canadian Institute of Health Information - benchmarks, to monitor those for length of stay in hospital. Then we look at where the appropriate placement is.

SUSAN LEBLANC: Okay, I'll leave it there. I wanted to quickly ask about Collaborative Emergency Centres. We know that we've pioneered this program and the approach has been exported to Saskatchewan and P.E.I. How do paramedics find the CEC experience in Nova Scotia, and do you find that the CECs are taking pressure off the ERs in places like Sydney?

THE CHAIR: Mr. Fraser, with less than a minute, I believe? Did you want to ask EHS?

JEFF FRASER: Thank you for your question. The Collaborative Emergency Centres - although I apologize, I don't have the stats. I would defer to the Health Authority on the number of patients that we see at night.

To be clear, at night the physician goes home and the paramedic and nurse work in collaboration with the online medical doctor group from EHS and Dr. Travers' team. We provide a service where we see patients who do come through the doors, so the facility is open and is maintained.

I don't think I can answer the impact on the regional hospital. I would probably have to defer that to Mr. Guest.

TIM GUEST: I would say the impact is very low. Our visits at the CECs at night are extremely low.

THE CHAIR: Thank you very much. We'll now move to the Liberal Party, beginning with Rafah DiCostanzo.

RAFAH DICOSTANZO: It has really been very informative this morning. I had something that I heard a few times from people around me, that if you take an ambulance, you get better service at the hospital.

I know this is a myth, and I try to correct that, but do you have many incidents where you arrive at the home or the place, and you know that it may not be something as urgent as others? Do they get transported just the same? And because they are a lower risk, so they take longer, and the stretcher is there and the paramedics are there, is this something happening? I know I've heard that many times within my community but I'm not sure if that's an issue that is happening, if you can clarify that.

THE CHAIR: Is that a question for Mr. Chapman or Mr. Fraser?

RAFAH DICOSTANZO: It was Mr. Fraser, I think.

THE CHAIR: Mr. Fraser

JEFF FRASER: Thank you for your question. One of the many relief valves, if you will, that we've put in the system is we've partnered with the Health Authority, back in October, and put a process in place which is "direct to chairs". There are some patients who we do see who utilize the service with an expectation that they'll be able to jump the queue at the hospital.

This process was one of the many processes that we put in place that would safely, in collaboration with the hospital, move those patients to the waiting room and allow our units to get back into the communities.

RAFAH DISCOSTANZO: That's great. Another very quick question. Pod 5, I wasn't aware of pod 5 until my husband got to use it one year, and how much the paramedics did a lot of the service within the hospital. If you can clarify that for us that would be a good thing as well.

JEFF FRASER: Thank you for your question. I'm going to defer that to Mr. Guest. Those paramedics actually work for the Health Authority in pod 5, not in the EHS system.

THE CHAIR: Mr. Guest.

TIM GUEST: To answer your question, pod 5 is a location in the Halifax Infirmary emergency department staffed by paramedics. They do look after a specific population of our emergency patients that are applicable to their scope of practice.

My understanding of it - the emergency portfolio is new to me - is a positive, that patients seem satisfied with their experience there. I believe it is providing a good service.

RAFAH DICOSTANZO: We went in at six o'clock and we were home by 10 o'clock. It was a dislocated elbow, it was an amazing service, so thank you. Pod 5 is working for some. I pass it on to my colleague.

THE CHAIR: We'll now turn to Ms. Suzanne Lohnes-Croft.

SUZANNE LOHNES-CROFT: Thank you for being here. I am a great believer in speaking your truth. Your truth is different than my truth, as is everyone's here. I'm hearing a lot of people's truths this morning and I really feel that is the only way we can resolve any issue, is to hear other people's truths and work together. I see that this is happening, so I'm really pleased about that.

Problem solving is another great thing that I believe in. I'm glad to see that people are getting together now with several units that are responsible for the emergency system and are working to problem solve and bring their best energies into resolving this issue.

One instance I've heard of is extending the hours at the Cobequid Community Health Centre a few weeks ago. I thought that was brilliant, that somebody had made that decision. It was on-the-spot. I'd like to know how decisions like that are made on-the-spot and who has the authority to do it, so that this type of thing can happen again, if needed. Would that be Ms. Perret or Dr. Travis?

