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STANDING COMMITTEE

ON

HEALTH

Tuesday, October 8, 2019

LEGISLATIVE CHAMBER

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HEALTH COMMITTEE

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[Hon. Margaret Miller replaced Hon. Gordon Wilson]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

811 Program

Dr. Todd Howlett - Medical Director

Natalia Gallant - Telehealth Manager,
Quality and Privacy

Wendy Boutilier - Telehealth Manager,
Operations and Clinical Services

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, OCTOBER 8, 2019

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SUZANNE LOHNES-CROFT (The Chair): Order, I call this meeting of the Standing Committee on Health to order.

My name is Suzanne Lohnes-Croft, the Chair of this meeting. Today we will hear from the 811 program regarding 811 Nova Scotia.

I remind members to put their phones on vibrate or turn off.

In case of emergency there are rules that we did not acknowledge before because we are in the Chamber. If there's an emergency, we exit Granville Street, go down to Hollis Street to the courtyard outside the Art Gallery, and that's where we gather. We were advising people to go to the Grand Parade; that's when you're in the Committee Room at One Government Place. Please remember that when you're in here, you exit and go to the Art Gallery.

I will note that there are members absent, only because they're stuck in traffic. There has been an accident on the Bedford Highway, so they are delayed, but they will be coming.

We will start with introductions.

[The committee members and witnesses introduced themselves.]

THE CHAIR: Dr. Howlett.

DR. TODD HOWLETT: Thank you. My position with the program is I am the Medical Director for Teletriage 811, so I'll begin.

Thank you for the opportunity to come before you and talk about Nova Scotia's 811 program. We look forward today to having a conversation with you and we hope to share with you what 811 does, clear up what it does not do, and share some of the opportunities that lie ahead. As you may know, this year marks the 10th anniversary of the 811 program; ergo, it began in 2009.

The 811 service has a number of facets that I would like to take a moment to outline briefly. First, and probably best known, is "symptom Teletriage." For many of you who may have used the program, this is the part of the program whereby you call the program, speak to a registered nurse, and you describe your symptoms. Through a series of evidence-based guidelines and an experienced nurse, a plan is sorted out as to where you should best go to receive care up to and including, in many cases, that you don't need to go anywhere and that you can be managed through self-care at home.

We share a lot of health information in addition to this service, and we have a large number of what we call HITs, or health information topics. Those can be found both by reaching us and online.

We do a lot of what we call provider referral. We have a large community database and we serve as a database for the province. During these times we refer patients to mental health lines, foodbanks, pharmacies, identify walk-in clinics, and we have some services available also for our First Nations.

There are two other important programs that some people don't know are associated with Teletriage. Those include Tobacco Free Nova Scotia, which is an online and telephone consultation for people attempting to quit cigarettes and smoking. In addition to that, we have the Gambling Support Network, again an online and telephone consultation service where we counsel problem gamblers.

In addition to all this, 811 serves as the repository for the Need a Family Practice list. It is important, however, to note that the content of this list is not ours but is managed by the Nova Scotia Health Authority.

There are a couple other important items that I wish to share before we start. One, and perhaps a fun fact, is our nurses work from home and we can talk about that more later. Through our tripartite agreement, we also provide services to one of our sister provinces in P.E.I.

The last fact I'll leave with you before we start is that the 811 program is supported by two clinical advisory committees whose memberships are often local clinical experts that support both our mental health programs - Gambling Support Network and Tobacco Free Nova Scotia - as well as our Teletriage program. They provide input as related to clinical guidelines, quality metrics, and outreach. That's all I have to say to start.

THE CHAIR: Thank you, Dr. Howlett. We will open up questioning, starting with the PC caucus - Ms. Adams for 20 minutes.

BARBARA ADAMS: Thank you, Dr. Howlett. I'm wondering if you could start off by giving us some numbers and I'm wondering when the last time there was an 811 report that we could actually refer to and look at.

For the 10 years that the 811 system's been in place, we don't have a good understanding of the breakdown of the number of calls, how many were for mental health, how many were for whatever. I'm just wondering if you could give us a sense of some numbers as to how the numbers break down.

TODD HOWLETT: I'm going to ask Natalia to provide some of the numbers. I think she has some data that you might find helpful, and certainly, you can ask more questions after that.

NATALIA GALLANT: These statistics are from April 2018 to June 2019. In terms of total patients serviced for the program, it would be 114,000. The majority of our patients are repeat patients, so that would be a total of 80,000, which would be approximately 70 per cent. In terms of mental health-type calls, it would be about 2 per cent of our calls.

BARBARA ADAMS: Thank you. That's helpful. Given that last year, the number of people who were without a family practice doctor or clinical nurse practitioner went from 45,555 to 51,802 - an increase of about 13 per cent more without a family doctor, according to the Nova Scotia Health Authority statistics - what percentage of people calling 811 are without a family doctor?

NATALIA GALLANT: That wouldn't be a statistic that I have here today.

BARBARA ADAMS: Is that a statistic you collect?

NATALIA GALLANT: Part of our call process is that we do ask patients if they currently have a primary health care provider; that is part of the call process that we follow.

BARBARA ADAMS: Is it possible for you to get us that statistic?

TODD HOWLETT: Yes, absolutely. I don't see any reason why we couldn't provide that statistic.

BARBARA ADAMS: I'm surprised that only 2 per cent of the calls were for mental health. I'm wondering, when those calls come in, if it's a physical ailment that's considered an emergency you would direct them to either a walk-in clinic, family doctor, or emergency - when mental health calls come in, what's the triage instruction?

TODD HOWLETT: We have guidelines. Perhaps I can take just a moment and talk a little bit about our evidence-based guidelines just to educate the committee a little bit, if I could. We have some 300 adult and 300 pediatric guidelines that are based on various symptoms, maybe it would be shortness of breath, it might be weakness, and we have some mental health guidelines that are related to people who are in distress or presenting in it.

The guidelines work in such a way - it's important to note that the system is not diagnosing or treating patients other than in what we call self-care. People call in and through the nurse interacting - it's important that it's a registered, experienced nurse interacting - using a guideline, we come up with an output.

As you mentioned, our output is, broadly speaking - and I'm going to get to the mental health one, but I think it's important to situate it, if I may - would be 911. There are some situations: perhaps they called 811 by error or mistake or it becomes clear that we should be sending an ambulance, go to emergency; and then we have a number of different ones: seen within 24 hours, seen within 48 hours, seen within 72 hours, seen within a week, seen within two weeks, and up to home care. That's basically around the idea that we hope you'll be able to see your family doctor within two weeks, and as you mentioned, that may not be possible.

For mental health it's similar. One of the important outputs that we partner with is both the Mental Health Mobile Crisis and Mental Health Crisis Telephone Line in the rest of the province. We've done this the same way with Poison Control and other organizations within this province that provide great care.

We're not here to take over their care but rather to partner with them and to work, so in many cases one of the outputs may be that we think you need to go to mobile crisis.

Now, on the other extreme, if we're worried about somebody - and remember, I want to be clear, this is not 911. You're calling 811 because you may not know what's going on. Say you called in, and during that conversation we have had scenarios where we have been significantly distressed by somebody to the point that we've actually sent a wellness visit to their house; we've actually contacted the police and sent somebody to check on a person. Say somebody was incredibly distressed and was threatening to harm themselves and we were worried about them, we would actually do a wellness check and actually send somebody to their house, so we do that.

BARBARA ADAMS: Thank you for that information.

The cost estimate for one call, I've seen documented that it's around $52 per call, and some have mentioned that a physician visit costs $38. I'm wondering if you can comment on whether those two numbers are accurate and why you think there's a difference to that and certainly whether that's a good value.

TODD HOWLETT: It's a great question and I've heard that quote; in fact, one of my colleagues - I think it was Barb O'Neil - actually put it. I know Barb, she's an excellent physician. Let me say that the cost estimate per call, it's an overly simplistic analogy. There is a lot that 811 does beyond just the calls that could not be provided by a physician, as such. First of all, it's available 24/7, it is available to every person in this province - assuming you have a phone - it provides a continuous service, data and information that a family doctor may not have.

[9:15 a.m.]

In addition, one of the things we talked about - and we like to talk about it - is it is a bit of a safety net for the community as well. If I may, I'd like to highlight that shortly after we started this program in 2009 - if you guys remember the Fall of 2009 - we were hit by H1N1. I know, and we have some volumes here, that our call volumes went up; I don't know if you can see this or not, but it peaked. We went 10 times the call volumes overnight because people needed to respond and get information, and 811 was there to do it.

It was extraordinarily challenging. We had to hire nurses beyond the province to actually cope with the call volume. This is one of the services that 811 has; it's not included in this $50 per call because that's part of what we're doing. I use the analogy that you don't know that you need a smoke detector unless you have a smoke detector; what's the cost of a smoke detector, because it has to be there.

