HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, September 8, 2020

LEGISLATIVE CHAMBER

Pandemic Response and Future Preparedness

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HEALTH COMMITTEE

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[Hon. Leo Glavine replaced Keith Irving
[Tim Houston replaced Barbara Adams]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dr. Robert Strang, Chief Medical Officer of Health
Dr. Kevin Orrell, Deputy Minister
Ms. Jeannine Lagassé, Associate Deputy Minister

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, SEPTEMBER 8, 2020

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Suzanne Lohnes-Croft

VICE-CHAIR
Keith Irving

THE CHAIR: Order. I call this meeting of the Standing Committee on Health to order. It is Tuesday, September 8, 2020.

My name is Suzanne Lohnes-Croft. I am the official Chair of the committee now. I was Vice-Chair until just recently, though I chaired every meeting but one of the Health Committee. I'm now officially the Chair. I'm also the member for Lunenburg.

Today we will hear from the Department of Health and Wellness regarding the pandemic response and future preparedness.

I ask that you all to turn off your phones or put them on vibrate. In case of an emergency, please exit through the back door, walk down the hill to Hollis Street and gather in the courtyard of the Art Gallery of Nova Scotia.

We have some new procedures in place to help protect the health of everyone here today. You will notice you are seated farther apart than usual. I am not masked but will mask if I need to converse with anyone at a close distance. Please keep your mask on during the meeting unless you are speaking.

We have provided bottled water instead of the usual pitchers. If you have a bottle at your desk, please keep the cap on while you're not drinking from it. This is to protect the new microphones.

Please try not to leave your seat during the meeting. If you must, you must of course. I suggest that we all take a break at the one-hour mark to allow for this.

Perhaps we could agree now to extend the length of the meeting 15 minutes until 3:15 p.m. in order to have that break.

Is it agreed?

It is agreed.

I will ask the committee members to introduce themselves, starting with the Liberal caucus.

[The committee members and witnesses introduced themselves.]

THE CHAIR: Thank you. I will now call on Dr. Strang to do his opening remarks.

DR. ROBERT STRANG: Good afternoon, Madam Chair and MLAs. As I said, I am Dr. Robert Strang, Nova Scotia's Chief Medical Officer of Health. With me today are Dr. Kevin Orrell, the Deputy Minister of Health and Wellness; and Jeannine Lagassé, Associate Deputy Minister of Health and Wellness. We would like to thank the committee for the invitation to appear and we look forward to our discussion this afternoon. Just let me take a few minutes to provide some brief opening remarks.

As we all know, this new virus - the virus that causes COVID-19 - is without precedent, certainly in the last century. We've had pandemics before, but never in a modern society with impacts that we're seeing. Prior to this winter, phrases like coronavirus, physical distancing, and self-isolation were unknown to most Nova Scotians. In short order, however, our day-to-day lives changed drastically and the systems that protect us had to react quickly.

Nova Scotia's government, health care system, and citizens responded well to a rapidly changing and uncertain situation. Overall, Nova Scotians' response was swift and appropriate. This is clear by our epidemiology: the goal was to flatten the curve and we achieved that by working together. Although Nova Scotia was the last province to have a confirmed case of COVID-19, we were ready.

In the early days, we had two key areas of focus: redeploying public health and health system resources to ensure access to testing and rapid follow-up on confirmed cases and their contacts; and in addition, we had widespread communication with Nova Scotians so people understood what we were doing, what they should be doing, and why.

811 staffing and technology were significantly increased to handle a large volume of calls. A network of 26 primary assessment centres was stood up in a short period of time across the province. Testing capacity at the QEII Health Sciences Centre's microbiology lab was increased from less than 200 tests a day to 1,500 a day.

Restrictions began before we identified our first case, and March and April saw a rapid succession of measures to slow the spread of the virus. Schools and daycares were closed, visits were stopped at long-term care homes and other places with vulnerable populations, and many businesses were temporarily closed. At our peak of new cases, we were testing more people per capita than any other province.