THE CHAIR: Mr. Guest.

TIM GUEST: I just want to clarify, Cobequid as an emergency department does not stay open 24 hours a day.

SUZANNE LOHNES-CROFT: I realize that.

TIM GUEST: It does work as kind of a satellite of the Halifax Infirmary site. There are times when we have had to care for individuals there overnight, where we haven't had the capacity to transfer them into the Halifax Infirmary site.

It's certainly used as a surge location, as a last moment thing. We don't plan to do it, it's not something that we encourage. I think it's one of those ones where we try to keep ambulances on the road and care for individuals where they are to not have them lined up at the Halifax Infirmary site. I think that's the only thing I could say about it.

[10:45 a.m.]

SUZANNE LOHNES-CROFT: Okay, thank you. So the review is under way with EHS. I'm just curious, have any of you participated in that review? If so, what has been your experience? Who would like to take that?

THE CHAIR: Mr. Nickerson.

MIKE NICKERSON: Thank you for your question. Mr. Chapman and I both had an opportunity to participate in the Fitch and Associates report. We were interviewed by them.

JEFF FRASER: Thanks for your question. I spent extensive time when the folks from Fitch and Associates were here, as our senior operations leader for the province.

They're looking deeply at the data that exists within our system, the principles of how we operate, and understanding the challenging environment we operate in, but also looking forward at what the opportunities are. There are some opportunities - we've talked about them today - around community paramedicine and about what the EHS system can impact from an inflow piece.

THE CHAIR: Dr. Travers.

ANDREW TRAVERS: I also had the wonderful opportunity to collaborate with Fitch, both wearing the EHS Provincial Medical Director hat and in partnership with the Health Authority, with the medical directors, with the various provincial, zonal, and site leads. It was a healthy conversation, so that Fitch was informed about the culture and choreography of care that happens in emergency departments within the province.

THE CHAIR: Mr. Crewson.

LARRY CREWSON: We've worked closely with Fitch as well. They have a full understanding of our system. We've given them that open door to seek out the stakeholders, because this is so important for our long-term plan for our system. They have been excellent in asking the questions and having an understanding of where we want to go, but we're not tying them to a design. We're asking them to have a look and assist us.

SUZANNE LOHNES-CROFT: Were there surveys as part of this as well, to paramedics who are on the ground, or conversations, focus groups?

LARRY CREWSON: There weren't surveys given out to paramedics. What we did is we offered the paramedic union to speak on the paramedic behalf, as well as EMC, the operator. They've had that reach-out-and-touch capability through all aspects, and that includes not only ground ambulance system but the LifeFlight ambulance system.

SUZANNE LOHNES-CROFT: Thank you. No further questions.

THE CHAIR: No further questions. Okay. Well, we're just about out of time anyway.

I will ask if there are any brief closing remarks anybody would like to make. It's not necessary. Ms. Perret.

DENISE PERRET: Thank you again for having us here. I think it is a very important discussion. I want to say that there have been a lot of examples brought forward of when the system doesn't work. We all do the jobs we do because we want to make the system better. We're aware of those missteps or the gaps in the system, and I just wanted to assure everyone that we care about it as much as anyone and are really focused on bringing forward options and bringing forward the talent that knows how to fix it.

Our hope in working together - especially on this issue - and the minister has been quite a leader in bringing us all together. I'm very confident that this matter is progressing in the right way. We are all in public service, and then we are doing our best to serve the people of Nova Scotia.

THE CHAIR: Any further remarks? Mr. Fraser.

JEFF FRASER: Again, I want to thank everybody for allowing us to speak today. I'd like to leave a message.

Although our system is under significant pressure, we are looking forward to some change and some relief. But it is important that Nova Scotians know that the EHS system is going to be there for you. Please don't hesitate to call. That's one of the big concerns we do have. We will get you a resource. We have a system where we will re-prioritize and re-prioritize again, but we don't want the public not to access the service. The service is there. Thank you.

THE CHAIR: Mr. Nickerson.

MIKE NICKERSON: Thank you very much for having us and listening to our concerns. I really hope it resonated with the elected officials. Our paramedics are tired, they're frustrated, and they're feeling devalued.

THE CHAIR: I would like to thank all of you and our committee members for a very insightful and respectful conversation around this. I appreciate it very much. You can leave.