The other things that are going on, and hopefully we'll get to that during some of the questions - and I'll try not to bore you with all the things I want to say - I do want to mention that we even have a role in medical surveillance in the province.

Yesterday, Dr. Robert Strang, our Chief Medical Officer, was visiting and as part of that - with emerging illnesses and the like - we're looking at using the calls that we're doing at 811 as a role for the medical surveillance of public health in this province.

Somewhere hidden in that sound bite of $50 versus $30 - and I understand what's going on with the family physicians and their concern about their pay and everything else - but I think there's so much more we're getting out of that. I'm obviously convinced that there's value to it, and I think there's some evidence that that exists.

BARBARA ADAMS: Everybody I've talked to finds the service of tremendous value, especially at 3:00 a.m. with a sick child. I wonder if you could tell me, how many of the calls are about children versus adults versus seniors?

TODD HOWLETT: I apologize, we've brought some data about our top 10 clinical guidelines that are both adult and pediatric, but we did not bring what percentage is pediatrics. We can certainly make that available to you and be happy to do that. I can share with you, from April of last year to June of this year, the clinical guidelines used, just to give you some interest in that.

The top guidelines used, one, was chest pain for adults; the next one was a medication question call around adults. People are calling about medication, many of those - depending on whether we deal with it or not - may actually go to Poison Control. They do some medication concerns and we work back and forth; pediatric cough is the third guideline, perhaps not surprisingly - there is some seasonal variability.

In our clinical advisory committee, if you were to come and watch it, you would see we know when flu season arrives, we know when RSV season arrives because we start to see some of these guidelines going on. I want to refer to my earlier conversation about medical surveillance. We can start seeing these calls go up, and working with Robert Strang, we can help some of that. The fourth one is abdominal pain, female; diarrhea, adult; vomiting, adult; colds, pediatric; vomiting without diarrhea, pediatric; headache, adult; and back pain, adult. Those are the top 10 guidelines used that people are calling in for.

BARBARA ADAMS: I'm wondering, given the fact you mentioned back pain and medications, whether there has been a consideration to having a pharmacist call a patient back or a physiotherapist call somebody with back pain. I'm just wondering if there's any opportunity to expand the service to other allied health professionals.

TODD HOWLETT: Interestingly enough, we do have a pharmacist who sits on the clinical advisory committee. He's from the Northern Zone and he's fantastic and we do a lot of work through it. We've explored that.

The challenge about 811 is we have to be a generalist. It's very hard to say, have a dermatologist to do skin. We're trying not to diagnose but to have a high-level response to what we do. Having a pharmacist, for example, on our clinical advisory committee and providing input into our clinical guidelines is very helpful.

If I can, I'll take a moment to say that our clinical guidelines come to us from an outside author. We partner very clearly with our local health experts to ensure that what we're suggesting is compatible. For example, breastfeeding - we have an organization. We wouldn't provide advice that was in any way incongruent with what is here.

I'll give you an example that happened yesterday. We have a new guideline coming around colonoscopy. Everybody may have had a colonoscopy or endoscopy - nobody wants to talk about those things, but they're an unfortunate necessity. One of the things we're finding, which was incredible, was that often people would lose their preparation instructions, it would be the weekend, and they'd be calling 811 and saying, I've waited eight months for my appointment, and I don't have the instructions. I need to get this prep right. What do you want me to do?

Interestingly enough, we now actually have a senior director and two physicians who are in charge of endoscopy in the province. I called them up, and said, what's the plan? We're working on that. I said, what do you mean, you're working on that? There are like 45 difference preparations that each physician has. I said, well, that's crazy - sorry, that's not the right word - that doesn't make any sense.

They've now standardized it to two, and I'd like to think we were part of that, challenging them to standardize it to two - if you have or don't have renal failure. We have these guidelines that we've shared with them, and they're going to provide some input. In the future, a couple of months from now, if you call in and you've forgotten your preparation, we've spurred the province to say we'll standardize it. There isn't enough evidence to have that many - 42. We can have two standard ones, and we'll be able to provide that. You can go to the pharmacy and get your preparation and hopefully not miss your colonoscopy. You might want to miss your colonoscopy, but you shouldn't.

In answer to your question, very important - Natalia and Wendy reach out regularly to experts in the field to inform our guidelines.

BARBARA ADAMS: If I call 811 and I get instructions to do one of several things - I'm wondering two things. One is, do you track whether I actually follow up on those? Could we say, 40 per cent are all sent to emergency, and we know that 22 per cent follow up on that? The other thing is, does a physician get notified that I've called 811?

TODD HOWLETT: Both great questions. On the first question, we would love to do some outcome research on what we're doing. Unfortunately - this is the privacy officer next to me - there are some privacy issues for us to actually find out if you attended a facility. It's not simple. You'd think we could just say did you show up in emergency? But we can't do that without your permission.

There was some recent external review that looked at it, and it talked about whether people followed the advice or not. Generally they do. We also try, at the end of a call - and it's fraught with some problems - to say, this is our advice; can we ask you what you would have done had you not called 811?

We have some of that data, and if you'd like to see that, we'd love to share it with you. But be aware that there's a bias there, because we've asked you at the end of the interaction - we've given you advice, and then we've said, what would you have done beforehand? It is very difficult to say, before you tell me about your chest pain, tell me what you were thinking of doing. It's hard to do it at the beginning of the call. We want to get to the chest pain. We don't want to ask you too many questions about what you were doing, and you're going to think it's a little crazy if you're like, what I want to do is call you, so I did that.

BARBARA ADAMS: Thank you for that. Apparently, there was an independent consultant retained by the department in 2018 to review the 811 system. I'm wondering if you have that report with you, and if so, what were the major conclusions?

TODD HOWLETT: We do not have that report with us. There were a number of very positive things that came from that, and I can speak to a couple of them if you'd like.

If you know me, I like to talk about the elephant in the room. One of the critiques about 811 - I'm an emergency doctor, so 1-800, go to the emergency department. I can tell you our breakdown from our dispositions of what has happened.

A lot of health care providers who are in busy emergency departments, including myself and my colleagues, see the numerator and not the denominator. We know the people who were sent in, and we remember them, but we don't know the people who weren't sent in. By our very nature, we have a bias.

In the last year, of all the people who called in, approximately 4 per cent were sent to 911, of all the calls; 1.9 per cent went to Poison Control; 0.3 per cent of people were forwarded to the Mental Health Crisis Line - I have heard from a number of members that in particular parts of this province, mental health is a significant concern; 18.7 per cent were directed to the emergency department, not everybody; and then those other dispositions, primary health care provider and the like, works out to be about 42 per cent. Self and home care worked out to be 30 per cent overall.

I'm not an expert in queueing theory but let me explain. Ideally, if everybody calls to us, and we can arrange that you be seen tomorrow or the next day, then it would help the system in some ways. The challenge is, you have to have an appointment tomorrow or the next day, and that's where the walk-in clinics come in sometimes and other things.

Those recommendations, we actually talk about the primary health care provider. The nurses spend a lot of time in every area - if they're in Cape Breton or on the South Shore, and the disposition is the next day, how that may look may be very different.

If you're lucky enough to have a family doctor and have a same-day appointment tomorrow, great. If you're not lucky enough to have that, you need to go to a walk-in clinic. If you're not lucky enough to do that, you may need to go to your local CEC. Though we say primary health care provider, there's a lot of problem-solving done by the nurses in each area to figure out where the person needs to get their care.

BARBARA ADAMS: I think I have time for one more question, and it's a bit off topic. According to the Nova Scotia Health Authority's "By the numbers," the number of beds in the 2017-18 report was 3,554, and the number of beds in 2018-19 was 3,150, so it's a loss of 404 beds. I'm just wondering, where did those beds go? Where were they lost?

TODD HOWLETT: What kind of beds are we talking about?

BARBARA ADAMS: I don't know. It's according to the Nova Scotia Health Authority beds. It just gives a list of the number of beds in the hospitals and says . . .

THE CHAIR: Order. Time has expired for the PC caucus. We'll turn it over to Ms. Martin from the NDP.

TAMMY MARTIN: Saved by the bell. I'd like to talk about the need for family practice and who actually is finding a doctor as opposed to just coming off the list. Are you tracking the demographics of those people who are finding doctors?

TODD HOWLETT: As I mentioned in my opening remarks, the connection to 811 and Need a Family Practice is purely to collect the numbers and pass those on to the Nova Scotia Health Authority. As such, we do not actively manage that list, and I actually don't have the numbers on the list.

The role of 811 was, we have a number, people can call there, and all of that data is then passed to the Nova Scotia Health Authority.

TAMMY MARTIN: Do any doctors actually have to take patients off the list, or is it fully optional for them? I understand that there was an incentive program in place that offered doctors additional compensation for every patient that they were able to add to their roster who was on the 811 list. I think many people aren't clear as to whether calling and registering themselves as someone in search of a family doctor will give them priority over searching on their own. Is that a priority list, being on the 811 list?