Our pandemic response also saw a sustained effort to communicate directly with Nova Scotians. The speed in which new information was becoming available required government to undertake comprehensive communication efforts, including advertising and social media content, and working closely with hundreds of organizations to ensure sector-specific information got to the right people.

Our first COVID-19 press conference was held on March 6th, and on March 15th we began what would become near-daily press conferences for weeks. On many days, tens of thousands of Nova Scotians tuned in. They wanted to know what was happening and how they could help. The position we're in today - with low to no cases - is because the people of this province took the virus that causes COVID-19 seriously and continue to work hard to follow the rules and encourage others to do the same.

Behind the scenes was a strong cross-departmental and cross-health system effort to ensure a coordinated and focused response. Examples include a table of partners responsible for purchasing and distributing personal protective equipment, support for our province's most vulnerable through the Department of Community Services and the Department of Municipal Affairs and Housing, and support on safe re-opening to businesses, not-for-profit agencies and community organizations through the Department of Business, the Department of Labour & Advanced Education, the Department of Communities, Culture and Heritage, and the Department of Health and Wellness.

I'd also be remiss if I didn't reiterate that the decisions we made have been based on the available evidence and science. In my position, I have to provide advice to decision makers that is based on the information that we have in front of us to protect the health and safety of Nova Scotians. That advice, and sometimes the resulting decisions, isn't always popular and may not always be easy to implement. However, in this case, I believe our province made the appropriate tough decisions and acted early and quickly to slow the spread of the virus. The same is true of when we began to reopen. It hasn't been easy, but I believe we have achieved the balance between protecting Nova Scotians' health and the province's economic health.

While much has gone well in our response, we must recognize the tremendous difficulties the virus brought to our province, including social isolation, physical and

mental health concerns, and financial hardships for many. Nova Scotians have worried about going to work and being safe as they went about their lives. Families have supported loved ones during recovery, and 65 Nova Scotians lost their lives to this virus, including 53 in the outbreak that occurred at Northwood in Halifax.

Every lesson we learned - including the recommendations that will come from the independent review of Northwood and the broad review of infection control in the long-term care sector - will be incorporated into our ongoing work in advance of a second wave.

I want to assure you and Nova Scotians that we are ready. Many of the measures we've announced this summer position Nova Scotia well for what's to come: enhanced border measures and check-ins, mandatory masking in most public indoor places, a robust testing strategy for returning university students, along with sector specific plans to ensure activities are resumed safely, including our back-to-school plan.

Aside from the government response, Nova Scotians have acted quickly. They've been kind and supportive to each other and to the work we've been doing. Most importantly, they've been vigilant about keeping this virus at bay.

While Premier McNeil and I have often been the public face of this event, every Nova Scotian who has played a role in protecting our province deserves our gratitude. Some went to work every day to make sure we could buy the food we needed. For others, staying home was the best thing to do.

It is impossible to summarize the work that has gone into responding to this pandemic. In most cases, it's work that started in January and continues as we speak with you today. But thousands of people across our health care system, including the Nova Scotia Health Authority, IWK, long-term care and home care sectors, EHS, 811, all levels of government, and all departments across the provincial government have worked harder than ever before to make sure the supports have been and remain in place to keep us all safe.

I do want to recognize my colleagues at the Department of Health and Wellness who have moved mountains to make sure what needed to get done happened.

All in all, Nova Scotia has fared well. What got us through the first wave - strong preparation and a commitment to keeping cases low - will get us through the second wave. We will now be happy to take your questions.

THE CHAIR: Thank you for your remarks, Dr. Strang. We'll start with the PC caucus - Mr. Houston for 20 minutes.

TIM HOUSTON: Thank you, Dr. Strang, deputy minister, associate deputy minister, for your service to the province over what has been an incredibly tense and

stressful time. I think Nova Scotia has fared well, so thank you for your guidance through that process.

Dr. Strang, back around March 17th, Minister Delorey halted all non-emergent health procedures in Nova Scotia. Tests like colorectal screenings - obviously to detect colon cancer - mammograms, pap tests, pelvic exams, all same-day admissions, and elective surgical procedures were all halted. I'm just curious, has the minister asked you for permission to resume these tests that are so key to early detection of so many illnesses?