We have a bit of committee business. First on the list of committee business is something I brought forward to a few members before we had the meeting. The April 9th meeting that we have, Ms. Paula Bond will be out of the country then. We are looking to move to have another alternate brought forward at the request of Ms. Suzanne Lohnes-Croft.

SUZANNE LOHNES-CROFT: I would like to make a motion. Seeing that Ms. Paula Bond is not available for our April 9th committee meeting on the Cape Breton Health Care Redevelopment Plan topic, we would like to replace her with Dr. Kevin Orrell, Senior Medical Director of the Cape Breton Regional Municipality Health Care Redevelopment project.

THE CHAIR: Discussion? Ms. Martin.

TAMMY MARTIN: I understood he was part of the committee anyway that was coming? He was already part of that.

THE CHAIR: Okay, so, no problem with that as a substitute then for Paula Bond, who cannot make it.

SUZANNE LOHNES-CROFT: If the rest of the committee is satisfied - she's not able to attend. Did you want a replacement?

TAMMY MARTIN: I would like to know her position first and who else is attending that meeting.

THE CHAIR: Ms. Kavanagh.

JUDY KAVANAGH (Legislative Committee Clerk): Paula Bond is the Vice President of Integrated Health Services of the Nova Scotia Health Authority.

TAMMY MARTIN: Who else is attending that meeting?

JUDY KAVANAGH: At that meeting, we have also invited Mr. Brett MacDougall, the Executive Director of Eastern Zone Operations of the Nova Scotia Health Authority; he works at Cape Breton Regional Hospital. We have invited the Deputy Minister of Health and Wellness and the Deputy Minister of Transportation and Infrastructure Renewal or his designate, and Dr. Kevin Orrell, who I gather has been recently appointed to work on this project. These witnesses, like all of our witnesses, will be invited to bring colleagues with them.

TAMMY MARTIN: Then yes, I would suggest that we have a replacement for Paula Bond from the NSHA.

THE CHAIR: We'll leave it to the NSHA to find somebody to replace her, if they have someone? We have representatives from NSHA coming I believe, already.

TAMMY MARTIN: But both of those are from the Eastern Zone specifically.

THE CHAIR: So you would like to have a representative from the Western Zone of the NSHA?

TAMMY MARTIN: No, I would understand that Paula Bond looks after the entire province, so I would like somebody equal to that. Not zone specific, but from the NSHA overall.

THE CHAIR: Ms. Suzanne Lohnes-Croft, and we have a motion on the floor actually that has to be dealt with.

SUZANNE LOHNES-CROFT: I can retract the motion, but I think maybe we could provide names and task the clerk with getting in contact with a substitute person.

THE CHAIR: You wish to retract? We'll need the unanimous consent of the committee to retract.

Do I have that?

The motion is retracted.

Is it all right with the committee that we go forward with having the clerk find a replacement for Ms. Bond, who that cannot make it?

Agreed. Thank you.

Any further committee business?

I'll quickly ask - we are scheduled until 11:00 a.m. Do we have unanimous consent to go over if we do go over?

Okay, no problem.

Ms. Karla MacFarlane.

KARLA MACFARLANE: This was a productive meeting, with sincere, honest questions from all parties and with honest, sincere answers.

As stated, we all have a common denominator, and that is to ensure public safety and not to delay in working collaboratively together to remedy the crisis happening in our emergency departments.

I move a motion that this committee draft a letter to Minister Delorey and the Premier to personally meet with business manager of IUOE Local 727, Terry Chapman, and business agent of IUOE Local 727, along with two members from each Party, and representatives from EHS to discuss the suggestions given today to improve the conditions for paramedics in our province.

THE CHAIR: There is a motion on the floor. Is there any discussion?

Ms. Lohnes-Croft.

SUZANNE LOHNES-CROFT: Can we just take a few minutes to discuss this?

THE CHAIR: Sure. We'll recess for a couple of minutes.

[10:56 a.m. The committee recessed.]

[11:02 a.m. The committee reconvened.]

THE CHAIR: I call the meeting back to order. We have a motion on the floor. I would ask the mover to read the motion, please, to start.