TODD HOWLETT: I'll refer to my previous answer. We don't manage the list, and the way that someone is taken off the list is managed by the Nova Scotia Health Authority.

TAMMY MARTIN: It strikes me that the service produces a ton of useful data, both about the service itself and about the health issues people are facing in Nova Scotia. What are we learning from the 811 data about health issues in Nova Scotia, and is anyone looking at the data in a systematic way? Is that data available to health policy researchers?

[9:30 a.m.]

TODD HOWLETT: I really appreciate that question, it's a great question, and I think we're challenging ourselves to do just that in two ways.

One is through working closely with the Nova Scotia Health Authority specifically around the new programs of care. We're systematically meeting with each of those. As you may know, the Nova Scotia Health Authority now has programs of care on cancer care, mental health and addictions, emergency care, critical care, and as such, they have a senior director and a senior medical physician.

We're making a point of reaching out to them. Last year, we sat down with Drew Bethune, who many of you may know, who is director for cancer and talked about what their challenges are and what we might help them with. This isn't specifically about data but is a shared opportunity.

One of the things that came from that - it may or may not work out - a lot of people who were getting IV chemotherapy are now on oral chemotherapy agents, which are still quite expensive; still quite effective.

Now the issue has become compliance with taking the oral medication, so they were exploring whether they should have a nurse calling out to ensure that somebody who now lives on the South Shore or somewhere else that doesn't come in for IV chemo is actually getting their chemotherapy agents.

I said to Dr. Bethune, perhaps we could partner together if we already have nurses and we could provide that service and it might be cheaper for the system than building another system on top of what we have. We're trying to do that each step.

One of the people I hope to meet is the new vice-president for research that the Nova Scotia Health Authority has. I'm quite passionate about doing some evidence-based and outcome research, and I think the program is well placed for that to meet with her and find out what data we can glean from this.

Primary health care is another example. We have a meeting coming up with Dr. Rick Gibson and Lynn Edwards to look at what we might learn from 811 when it comes to primary health care.

So, it's a great question. It's certainly a focus, and something we want to do is to share. The province deserves us to do this. We need to get this right, and we need to figure out what we can get from this system to show the Nova Scotia Health Authority what might be needed. Absolutely.

TAMMY MARTIN: Just to follow up on that then, is the data that's being collected being studied and evaluated to provide suggestions and/or comments to the NSHA?

TODD HOWLETT: Yes, we are doing some of that through our clinical advisory committee. One of the people that joined us recently is a researcher and has an interest in this from the IWK.

A large number of our calls are from the IWK and we're exploring how we might do this. We talked about some outcome research, trying to figure out what's actually happening to people. Do we have that right yet? No, I don't think we do, but I think we will do that.

One of the neat partnerships that has changed recently is our program was taken over by EMCI, from McKesson, so we're third party. EMCI does a lot of research, and we're having some meetings and collaborating both on continuous quality improvement projects and with research, as well, because they have more resources than we have. Yes, we're in the infancy of that, but that is exactly what we intend to do.

TAMMY MARTIN: To clarify, has the data not been used for the last 10 years, and is this a new approach?

TODD HOWLETT: I don't think that's a fair characterization of what I said. I think we have always shared the data. We have always passed the data on to our partners.

Formal research has not been done on this; I think that's fair. We did a micro research project with a former dean. There are different levels of research: there's publishable research and there's CQI-type research. We have continuously fed that data back to various stakeholders within the organization when we've found something that seemed amiss, so there has been a lot of interaction with stakeholders within the province.

I think what we're suggesting now is we might be able to take it to another level and leverage some of the resources that exist within EMCI. I think you guys know that we have one of the premier pre-hospital systems in the province, our EHS system. They are doing a lot of research and we're hoping to partner to do even more with what we have now. It would be wrong to say we haven't done this. We have, it's just that I think we can do more.

TAMMY MARTIN: Thank you for the clarification. Aside from H1N1, what has the trend been in the usage of - you spoke about H1N1 showing a significant increase, but has it been an upward or downward trend?

TODD HOWLETT: I think the last conversation we had is that overall the numbers have been slightly less and one of the external reviews questioned as to why. The premise had been that the program - you should see an uptake and increase to that.

One of the challenges we have at 811 is that we are not responsible for our own advertisements. It's all done through the Department of Health and Wellness, so we are encouraging them to maybe make more fridge magnets - to advertise it. I think that's getting better.

During some of the conversations we had, the hypothesis that the 811 number should always increase is something in particular I'm not sure about. I'd like to think that a large part of what 811 does is education. If you're a young mother and you have three children and you have a fever and you don't know how to treat it and you've called 811 and we've given you advice and we've educated you, then perhaps you don't need to call us the second time because we've done that.

I do think in a lot of what I do, you always say more is better. I think we can do a better job of advertising the program, there's no question, but I'm not sure that the slightly decreased number is necessarily a bad thing. It may mean that we're actually educating people, but we can provide those numbers.

I apologize that we don't have all these numbers in front of us, but we can certainly tell you what the numbers were and the calls for the 10 years of the program. We'd be happy to provide that for you, if you like.

TAMMY MARTIN: Earlier you spoke about in 2010 there were reports on HealthLink 811 that would include analyses and trends. What is success for 811 at the end of the day? What are the outcomes that 811 needs to meet at the end of the day or at the end of the year? How do we know that 811 actually is successful?

TODD HOWLETT: I'm not sure it was 2010. I think the report was from 2018; it was within the last year.

The external report looked broadly at whether we had value and whether there was value for Nova Scotians, whether people who called us, who went to the emergency department in a match control might be sicker - I'm using simple terms - than people who went on their own, there was some data. They got permission to follow people through, using an MSI billing number. They showed during that time that for matched patients - and I may not have this exactly right - the people being referred by 811 were at a higher acuity level.

I imagine many of you are aware that in the emergency department - and I'm an emergency physician - we use this CTAS level, Canadian Triage and Acuity Scale, of one to five, with one being the sickest patient and five being the least sick patient. It's sort of a proxy for sickness, the idea being that if you were doing CPR, you're a one; if you've come in because you've run out of your antacids, you're a five; if you're going to Boston this weekend and you want to be sure you don't have heartburn, that would be a five; and there's all kinds of stuff in between.

Now, there are some fives that are not quite that frivolous, but it looked like the data suggested that the people referred by 811 were higher acuity and different than those people.

Success is an interesting thing because I guess success is in the eye of the beholder. We have a performance contract with the Department of Health and Wellness, and there are deliverables in that contract that we have to deliver certain calls.

We were one of the last provinces to adopt an 811 system, for whatever that's worth. The overwhelming responses from the people who use 811 are overwhelmingly positive. We will always hear the negative of 811.

We are constantly struggling, and it's a struggle, in our CAC to find the balance between making sure we do not miss anything serious and creating a program that's sensitive enough not to miss a serious case, and at the same time having sufficient specificity so we're not sending everybody into the - you know, those are the two risks of the program, I'll be honest with you. One is, it seemed to be, we're too sensitive and everybody's sent in to be seen by somebody, and the other thing is that we miss something.

I think it was wrong to characterize the program early on that this would be a way to divert patients from the emergency department. I don't think there has ever been any evidence that that's the case; we just changed the people who go, people who went to the emergency department or who should go to the emergency department who didn't.

As an emergency physician, we sometimes hear about the person who stayed home, had heartburn, they had a heart attack three days ago, and their heart's in trouble - now. Those people we're sending in, and other people we may be not sending in; so, yes.

TAMMY MARTIN: In 2010, there was an accountability report done and in 2018 there was an external review. Typically, these are made public and published on the Department of Health and Wellness website. Can you confirm that these are public documents, and if so, that we could actually have copies of them? I believe we received the 2010 one, but nothing further.

TODD HOWLETT: Thanks for clarifying that, the recent review. That was done by the Department of Health and Wellness, and as such, it doesn't belong to us. It was an external review, and I'll have to defer to them as to how they make it public because it's not within our purview to actually make that public.

TAMMY MARTIN: Is there an accountability report published every year, and if not, why isn't there?

TODD HOWLETT: I'm unaware of accountability. Just like our EHS system, we have performance requirements that are done, an accountability as such. We have regular meetings with the Department of Health and Wellness on what our performance contract obligations are, but I'm unaware of - and it may just be that I need to get some more information about whether this actually is called an accountability report.

We have a compliance review. Do you want to talk about that?

NATALIA GALLANT: As Dr. Howlett stated, it is a performance-based contract, so a yearly compliance review is completed, ensuring that certain metrics are followed within the contract. That's completed on a yearly basis.

TAMMY MARTIN: Are these public documents?

NATALIA GALLANT: That would be something for the Department of Health and Wellness to speak about.