ROBERT STRANG: Thanks for the question. The closure of those non-urgent health care procedures was not done under my authority under the Health Protection Act, so my permission is not required for that. I've certainly been involved in a lot of discussions with my colleagues from the Department of Health and Wellness who are here with me today, with the minister and with the Premier's Office about finding the balance between opening up access to a broad range of health care services and making sure we maintain capacity in the health care system to do the necessary testing and assessment that we're doing, as well as to make sure that we are prepared if there is a surge of COVID-19 again that we can actually handle that.

TIM HOUSTON: Thank you, so permission is not required to restart presumes that you didn't direct all those non-urgent procedures to be cancelled? Was that something that . . .

THE CHAIR: Mr. Houston, Dr. Orrell would also like to add to that question.

TIM HOUSTON: If you don't mind, I'd like to ask the questions and get the answers, and I'll keep asking questions. I'm sure we'll have a lot of questions for Dr. Orrell.

So the closure of all non-urgent procedures weren't ceased at your direction?

ROBERT STRANG: No, they were not part of the public health order. There were different policy discussions and conversations, but not directed under the public health order.

TIM HOUSTON: So they can be restarted at any given time. Are you surprised that they haven't restarted at this stage?

ROBERT STRANG: I'm going to defer to my deputy colleague who has been more directly involved in those, but my understanding is there has been a lot of movement in opening up those non-elective, non-urgent procedures.

THE CHAIR: Dr. Orrell.

DR. KEVIN ORRELL: I came to the job on April 1st and I came out of the clinical side, or the operational side, of the health care system. The decision was made to restrict

all non-urgent and emergency cases. Before I left my practice to come to Halifax, the provision was made for urgent care, emergency care, and for cancer care. Screening and all those other elective investigations were put on hold.

However, the need for that came as much from the operational side - from NSHA and the IWK - that recognized that they would have to have the capacity that was anticipated for COVID-19 management. If we at the time looked at the experience and situation around the world, there were many countries, many jurisdictions, many cities in the United States that were simply out of control and had run out of capacity. This was a way of freeing up capacity.

[1:15 p.m.]

The other issue was that we required staff to be available for COVID-19 management. Some of the people who normally would have been in outpatient investigation and diagnostic imaging were required for redeployment so that we had capacity in terms of human health resources, as well. Having gotten through the first wave and flattened the curve, it became a very significant discussion point that we should initiate the ability to look after people outside of COVID-related illness.

Again, I think my clinical background played to that point that there are a large number of people who do require care outside of infection and pandemic response. These people were wait-listed and the discussion with NSHA and IWK was to get these people that were delayed back on the list to have their investigations or their treatments initiated again.

We now have a joint committee that basically is re-establishing all of the vision for health care that is normal in a normal situation.

TIM HOUSTON: Thank you, deputy. If I understand correctly, as we sit here today, there is a committee that is looking at how the testing can resume. Would that be a fair summary?

KEVIN ORRELL: Well, the testing has actually resumed. There are procedures and investigations and provision of care that are normal in our normal health care system taking place now. It has been a gradual process, but it’s ramped up almost to full capacity at this point in time.

The hospital admissions, for example, now are in the 90 to 100 per cent range. In fact, that’s probably more than we would like because we still have to maintain capacity for the next wave, so there has to be some adjustment of that. As soon as possible, the health authorities were advised and they went to full capacity for much of the services that had been delayed during COVID-19.

TIM HOUSTON: Has the minister provided a deadline as to when the minister would like to see the backlog cleared?

KEVIN ORRELL: I don't have an exact deadline for that. I think that it's a little bit difficult to predict based on what may happen during this second wave. As stated, the capacity to look after another wave anticipated in the Fall will have significant bearing on how we do that.

During the first wave, we basically had shut down almost everything - again, not knowing what was to be anticipated, not having a playbook that would predict this, and looking around the rest of the world and seeing how disadvantaged some jurisdictions were.