KARLA MACFARLANE: This was a productive meeting with sincere honest questions and answers. As stated, we all have a common denominator to ensure public safety and not to delay in working collaboratively together to remedy the crisis happening in our Emergency Departments.

I move that this committee draft a letter to invite Minister Delorey and the Premier, or perhaps the Deputy Premier, to personally meet with business manager of IUOE Local 727, Terry Chapman, and business agent of IUOE Local 727, Mike Nickerson, along with two members of each Party and representatives from EHS to discuss the suggestions given today to improve the conditions for paramedics in Nova Scotia.

THE CHAIR: There's a motion on the floor. Discussion?

KEITH IRVING: I agree with my colleague that we had a very productive discussion here today and I think all parties participated with members of the union and the emergency service provider. I think we had a good dialogue. The Minister of Labour and Advanced Education, the Minister of Health and Wellness met with those parties just last week I believe. The Premier meets regularly on this, so we don't see the need for this at this time. We've fully fleshed out what is happening on this issue and there are some very positive things under way - for that reason we will not be supporting this motion.

BARBARA ADAMS: The one thing that we were directly asked for during this Health Committee meeting from Mr. Nickerson was a meeting with the minister with all three Parties present. That has not happened. He has asked for that several times. Whether he's met with each of us individually or with the minister, that's not what they asked for today. He made it very clear, so I'm very disappointed that the Liberal Party will not be supporting this motion.

TAMMY MARTIN: To say that the issues have been fully flushed out I think is a grand overstatement. We could have probably used the entire day to discuss, especially with the paramedics, what they deal with day-to-day. They have the lives of every Nova Scotian in their hands and I believe the least we could do is agree to sit and meet and listen to their concerns.

What is this Liberal Government afraid of - to sit down and have members of other Parties, along with those that are involved in the crisis? We need to have open and frank discussions with the stakeholders. We deserve to be at the table. What are the Liberals afraid to hear?

THE CHAIR: Mr. Irving.

KEITH IRVING: We are not afraid of anything, Mr. Chair. We just agreed to this emergency meeting and had all parties at the table discussing the issues.

THE CHAIR: Ms. MacFarlane.

KARLA MACFARLANE: I think we heard loud and clear today that there are some good things happening in our health care system, but this is a new level of crisis that is happening in our emergency departments. I know it was stated here earlier, they admitted that it has just been recently that they are addressing this situation and looking at it.

I think in all fairness, looking at paramedics from Yarmouth to Neils Harbour in Nova Scotia, I believe it would be considerate, show empathy, show that we are solution-focused, that we care; and, that there is meaning to this Health Committee. Without having something to present at the end of the meeting kind of negates the purpose of this committee.

I am certainly flexible in the Liberal Government wanting to perhaps find substitutes if the Premier is unable to attend. I'm sure the Deputy Premier could attend, and I believe that not only the Liberal Government, I believe our Party, I believe the NDP, we all owe it to our paramedics, the 1,300 paramedics in this province right now, we owe it to them to sit down with them face to face.

THE CHAIR: Ms. Martin.

TAMMY MARTIN: Mr. Chair, I think it's important for all of us to remember who we work for - we work for the taxpayers of Nova Scotia. When they request a meeting, the Liberal Government shouldn't be able to deny that because of their majority.

I would suggest that it is incumbent on all of us that when a constituent asks to meet with us, that we meet with them, regardless.

THE CHAIR: Thank you. There's a motion on the floor. Would all those in favour of the motion please say Aye. There has been a request for a recorded vote. I will begin with the Liberal Party, with Ms. DiCostanzo

YEAS	**NAYS**
Karla MacFarlane	Rafah DiCostanzo
Barbara Adams	Keith Irving
Susan Leblanc	Ben Jessome
Tammy Martin	Suzanne Lohnes-Croft

THE CHAIR: The Chair votes no.

The motion is defeated.

There being no further business, I would say that our next meeting is Tuesday, April 9, 2019, from 9:00 a.m. to 11:00 a.m. on the Cape Breton Health Care Redevelopment. Witnesses will be the Nova Scotia Health Authority, Department of Health and Wellness, Transportation and Infrastructure Renewal, and Dr. Kevin Orrell.

I appreciate everybody's time today.

This meeting is now adjourned.

[The committee adjourned at 11:09 a.m.]