TAMMY MARTIN: When we talk about data, we need to talk about privacy. I'm wondering with 811, how do we ensure that the personal information of people contacting 811 is not at risk or distributed to those who shouldn't have that information?

NATALIA GALLANT: Just to clarify, are you speaking internally or externally in terms of access of information?

TAMMY MARTIN: I'd like to know the procedure. If I was to call 811, what is your privacy policy around my personal information and where that could end up?

[9:45 a.m.]

NATALIA GALLANT: When anybody phones into 811, a confidential chart is started with their information so that we're able to document the reason for their call. Anyone having access to that chart is delivering care or service to that patient, so it is role-based access. Any access to any charts is monitored on a regular basis.

TAMMY MARTIN: Just as a follow-up to that, is that connected in any way with the NSHA patient information?

NATALIA GALLANT: It is separate altogether. The information rests within EMCI. We are an agent for the Department of Health and Wellness, which is the custodian of the information.

TAMMY MARTIN: But it's not connected to my chart? I guess to be clear, if I had a heart attack, would there be a record of that in my family doctor's chart, or if I was sent to emergency?

NATALIA GALLANT: For continuity of care purposes, if someone phones into our service and we recommend that they go to the emergency department, we ask if we can send a referral of the 811 chart to the emergency, and if they give their consent, then we send that over immediately.

TAMMY MARTIN: I'm wondering, too, with people calling in and their personal information being held by a third party, is that on-site - how is that physically held?

NATALIA GALLANT: It is on-site and there was an in-depth privacy impact assessment completed at the start of the program and with each contract, ensuring that privacy standards are met.

TAMMY MARTIN: Is it something that's reviewed annually - privacy policies and concerns? By the look on the doctor's face, I'm guessing it's a yes. We've heard recently of breaches - sadly, accidents happen - but is this something that's scrutinized frequently?

NATALIA GALLANT: Privacy is of the utmost importance and ensuring the safety of patient records and patient information.

THE CHAIR: Order. The time has expired for the NDP. We'll move on to the Liberal caucus for 20 minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: I'm delighted to see you guys here. I remember receiving a call 10 years ago - and I think it was six months before 811 was to be opened to the public and I thought, wow, what an amazing service that we're going to have. It was something for the future that we can call 24 hours. The call that I received was from the organization on how to provide interpreting services, as I was the president of that organization.

I'm wondering, in 10 years - I know at the time, privacy was the biggest thing for me to provide interpreters 24 hours and to make sure that they had a room where they can answer with total privacy and other things. First, my question is: How are you providing services to newcomers in different languages, and how many calls do you receive from non-English speaking clients?

NATALIA GALLANT: We do partner with LanguageLine Solutions, which is an interpretive language company. They provide a language within 240 languages. It's typically if a person phones in to our service, requiring an interpreter within a one-minute time frame or less, we do have that interpreter on the phone. It is part of our contract with LanguageLine Solutions that it is an interpreter with medical terminology, because that would be really important in providing our services.

We do have some bilingual staff as part of the 811 service to provide French services as well. If there are no bilingual staff on, then we can escalate those calls to LanguageLine Solutions as well.

RAFAH DICOSTANZO: Do you see the numbers? Are the newcomers using your service? I just want to know how it is promoted, how is it reaching the newcomers? It's a wonderful service, especially if they're new to the country. What are you doing to make sure that they know about you?

WENDY BOUTILIER: We work diligently with newcomers. (Interruption) I work with ISANS as well, but we do the outreach with newcomers, is what I'm trying to say. So, yes, we work closely with ISANS. We're building a partnership so we can learn what we can do to help them and what their needs are and what they're looking for from us, how we can better serve them. We're working closely with them and ISANS.

RAFAH DICOSTANZO: I didn't hear the percentage of calls that require interpreting, from the patients - I don't want to call them patients or clients. Am I allowed to call them patients? - who are calling who have medical issues.

WENDY BOUTILIER: I will refer that to Natalia, who keeps track of those statistics.

NATALIA GALLANT: We keep track on a monthly basis in terms of usage with LanguageLine and what specific languages were used. I don't have those specific stats, though, here today.

RAFAH DICOSTANZO: The other question I had for you is for the future: Where do you see 811? What are your hopes? What else can you do to improve, or what is happening in other jurisdictions or across the world? Is having a Skype method where, to me, if somebody has a rash and it's so hard for somebody to describe the rash, compared to a different rash, is there a way for the future that we can have video teleconferencing?

TODD HOWLETT: Yes, that's really exciting, and we've had some of those discussions at our clinical advisory committee. One of the challenges we presently have in this province is to ensure that we provide a universal service to all people in Nova Scotia. I know we're looking to have high-speed Internet in all areas but it's not available at this point, so not everybody has access to it. I think we have to be careful just to make sure we have a universal service.

I think the future of doing that, and I've even sat down with somebody from Bell and said, perhaps there would be a biometric device on your cable box that was built in, so you'd go over and put your finger on it and we'd know what your O_2 saturation was. If we're really going to think outside the box, we need to start thinking towards something like that, and then we could inform a guideline by knowing what the person's saturation level was.

The future might be visual or even some sort of biometric device. So many people have this crazy thing now - and I have one of these crazy things here - you can now get an EKG, so to think ahead and wonder whether this is something we could do is there. It's the art of the possible. I don't know what it is yet but clearly it will change, there's no question.

RAFAH DICOSTANZO: What do we know about what is happening in other jurisdictions in the world, that is more advanced than what we have here in Nova Scotia, that we are aspiring to have? Is there anything like that?

TODD HOWLETT: It's interesting. One of the things I think we need to be a bit proud about in Canada, and I'm going to speak up, is that our socialized medical system is very different than in places like the States. We often think the States are very advanced, but they're not advanced in a systems sort of way.

I'm just going to lead back to the question, but I want to explain this to you. When dealing with one of the guideline authors and we were talking about the work we are doing between 811 and 911, which is really important to say, what if we get somebody who goes to 811 and then 911 - or, more importantly, 911 to 811.

We've explored, what if you call 911 and they're like we don't really think we need to send an ambulance to this person - we've heard about some of the problems they have with ambulances - but maybe we can run it through 811 and come up with a different disposition with the understanding they could bounce back to 911 if we could come up with something. Just imagine that for a moment.

He was like I would love to have a system like that, but they don't run their health system in the same way we do at a provincial level. They don't run their ambulance service - sorry, at a state level, so it's very cut up. We're leading in this sort of coordination. Having said that, some other areas are using their system and if they're in a well-to-do area, I imagine somebody's now using their Apple Watch to do all that. I want to continue to explore those, but I'm just saying in Canada it's a little bit different because we don't have everybody necessarily with an Apple Watch.

Now, across Canada, I think we're similar to what's going on. We are interested, and we're big fans of benchmarking. Wendy sits on that committee. It would even be helpful, if I may say, that if somehow it could be legislated that all 811 programs had to be part of a national working group. One of the downsides of having a third party is sometimes its proprietary, but those of us who work at it would love to actually say there has to be a national working group and that every province's group has to be part of it, and that would help us with the benchmarking.

We've created some internal benchmarking; we've created some standards around our callback times; we monitor a great level of the stuff. We haven't gotten to the quality metrics that we use, but it would be fantastic to be part of a benchmarking group. The very nature of 811, and rightly so, that is provided by a third party in many provinces means that it's not quite the same. It would be great if somehow there could be support to suggest that some sort of national working group that every 811 program medical director would have to be part of a benchmarking group nationally. I think that would be a really important thing for us to do, and it would hold us accountable. Does what I said make sense?

RAFAH DICOSTANZO: I think so. I didn't even know if the same number is across Canada, so every province has the same number: 811? Is that something that you're referring to?

TODD HOWLETT: Thank goodness for that; yes, 811 is the standard number across Canada. Most places are run by a third-party provider, as we are here. There is one province that does it themselves and we interact quite a bit with that province: Alberta.

We are big fans of benchmarking with other provinces, recognizing to your point, that we may not know it all. There may be advances somewhere else that we should be adopting.

RAFAH DICOSTANZO: You talked about benchmarking. Where are we compared to Canada and maybe Australia or England; is there anybody else who's gone further or invested more finance into this service?

TODD HOWLETT: It is difficult for us to get those benchmarks because of this proprietary sense of it. The national health services - I haven't looked at it for a while, it might be appropriate - Australia has some fundamental differences in the way they approach some things. There are some things to learn, but it's not completely the same.

I think there needs to be more benchmarking so we can answer that question clearer for you. I'm here to say that we have the best program and I think we have an excellent program. Do I have benchmarking data that clearly shows that? No. Am I desperate to get that? Yes.

[10:00 a.m.]

RAFAH DICOSTANZO: I used your service when the kids were small, and I was very grateful. It's more comforting going to bed and knowing that you didn't have to go to emergency that night. It has worked amazingly for us.

I think I'm done with my two main questions and I pass it on to my colleague.

THE CHAIR: Ms. Miller.