At this point in time, we have to maintain enough capacity to anticipate a resurgence. We have to do it in a manner that allows us to free hospital staff and free people from the system if need be, should the resurgence be more than we anticipate based on our first wave experience.

TIM HOUSTON: Obviously, there are a lot of Nova Scotians waiting for a procedure or a screening or a test - their stress levels are very high. I'd certainly have a great deal of sympathy for those Nova Scotians. I'm sure your team does, as well.

Has the minister asked for some quantification from your team as to how big these backlogs are?

KEVIN ORRELL: I'm sorry - how big are the backlogs?

TIM HOUSTON: Yes, how many people are waiting for which procedures?

KEVIN ORRELL: Well, I don't have absolute numbers, other than the time frame for which someone would take to be investigated. For example, in my specialty in orthopedics, different zones in our province had a different wait-list time. When I left Cape Breton, we had a wait time between three to four months, which was considered to be well within the Canadian standards for a wait time for a joint replacement. With COVID-19 and the shutdown that occurred, this has probably expanded now to about a year.

I'm not aware of absolute numbers that we've been given by NSHA, but I am aware that certain procedures take this amount of time or that amount of time, so it's the time frame that would be more identified to us.

TIM HOUSTON: That's certainly based on your professional knowledge and experience, which the minister wouldn't have. Has the minister asked how long until we can clear the backlog for mammograms, how long until we can clear the backlog for pap tests, how long until we can clear the backlog for colorectal cancer testing, how long until we can clear the backlog for blood tests?

These are the types of questions that I would assume the Minister of Health and Wellness would be interested in. Are those things that he is interested in? Has he asked you those things?

KEVIN ORRELL: We have a meeting almost daily and he is aware of the backlog of procedures and investigations in Nova Scotia. I obtain information from the health authorities and relay that information to him, so I would say he's very aware.

TIM HOUSTON: In fairness, I think every Nova Scotian is aware that a backlog exists, particularly those who are waiting for a procedure. I guess my more direct question to you is, how aware is the minister? I would expect the minister to be more aware than me or a member of the public, so it's a very specific question. Has the minister asked how many Nova Scotians are waiting for which specific procedures and how long until they can get it? That's what I'm trying to get at. I want to be able to assure those people who are reaching out to me as an elected official, who are waiting for a procedure, that there's a very detailed knowledge of what's happening here.

I don't want to paraphrase, but I heard you in your initial response say that you weren't sure when the backlog could be cleared, because who knows if there's a second wave. I also heard you say that in your specific area of practice, you thought it might be a year in your home region to be clear. I'm just wondering if you can provide some clarity, and maybe you can provide it in writing. What type of questions is the minister asking, specifically? We all know there's a backlog, but I would hope that the minister is more concerned than just knowing that it exists and be more specifically interested in knowing when Nova Scotians can expect their procedures. Has he asked specific questions?

KEVIN ORRELL: He has not asked specifically procedure by procedure, but we have been made aware from the health authorities that their ability to handle outpatients is taking x-amount of time, the ability to handle in-patients, outpatient surgery, and hernia repair. There's a huge number.

Specifically, I would say that no one in our department has the exact details because, again, I don't think we can obtain those from the Health Authority at this time, largely because the staff that would normally collect that and evaluate that kind of data are very busy with other parts of looking after COVID-19. The manpower necessary to give exact wait times for each procedure would be enormous. I don't think that information is available even to the health authorities, other than to say we have x-number of people on the list and, at the current rate we're operating, it would take this amount of time.

I can look into that and get the details that are available, but I would say that the details from both the IWK and NSHA would not be complete with respect to each procedure.

TIM HOUSTON: In your response, Dr. Orrell, you said that you wouldn't have the information available other than to know that there are this many people waiting for this

procedure, so it would take that long. That's actually the level of detail that I'm interested in. Is that something that the minister has inquired about and has at his fingertips: this many people waiting for this procedure?

KEVIN ORRELL: I think the minister's interest has more to do with how we are moving with respect to those procedures and getting them started again, in encouraging and supporting the Health Authority in their ability to do that.