HON. MARGARET MILLER: Thank you for coming in. This is such a good-news story for Nova Scotia, and the work that you're doing has helped so many people. I have been one of the people, too, who has called 811 in a situation where I wasn't quite sure - do I go to the hospital, do I not, maybe a doctor wasn't available. I don't remember the exact circumstances, but I know that person on the end of the line gave me the confidence that I needed to be able to make a decision on what I needed to do. It seems to me I remember them calling back to follow up. It was quite a while ago; I was even more impressed that they even called back. Thank you for that.

I loved hearing you talk about the future, where 811 could possibly go. Do you have anything else on your wish list? What do you envision happening in the future? Do you have something on your wish list that you would like to be able to add to the program that you think could add value?

TODD HOWLETT: Thank you for the opportunity to ask me that question. Yes, I think the best way to think about 811 - the way that helps me to think about 811 - is it's a platform of which we can connect and build up with others. We have this platform; it exists. We have a number that everybody knows, and we can build services around that.

As the Nova Scotia Health Authority establishes standards across the province through their programs of care, which I've talked to you about before, we are meeting with each of them and asking, what can we do to help?

We are exploring ways to work with our colleagues in primary health care to maybe even help them prioritize which patients should be seen the same day. I always use this analogy that if you call your family doctor, who do you speak to and how do they decide whether you should be seen today or two weeks from now? What guidelines are they using to make that decision? It's often their assistants and it might be the next available appointment.

But what if we can partner with them - we're trying to do that - and help use the guidelines to perhaps triage the people that are trying to see them and work through their appointments. We're looking to trial that in some areas so that we might actually be able to help the primary health system to do that.

We did that some time ago with Dal family practice, where the people were calling in during the day and the nurses were quite uncomfortable about new complaints because they didn't know these were new complaints; there had been a bad outcome, because somebody had called them with back pain, and they didn't have any evidence-based guidelines. We helped Dal family practice so that people that called in would call us and if they needed to be seen that day, we would send them to Dal family practice. That's one that I think is important.

The idea of chronic disease management is something that's very appealing to me. The future of that is quite interesting. There are a number of people in the Nova Scotia Health Authority, researchers, looking at chronic disease management. I think the model probably needs to change at some point. I think most people that come in who have diabetes also have hypertension, might have COPD, and they have something else. Yet in our current model - many of my good colleagues would acknowledge this - we divide those parts of the person up. You go see your lung doctor, and then you go see your heart doctor, and then you go see your diabetes doctor; the family doctor is sort of quarterbacking all that. But to actually have a chronic disease, what could we do to support that?

We did do a trial some time ago. It didn't quite take off, but part of trying to do something different is you have to fail. But we looked at using it for diabetes and supporting people as an outpatient in diabetes. I think there is a role for us as 811 not just to be on the receiving end, but to be on the calling end and helping people in doing that.

There are a couple of other programs that you should be very proud of in this province. One is called the INSPIRED program. Some of you may have heard about it. INSPIRED was a program that was done by Graeme Rocker. It's gone across the country, and it has to do with the treatment of COPD. We've partnered with them.

There are a lot of great things that are happening in Nova Scotia. We sometimes need to talk about them a bit more.

But back to your question, what is it - I think it is this ability to connect and serve as a platform with all these other things. Like I said with Drew Bethune, there will be a connection there. Mental health, which is a struggle - we're not the answer to mental health in the province, but we can connect to the answer. When people end up with us, we can call and connect people to Mental Health Mobile Crisis and the like. There are a lot of different things like that that I think we can do.

Just a moment on our quality - I want to brag a little bit about Natalia. It's a little bit different. As many of you know, I have some other leadership positions, and as such, I often have to deal with potential concerns or complaints. I just want to talk about that if I could, for a moment.

I would encourage you that people do call us because they're unhappy with the service. Like any mature service, we need to welcome those concerns and recognize whether there may be something there that needs to be done. The process when you call 811 and there's a concern, that Natalia investigates it, we talk to the person - it may be a provider - I may call them. We find out what's going on and we review the case.

When we review the case, it is unlike anything else I've ever done, because 100 per cent of the interaction is recorded. Can you imagine? Sort of like this, I guess. So it's not like, what did the nurse say to the doctor, what did the doctor say to the patient, what was the body language? It's 100 per cent recorded.

THE CHAIR: One minute.

TODD HOWLETT: I can talk forever. It's unlike that. And then we typically will get back to the person and figure out what's going on.

I'll cede the rest of my one minute to you.

MARGARET MILLER: I just want to thank you again for the service. I don't know which government started that, whether it was the end of the Progressive Conservative Government or the NDP, but I certainly want to give credit where it's due. It's a great program. Thank you so much for all your work and dedication.

THE CHAIR: We will turn it over to the PC caucus - Ms. Adams, 14 minutes.

BARBARA ADAMS: I'm just going to ask the one question we didn't get finished. The Nova Scotia Health Authority "By the numbers" report for 2018-19 - there's one every year - and this one specifically states under Care Delivery, Beds, in 2017-18, 3,554 beds were staffed and in operation, and the next year it was 3,150. That's 400 less beds.

We hear all about the escalating emergency room closures across the province over the last few years, which is causing havoc, but I'm wondering if you have any comment on why we have 400 less beds in operation from one year to the next.

TODD HOWLETT: Today I've come here in my role as the Medical Director of 811, and as such, I would, respectfully, like to answer questions related to 811.

THE CHAIR: Mr. LeBlanc.

COLTON LEBLANC: Thank you for joining us here this morning to discuss this important system. It plays an integral part in the health care system here in Nova Scotia.

Just to be clear, when it comes to the need-a-doctor registry, your role is strictly collecting names and data?

TODD HOWLETT: I think we've been asked to perform another role, but it's to call the people on the list and verify whether they have a doctor or not. Again, that data is not our data. It is data that we're sharing back to the Nova Scotia Health Authority. I think I'm getting that correct. So they call in, need a family doctor, we take the information, we pass that on. More recently, I think we contacted 20,000 people just to find out if they're still on the list.

I literally do not review the data. I don't have the data. But I think it was a building-upon scenario that 811 was a number that everybody knew, that they could call, and it was easier, rather than creating a new number.

COLTON LEBLANC: Thank you for that answer. I guess when we're going to be discussing questions as to how we're dealing with the registry and taking people off the registry, it would be nice to have some guests from the Department of Health and Wellness or the NSHA.

What's the average wait time when people call 811; is there a delay when it comes to answering the phone?

WENDY BOUTILIER: We strive to answer our calls within 30 minutes 90 per cent of the time, and for the most part we're very successful in doing that.

If the nurses are all on calls, we have non-clinical staff who will answer the call within 20 seconds 80 per cent of the time. What we will do is we have a prioritization list, if the non-clinical staff deem the call an emergency, they have the ability to transfer directly to 911, or if they deem the call high or more urgent than a medium call, if you will, then they could transfer that patient directly to a nurse.

We ensure that there is no delay in care. If the call is of an urgent matter, we take care of it; otherwise, we will call back our patients within 30 minutes.

COLTON LEBLANC: Earlier you noted that 70 per cent of the calls received are repeat calls; that's a very large percentage. You spoke about the 811 chart - in your system, is there a patient database or a patient charting database that there's a follow-up? If I call today with one complaint and I call next week, is there a way that your nurses can actually follow up on the same patient?

NATALIA GALLANT: Each record of the patient is kept but each transaction or each call into our service is kept separate because if they are calling in for a different symptom, perhaps symptoms have changed or worsened in that, so we do keep them as stand-alone for each call.

There are certain situations, depending on what recommendation we are giving, that we will follow up with a patient in an hour to see if that interim care advice that we have given them has worked. If it has, that's great, then we'll continue to provide them more advice at that point in time. If not, then we may recommend for them to go and be seen, just depending on the severity of their symptoms. There are times that we do telephone callbacks within an hour, depending on the situation.

COLTON LEBLANC: Earlier you alluded to time frames that are acceptable for different patient outcomes. If I have one ailment targeted time to see my doctor the next day or two days or within the week, does 811 collect information to see if that timeline or those timelines are actually achieved?

TODD HOWLETT: That's not completely true. We do a callout on a percentage of our patients to find out what actually happened. Ideally, and this is the outcome of base research in trying to sort out what's going on, we made this recommendation, what did you actually do and how did you actually get in? That issue is usually dealt with at the front end, i.e., if we say to the patient that you should see your family doctor in two days and they say it takes six weeks to get in to see my family doctor, the nurses typically will problem-solve at that point. They won't say, well, good luck; they'll say, okay, where else could you go see somebody?

One of the concerns is sometimes people end up in the emergency because there's no option other than to go to the emergency, but it was not our intention to send them to the emergency department per se.

It's interesting, and it sort of works out - and I'll explain why it sort of works out. In the major areas where the emergency departments are - and I work in a major emergency department at Dartmouth General, it's a very high acute emergency department at Cape Breton Regional Hospital, and it's a very high emergency department at QEII. As you get out of the city the emergency departments tend to be less high acuity, just by the nature. It's just a population thing, how many people are there, and in the major cities there are a lot of walk-in clinics. So, again, it's numbers. You can move them to a walk-in clinic, but if you go to smaller places, it's not necessarily - Cape Breton may be different. So it sort of works out, yes.

[10:15 a.m.]

Just so everybody is clear, when you call 811, if there's a nurse available, they pick up the phone, but it is our Telehealth associates who take your call and then we've created clinical categories of high, medium, and low, urgent things, and then the nurses call back. The call to pick up the phone is less than a couple of minutes - 20 seconds. The callbacks - 90 per cent were within 30 minutes. Occasionally, we struggle with that. Like anything, if there's a manpower crisis, we do that very well, but there are occasional times when we don't meet it.

COLTON LEBLANC: Earlier you stated statistics based on the outcomes in our province with 811 - 4 per cent go to 911, 1.9 per cent go to Poison Control, et cetera. Are there regional breakdowns of these outcomes? Is that something that's available?

TODD HOWLETT: We have not looked at that. We could probably look at it like that, there is no reason we can't. Interestingly enough - because as I mentioned earlier, we have P.E.I, so we actually break out P.E.I. from us. We have presented previously to the four zones, so there's no reason we can't do that. We could create that data and just say if there's something specific around one area where we send more people to it. That would be something really interesting to look at, but I don't think we have a hypothesis that it would be different in an area, but it would be worth looking at for sure.

COLTON LEBLANC: When we're examining issues of hospital closures and over-burdened emergency rooms, it would certainly be nice to have a regional approach to examining these different percentages.

You spoke earlier about outcome research - like data, like information - in those reports. 811, operated by EMCI, the pre-hospital ambulance service is operated by EMCI. There's an opportunity to share information and conduct internal research.

Just because a patient is forwarded, that 4 per cent of your calls are sent to 911, it doesn't necessarily mean that there's actually a patient transport out of that. Internally, are you guys performing outcome research?

TODD HOWLETT: It's almost like you set that question up. Thank you, I don't think you knew that. We actually have a meeting set up, just continuing quality stuff - myself, Dr. Travers, Natalia, and the equivalent of Natalia at EMCI - to internally do a CQI to review all the patients that get sent from 811 to 911 and how we're doing it, so we're in the process of looking at that - so, yes.

COLTON LEBLANC: Just to be clear, I think my colleague asked the question earlier: If a patient does call your service, is the family physician - if they're lucky to have a family physician - notified of the call in any manner?

TODD HOWLETT: They're not at this point. It certainly could be something we do. We'd have to figure out how to do that, but we are planning to meet this Fall - hopefully in the next month - with a GP council at Doctors Nova Scotia. I don't think I've ever had anybody come and say, I wish you'd told us that they called 811, but I'll bring it up during that conversation. That's a great thought, actually.

COLTON LEBLANC: 811 operated for P.E.I. and Nova Scotia at the same time. Is it the same nurses that are operating for both provinces at the same time?

WENDY BOUTILIER: Yes, it's the same nurses.

COLTON LEBLANC: Are those nurses from P.E.I. or are they from Nova Scotia?

WENDY BOUTILIER: The nurses actually work all through Nova Scotia and P.E.I.

COLTON LEBLANC: Do you know percentages of Nova Scotians versus P.E.I.?

WENDY BOUTILIER: I don't have those exact numbers. We do promote the nurses to work from P.E.I. It's a matter of recruiting them. We do our best to recruit nurses all through Nova Scotia and P.E.I.

THE CHAIR: You have two minutes.

COLTON LEBLANC: Speaking a little bit about the list. If my grandmother, who's 70-plus-years-old, gets a phone call saying we have a family doctor for you and that doctor is greater than an hour away and she's not comfortable driving more than an hour, and she declines that opportunity for that family physician at that time, what happens to her priority on the registry, if you're able to answer that?

TODD HOWLETT: I'm not able to answer because I don't have that data and we don't manage that list.

Just going back to your question, there's one nurse in P.E.I. and the rest are from Nova Scotia - oh, and there's one in New Brunswick.

COLTON LEBLANC: I assume that you guys go through clinical auditing and quality control for your calls?

NATALIA GALLANT: Yes, we do have a rigorous program in terms of call auditing and monitoring, and that's based on their performance and on their experience as a Telehealth nurse. We do work closely, and we monitor that on a monthly basis.

COLTON LEBLANC: I just want to make sure, for the record, are you guys private with EMCI or with the Department of Health and Wellness?

TODD HOWLETT: Private.

COLTON LEBLANC: Are there plans to examine, improve patient outcome - or not necessarily the patient outcome, the tracking of the patient outcome?

TODD HOWLETT: Absolutely.

THE CHAIR: Order. Time has elapsed. We'll turn it over to the NDP for 14 minutes. Ms. Leblanc.

SUSAN LEBLANC: Thank you very much. Before I ask my questions, I also just want to give a "three cheers" to 811. I have, as a mother of two, done many calls in the middle of the night.

That's actually part of my first question, because in my experience, if I think back to the times I've called 811, it's mostly, literally been in the middle of the night or 11:00 p.m., sometime when a walk-in clinic is not an option, or it would be a real pain to get up and get out of the house. So, we call 811 first.

I'm wondering if you have any statistics on the volume of calls at different times of day.

WENDY BOUTILIER: Our call volumes do vary. Generally, in the morning, call volumes are quite low. As the afternoon goes into the evening, around suppertime when everybody starts getting home from work and school, our call volumes increase. They do decrease overnight; they decrease from 12:00 midnight on, it's a lower call volume.

SUSAN LEBLANC: I wanted to connect that with something Dr. Howlett said earlier which was - and this is also going to go into another question - that the 811 system hasn't lessened the people who go to the ER but has changed the people who go. Number one, is that an accurate retelling of what you said?

TODD HOWLETT: I think that would be a fair representation of what I said, and it would be accurate.

If I could expand on that, there were some people that were able to manage at home; but there were some people staying at home that quite rightly should go to the emergency room.

It's quite humbling. I get a lot of flack for being the emergency doctor associated with 811, as you can imagine - because my colleagues are busy in emergency - but it is also quite humbling to bump into somebody that literally says, the program saved my kid's life.

This happened to me when I was at Capital Health. One of the PR people just said look, I was calling in, I was in charge of the kid - Mum was away - and I said how much Tylenol should my five-month-old have? They said your five-month-old shouldn't have Tylenol, your five-month-old shouldn't have a fever; you need to get to the IWK. He said, so we went to the IWK - they had a serious bacterial infection and they did well. He said, thank goodness you showed up.

Those are some of the things that are quite rewarding about this program.

SUSAN LEBLANC: Listen, I think the program's awesome. Earlier you also mentioned, at the very beginning you said - assuming you do have a phone - the service is available to all Nova Scotians, assuming you do have a phone.

That's a big, important point here, because in terms of people who don't have phones, obviously they are people who cannot afford a phone. I'm wondering if you can comment on that.

In terms of also being an ER doctor, would you say it's fair that the people who then present at emergency are people who don't have access to the 811 system first, like that they haven't had a first line of triage? I guess secondly, would you agree with me when I say that every Nova Scotian should have a phone?

TODD HOWLETT: There are a lot of questions in there. Thank you for that, Susan.

Fair - I look after Dartmouth General. A lot of my favourite people come from Susan's riding, and they are some of our more hardscrabble people in our society, less blessed than you and me, but most of them have phones, interestingly enough.

I don't see very many people who don't have phones. I can count on one hand in the last month the number of people who don't have phones. Somehow that seems - so the short answer is yes, I think the phone should be. I think 811 is helpful, and it's a matter of continuing to educate people to call it when they do.

I was trying to make the differentiation between the Internet and the phone, that sometimes we think, why is this all Internet based? I think very few of these people may not have access to reliable Internet. That is really where I see the difference in many of the people I see, but most of them seem to have access to a phone.

SUSAN LEBLANC: Well, I'm glad that's your experience. I have to say that I have many people come into my office who don't, who come in to use my phone.

I wanted to ask a bit about the nurses working from home, too, which is something that - as someone who calls 811, you know how when you see someone who is a radio personality in person for the first time, and you're like, this is not at all who I thought you were? That's how I'm feeling about 811 right now. I had this image of all these nurses working together in this cozy office and everyone on the phone together, but the nurses work from home.

Can you talk about that? Because they're not connected with a site - are they unionized? Are they paid in the same way as NSHA nurses or people who are working in more conventional nursing situations? Is it this EMCI, which I'm assuming is a company, but I've kind of lost track there - like, who's paying the nurses?

WENDY BOUTILIER: All the nurses work from home. They are non-union nurses. They have various backgrounds and experiences that we're looking for.