TIM HOUSTON: I think what I'm trying to get at is the allocation of resources to make sure that Nova Scotians get the health care that they need. That's what I'm trying to get at. Honestly, I'm not getting a great deal of comfort that that analysis is happening.

For example, according to the Nova Scotia Health Authority Cancer Care Program, between 2009 and 2017, the Colon Cancer Prevention Program was able to identify 500 individuals with cancer through the stool testing. That same program identified 4,000 individuals who had pre-cancerous polyps detected and removed. That's a pretty powerful program that impacts the health outcomes in a very favourable way of a lot of Nova Scotians. If I do a quick analysis, to me it would suggest that right now today, there could be 30 Nova Scotians walking around with undiagnosed colon cancer.

I heard your earlier comments that there could be a second wave and we have to save some resources to be responsive to that should it come - or when it comes, some might say. I guess between now and then, I'm wondering if the minister's providing the guidance to direct the resources to where they can be best used.

Has the minister asked you what's the longest wait-list for which procedure and how can we focus on that? Is that a question he has asked?

KEVIN ORRELL: I came to the job in April and I came out of a clinical background. The administration of a large department of 352 people with all of the considerations for the general work of the department, as well as the COVID-19 related issues, were very new to me. I have received very significant direction from the minister and part of that direction has to do with the initiation of service so that we can get to the backlog of people who have been waiting.

If you take colon cancer as your example, there may be 30 people with undiagnosed colon cancer, but many general surgeons will tell you that disease exists for years and years and years before it's actually something that is diagnosed. Some would say it is many years; five, seven, eight years.

In the time frame over which people can develop that cancer, the wait of a few months may not be as significant as it sounds. It's a diagnosis that needs to be made and that diagnosis has to be made in a timely fashion to get on with treatment, but the disease has probably existed a great deal longer than three months.

TIM HOUSTON: I take your point, but obviously there could be Nova Scotians who have had it for a long time and were waiting until they turn 50 to get their kit in the mail and be identified. I know you're not, but I wouldn't minimize the importance to people of getting the test.

I'm most interested in understanding the urgency that the minister may or may not feel to getting this backlog cleared. To me, the only mechanism that I have to evaluate urgency is to try to understand what questions the minister is asking. I'm not getting the sense that the minister is asking very specific questions. I'm hearing kind of rough guidelines - yes, we want to clear the backlog; sometimes it won't matter as much in other illnesses and stuff.

That's why I'm so focused on what the minister is asking about the backlog, because then I would have hoped - and time won't permit because we never really got to the answer of how many people are waiting. I would have hoped that then we could have a discussion about resources that can be allocated to address the backlog.

[1:30 p.m.]

I do appreciate that you're relatively new in the job, and what an interesting time to take on that position, so thank you for taking it on in the middle of a pandemic. For me, there are a lot of Nova Scotians who are waiting for a procedure. I'm hearing from them and I'm sure my colleagues are, and it's as simple as a blood test. I am most interested in the involvement of the minister in understanding that urgency, but I'm having a hard time getting that.

THE CHAIR: Order, the time has elapsed. We'll turn it over to the NDP caucus with Ms. Leblanc, for 20 minutes.

SUSAN LEBLANC: Thank you for being here today and for your opening remarks, and for the work you've all been doing. I want to thank you for reminding us that a great part of our success in flattening the curve in Nova Scotia has been largely because of the front-line workers, health care workers, essential workers who have put themselves and their families at great risk to protect the rest of us. We're grateful, I'm grateful to the many Nova Scotians who stayed home as much as they could and kept their kids at home and put their lives on hold for many months. Many are still doing it, although it is the first day of school and I've had many conversations with parents in my community about mixed feelings about that. Many are relieved that they may actually be able to get a few hours of work done each day.

We also know that we have been protected by our geographic location and our federal border restrictions. We also know - as you have mentioned, Dr. Strang - that there have been a lot of communities that have not been spared by the pandemic.