You had a lot of questions there. What's another question that I could answer?

SUSAN LEBLANC: Who pays them?

WENDY BOUTILIER: EMCI pays them. We work for EMCI. We're regulated through the Department of Health and Wellness, but we work for EMCI.

SUSAN LEBLANC: Just to be clear, EMCI is a company that runs this system that the department contracts to run 811 for the citizens of Nova Scotia, and you folks are paid by EMCI and the nurses are paid by EMCI?

WENDY BOUTILIER: Correct.

TODD HOWLETT: The same thing happens with EHS. The EHS system is a very similar agreement.

I just wanted to talk a little bit about the nurses, if I could, because it's not intuitive, what these nurses are and what they do. I spend a lot of time with them. We have - it's kind of goofy - "ask Dr. Todd" sessions regularly, but we spend a lot of time doing some education.

What the nurses do is very difficult. It is as much of a nursing - these two are nurses. I'm an emergency physician, and I work with wonderful people, but what they do is very difficult, so I want to brag about what they do.

It is very hard to assess a sick person over the phone and decide what's wrong with them. It is as much of a specialty skill as being an ICU nurse, being an emergency nurse, and it is not for all nurses. Some of them think, hey, I'm going to go home, and I don't have to go anywhere else. Then they try it and are like, wow, this is way more difficult. Unlike a lot of the nurses who work when I work, many times they're the final word on the patient. They've seen the patient and they're leaving the patient at home.

[10:30 a.m.]

That is very different than from where many of them have come, because it is often a physician, but that doesn't mean nurses don't work with some independence. Typically they work in a team; where in this case, they may actually be using a guideline and recommending self-care. We spend a lot of time doing that and lots of time to figure that out.

We have some excellent well-trained nurses, and this skill is very difficult to do. There are some advantages. Nurses have to be in an office; they cannot be in the kitchen; they're set up specifically; they do home visits. It all has to be done very professionally. They're expected to dress properly. They can't show up, roll out of bed, put their pyjamas on, and start taking calls. It doesn't work like that. It is important, and it's difficult.

It does allow a group of nurses who may not be working somewhere else, for whatever reason, or if they have an Internet connection, they may be able to stay with their family somewhere in a rural area and do this. The real challenge is that we have to have a high-speed Internet connection to allow them to do this.

SUSAN LEBLANC: Given those special skills and that particular way of working, can you talk about the comparative salary of an 811 nurse to, say, a nurse working at a hospital?

WENDY BOUTILIER: We strive to do comparative salaries with our nurses based on the hospital wages.

SUSAN LEBLANC: So, the nurses who work at 811 are paid the same as nurses at the hospital?

WENDY BOUTILIER: Again, we strive to match what the wages are in the hospital.

SUSAN LEBLANC: I'm sorry. You're saying you strive to match the wages in the hospital, which suggests to me that they don't make the same. I'm just asking a question; there's no judgment. I just want to know. Also, I would be curious to know if they have health benefits.

WENDY BOUTILIER: We absolutely do have health benefits. Again, we strive to match, and it's performance based. We do yearly performance reviews with our nurses, so on a yearly basis we do increases based on performance. So, it's performance-based salaries.

SUSAN LEBLANC: Can you talk about what the base salary is, the starting salary?

WENDY BOUTILIER: I think I'll pass on that question at this time.

SUSAN LEBLANC: I think it's important for Nova Scotians to understand what people who are serving them are making.

WENDY BOUTILIER: I just wanted to be sure I was allowed to reveal that the starting wage is $36.78 an hour; we start our nurses with that.

SUSAN LEBLANC: That goes up annually or whatever, based on performance?

WENDY BOUTILIER: That is correct.

TODD HOWLETT: I think we're all a little bit uncomfortable because we've never been here before, and we want to make sure we get this right. I don't know exactly because I haven't been involved in the wage gaps; I understand why you asked the question. It makes a lot of sense to me.

One of the things we know about the nursing here is that we seem to have found an opportunity to find nurses who want to work in this environment. The other thing is, as many of them would also tell you, there's a lot less expenses if you don't have to travel to work. There's a bunch of other things specifically around parking, or travelling, or cars and everything else; it does provide a certain economic advantage if you can actually find a job where you work from home.

SUSAN LEBLANC: I totally get it. Obviously, there's many different working situations for many people, and things work well for people. I have a sister-in-law who worked from home for many reasons, and it was really perfect for her. She lived outside the city; she didn't have to deal with any of that stuff.

I'm wondering if you could - we don't have to discuss it any further now - table or send with the other data that you're sending us, the information around how those performances work. What would the annual review entail? What happens if a nurse is not meeting their performance targets? Does their salary go down? Does it stay the same? That kind of information would be great.

I'm just going to move on to talk a little bit about the integration of the 811 system in the future with the electronic One Person One Record.

Are you sitting like that because my time is up?

THE CHAIR: Not yet, but soon.

SUSAN LEBLANC: Is there a future of integrating 811 with One Person One Record, so that a Nova Scotian has one chart which 811 would also be included in?

TODD HOWLETT: It's fully my expectation that we will be included in that, from my understanding. We have not had those conversations now, but it is my understanding, Susan, that we would be included in the OPOR.

SUSAN LEBLANC: How much time do I have?

THE CHAIR: About 20 seconds.

SUSAN LEBLANC: I'm wondering if there's any way to currently look, until we get One Person One Record, if there's a way to maybe implement this idea of having records or the 811 call be transferred to . . .

THE CHAIR: Order, time has elapsed for the NDP. We'll move it over to the Liberal caucus with 14 minutes. Mr. Irving.

KEITH IRVING: Thank you all for being here today. I just wanted to go back to trends of usage. You mentioned there were 114,000 individual calls, I guess, and I think I understood 80,000 individual clients in the course of a year, but you also inferred that numbers had dropped a bit. I'm just wondering, over the 10 years, removing the blip of - it wasn't SARS - H1N1, is there a general downward trend over a number of years with respect to the use?

TODD HOWLETT: I don't have it in front of me, so I'm happy to get it to you and you can look at it. It is my memory that it has come down a bit.

One of the things we do know is that every time we embark on advertising that we do have an upsurge. I think there is an opportunity there that we haven't - it has gotten much better. The coordination between advertising and us being aware that advertising wasn't always perfect, so we suddenly advertise, and our volume jumps 30 per cent overnight and then it comes off. We're much better at knowing that because sometimes it has staffing implications if we're not ready for that.

I'll get that data for you. I do think advertising is part of it, so I'll leave it at that.

KEITH IRVING: To that point of advertising, in terms of advertising your own services, when we have people calling up to be put on the family practitioner list, I assume that you do, I mean it would be the perfect opportunity to say you can always call back, you don't have a family doctor, we're here to help fill that gap during this waiting period - does that actually happen?

WENDY BOUTILIER: Yes, that does happen. If they do call the Need a Family Practice line and they are exhibiting symptoms or are requesting health information, the Telehealth associate will refer them back to 811 to speak to a registered nurse.

TODD HOWLETT: One of the other things, we're working with some of our primary care colleagues to make sure it's on their answering service, so if you call the family doctor's office as well, so you've reached Dr. Jones' office, it is after-hours, if it's an emergency, please go to your local emergency; if you're unsure what to do, please call 811. There's education that's happening in there as well.

Rick Gibson, whom you may have met who is the senior physician for primary health care, has been very good about putting that out. The whole adage is: if it's an emergency, go to emergency; if you need to see your family doctor, then go to your family doctor; if you're not sure, call 811.

KEITH IRVING: The high number of repeat calls - and I'm sure many of them, like Ms. Leblanc with three kids, use the service over and over and it's providing great value - I'm curious if there's very much low-need use, seniors who are lonely. That's kind of a mental health thing as much as anything, but as any politician who knocks on doors knows, every once in a while, you meet a senior who wants you to sit down and have a long conversation. I'm wondering if that is something that happens in this service and whether nurses are trained to try to weed through the loneliness calls, I guess.

TODD HOWLETT: First of all, I just want to say that I think Susan only has two kids. I just wanted to make sure that was understood - but thank you. I think our experience with the elderly is they don't call this line just for loneliness. I'm not sure why. It may just be because they respect it and they don't want to do it.

We do have a group that in emergency we call "familiar faces" that now use the line. We call them multi-caller or multi-visit patients that are sometimes difficult to manage, and they may call for all kinds of interesting reasons - some of which we have to actually create care plans around what they would do. They're calling to interact with nurses in an unusual way, so that's the reality. That's the reality in anything. We see that in emergency departments and it's not surprising we'd see it on this.

For elderly, no, I don't think we've seen that as an issue. We do some outreach to provide a referral to various things that can help people. I can imagine, though, that once you sit down for tea, you're there for a while.

KEITH IRVING: That's right, and I do agree with you - we're in public service and we're serving the public, so I appreciate your comments. I understand you also have a website and online services. Do you have any sense of whether that is providing service - through hit rates or whatever - that is foregoing calls and providing advice without talking to a nurse, but helping folks navigate to the most appropriate health professional to deal with needs? Could you tell the committee a bit more about the online services or your website?

TODD HOWLETT: I was just asking if we had any data on hit rates. The answer is that I don't know. I'll be honest with you, I don't know. We're exploring whether we can put symptom triage online, so we are exploring that. Some other areas have done that and we're looking at perhaps doing it.

We had quite a conversation yesterday at the Clinical Advisory Committee about the pros and cons of doing that, just letting somebody go through a list and their symptoms, and not having a nurse assist in that process. I think it's really important. A lot of people ask, if it's just a pick list, why do you need nurses? That's kind of a silly question. There is an art to it. You need to have somebody. You need to clarify a question. You need to have a health care provider to basically say, it sounds like this - or the person might minimize their symptoms.

For those of us who work the front line, we know that some people minimize their symptoms. Some people are on the other end of that spectrum, where we're always trying to sort out and help the person understand what's their most accurate symptom and what's the most accurate disposition for them.

We're still struggling a little bit and we're trying to get some data from some other areas about how successful they are using an online one and what are the results of that. That was actually on our action items yesterday to figure that out, so we are looking at that.

KEITH IRVING: I guess I have one more question before I turn it over to my colleague to the right. It goes back to data. I'm curious as to whether you had any kind of regional data that indicated any trends regionally that are helpful for health care planning.

TODD HOWLETT: I know some time ago we presented regional data around zones. Maybe I can put it back to the committee because we're planning to meet with the Nova Scotia Health Authority again, and we'll probably break it out by zone. I guess the question for the committee, if I may, is how granular would you like the data and would you like it based on the people who vote for you? What are we actually looking for?

[10:45 a.m.]

THE CHAIR: We don't normally do answering questions in the reverse but it's interesting. You can give us thought to ponder, for sure. People may want to submit from their caucus, if they have suggestions to you, but normally it's not our process.

TODD HOWLETT: Sorry about that.

KEITH IRVING: I think the purpose of my question and those of other members on the committee is, it really does seem like there is valuable data within this service, and I encourage us to find ways to investigate that and garner the benefits of that data. I think it does have value to the system and our hospital planning or health services planning. With that I'll turn it over to my colleague to the right.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Madam Chair, through you to our witnesses, as the intake mechanism for Nova Scotians attempting to find primary health care, find a family doctor, does your shop have the capacity to triage patients as they're making calls, based on who has higher needs than perhaps the next patient?

TODD HOWLETT: If I understand the question correctly, are you specifically talking about the symptom of the patient or are you talking about whether the patient has a family doctor?

BEN JESSOME: I'm referring to the group of Nova Scotians who do not have a family doctor. Does your shop have the capacity to triage, 1 to 10, who is in highest need; who has the highest urgency to be matched to a family doctor?

TODD HOWLETT: On the Need a Family Practice Registry, other than collect the data and pass it on to the Nova Scotia Health Authority, we're not involved in taking people off the list, calling them back, giving them a family doctor. That resides completely with the Nova Scotia Health Authority.

BEN JESSOME: My question is, would your shop have the capacity . . .

THE CHAIR: They don't do that.

BEN JESSOME: I appreciate that they do not do that. I'm asking, do they have the capacity to do that?

TODD HOWLETT: I believe I understand your question now. We have never been asked to do that at this point; I would have to talk to some people and see whether we could do that. It's an interesting proposal. It has never been asked and, clearly, there would have to be criteria, so there's a bunch more - I haven't put enough thought to it to actually answer that question in a meaningful fashion, if that's helpful.

BEN JESSOME: I guess I'm trying to understand, would it require the intake personnel to have a certain background or would it be something that a questionnaire, or something along those lines, that any intake person could administer?

TODD HOWLETT: There have been conversations amongst physicians outside of this, about how they have somebody who has three chronic diseases and perhaps they were a priority for a family doctor. I'm sure there could be criteria established. Whether that would need a clinical person, a non-clinical person to administer it to the patient, I'd have to give it some more thought and involve some people maybe smarter than me right now to figure that out. But I think that would be an approach that would make sense somehow.

BEN JESSOME: For those people without a family doctor who call in, are you informing them automatically about 811 as a service?

NATALIA GALLANT: Yes, that is part of our process; we will advise them that if they have symptoms, they can call 811, 24 hours a day.

BEN JESSOME: Oppositely, would those without a family doctor who call in automatically be added to the 811 list?

NATALIA GALLANT: It's not an automatic part of the process, but if they ask, we can definitely transfer them over to the Need a Family Practice program, if it's during regular business hours. If it's after-hours, we would advise them of the hours and to phone back to be added to the list, for sure.

BEN JESSOME: Thank you for your time.

THE CHAIR: Are there any more questions from the caucus?

Time has elapsed. Dr. Howlett, would you give some closing remarks?

TODD HOWLETT: Yes. Thank you. I had hoped we would have a meaningful conversation and I'd like to think that we have. I've also been very impressed by a number of the speakers and some really interesting, tough questions and some ideas.

I came here with an idea that we would hopefully educate you, but I've heard some great stuff from you, so thank you for that. We'll take some of those ideas back and challenge ourselves to continue to do better to serve the populous.

I do believe strongly that 811 has a role to play in our health care system, in helping coordinate it. I don't think it's wrong to suggest that we still have some work to do, and I think 811 could be part of that.

The one plea that I've asked about is if there's some way that we could mandate - and I think you've heard that from me - a mandatory federal working group, all third party. I think that would be very helpful.

I think it would challenge us and allow us a benchmarking and proof that we can do things in Canada. It's the Canadian way, but sometimes when you put the third party in - there are a lot of good things, by the way, of having a third party run this organization - there's an accountability and a rigour that I've seen that I don't always see in my other job.

There are some really good things to that but, like anything, there's a negative side to that. So, again, I just wanted to express my appreciation and thank you for coming here.

THE CHAIR: Thank you, Dr. Howlett, Ms. Gallant, and Ms. Boutilier. You may leave. I'm sure there are people out in the media gallery waiting to interview you.

We have a short business meeting. We started the meeting a little late today, so we can't stay here forever because Legislative TV needs to get in and use the room, but can we have a five-minute extension in case we need it? Do I have consensus from the entire committee? Thank you.

We will move on. We have a bit of business. The NDP had asked for representatives from the College of Dental Hygienists and for the Deputy Minister of Health and Wellness.

The committee approved, along with a Liberal amendment that added Angela Purcell, the Dental Association's executive director or a designate, but it should be clarified that Ms. Purcell does not work for the Canadian Dental Association. She is the Executive Director of Pharmaceutical Services and Extended Health Benefits with the Department of Health and Wellness.

Given that new information, does the committee still wish to invite Ms. Purcell to attend the meeting? Do we have consensus on that? (Interruption) You asked, but her position was different, from what I understand. She is the Executive Director of Pharmaceutical Services and Extended Health Benefits with the Department of Health and Wellness. Ms. Leblanc.

SUSAN LEBLANC: My understanding is that this was the person the Liberal caucus wanted to add to the roster of witnesses.

THE CHAIR: Are you fine with that? Do we have consensus from the committee? Okay, great.

The 2019 annual report - we'd like to have approval. You were all sent the report by email. Can we have a motion to approve and have it sent to the Legislature? Mr. Jessome.

BEN JESSOME: So moved.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Ms. Kavanagh, you will get that ready? I'll sign it, I guess, today after the meeting.

We also have correspondence from Dr. David Anderson, Dean of the Faculty of Medicine. It was a request from the August 14th meeting, and you all received it by email from the clerk. Are there any comments or questions? Okay.

Our next meeting date will be Tuesday, November 12, 2019. We are hoping it will be 1:00 p.m. to 3:00 p.m. If the House is still sitting, it will be in the morning. Ms. Adams.

BARBARA ADAMS: At a previous Health Committee meeting, I asked for hierarchy charts for the Department of Health and Wellness and the Nova Scotia Health Authority, and to date, I haven't received them.

THE CHAIR: Is that the organizational chart?

BARBARA ADAMS: Yes.

THE CHAIR: I do remember that, yes. Ms. Kavanagh.

JUDY KAVANAGH: I have written to the department and asked for that. It normally takes a week or so to send these letters out to witnesses because we have to wait for the Hansard transcript to be available. I make a list of all the requests made in the meeting and send it to the departments. They've received it, so we're just waiting now.

BARBARA ADAMS: Just to clarify, that was for both the Department of Health and Wellness and for the Nova Scotia Health Authority.

JUDY KAVANAGH: Yes, I wrote to both organizations.

THE CHAIR: Thank you. Are there any other questions?

I will adjourn this meeting. Thank you.

[The committee adjourned at 10:56 a.m.]