The first question I want to ask is in relation to racialized communities. We know from research in other jurisdictions - the United States and elsewhere - that COVID-19 is having a disproportionate impact on marginalized and particularly racialized communities. Unfortunately, we don't know exactly what's happening in Nova Scotia, because we would need to have data publicly available and we don't have that. It would be very important to be able to understand the dynamic of the impact of COVID-19 on racialized communities in particular, as we head into a potential second wave.

I wrote a letter and I was very pleased to receive the letter back from the Minister of African Nova Scotian Affairs which explained that the Province is considering implementing the Canadian Institute for Health Information's proposed standards for race-based and Indigenous identity data collection and health reporting. I'm wondering if you can tell us what we might already know about the unequal impacts of the virus in our province, first off.

ROBERT STRANG: We do not yet, as you're absolutely right to point out. We're involved in national conversations with CIHI and Statistics Canada about providing better race-based information. That's a national issue that we're involved in.

We do know from our experience in the first wave that we have aggregate living populations - one of the key ones being long-term care facilities - that are at greater risk. We also know that there are certain populations because of socio-economic status, over-crowding, et cetera. Part of our big community outbreak was in one of those populations.

We're well aware of the implications of the importance of protecting populations that could be at higher risk. We continue to have a strong focus on long-term care. We continue to have discussions regarding some of the federal restart money around, for instance, how we can make sure we continue our different model of supporting people who are homeless.

As I said, during wave one we had a vulnerable communities committee that was led by the Department of Community Services and the Department of Municipal Affairs and Housing with a specific focus on those vulnerable communities. When we needed to work with one of those communities - with the two deputy ministers from those departments leading - we were very quickly able to bring across-government supports to bear to work with local public health.

For instance, when we were dealing with North Preston, we had a lot of people who had housing issues, were concerned about their income, were concerned who would be looking after their family if they got a test and tested positive. We were able to very quickly bring housing and financial supports to that specific community on the ground through this vulnerable populations committee that was able to very quickly engage those government supports.

We will continue to work with that model. We may not have all the specific race-based and other data, but we're very aware of vulnerable populations and the mechanisms we used in wave one will be the exactly the mechanisms we'll continue to use to support specific vulnerable communities, if and/or when necessary.

SUSAN LEBLANC: That's great to know. I do think that the data, though, has been long called for and long overdue - the collection of the aggregate data for race-based statistics.

In the letter from the minister, he did say that the consultation will be starting. I'm wondering if you can tell us about the consultation plans with the Indigenous and African Nova Scotian communities. Is there a timeline for implementing the standard - or another strategy - for collecting race-based demographic data?

Maybe Dr. Orrell might want to take that one. I'm not sure.

KEVIN ORRELL: I don't know much about the time frame. I do know that it's a significant part of our discussions. To augment some of what Dr. Strang said, there were some communities, like the Indigenous community for example - we have provided them with PPE and made sure that they have everything they need in terms of managing in the communities in which they live.

When there was an outbreak in North Preston and communities around there, we were very quick to go to those communities with the mobile and door-to-door testing to ensure that their communities were as safe as we could possibly make them.

SUSAN LEBLANC: As Dr. Strang said in his opening remarks, unfortunately we did have 65 deaths in Nova Scotia; 53 of them in long-term care. I want to focus on questions around long-term care, which is a sector that is under the full regulatory scope of the Liberal government.

I'd like to begin by asking generally: What can you share with Nova Scotians about what is needed in the long-term care sector both to prevent the spread of COVID-19 in future waves and to strengthen the sector generally?

ROBERT STRANG: Maybe I'll start and look to my colleagues to add. Long-term care has well been known to be at an increased risk for respiratory viruses. We have, for a long period of time, focused on immunization against influenza. This will be my 21st Winter coming up in Nova Scotia and every year we work substantively with every long-term care facility to make sure they have a robust response planned for respiratory illness outbreak.

We use that plan to then adapt that for a very specific COVID-19 virus outbreak, and we substantively strengthened our measures. Just an example: closing down long-term care facilities to visitors well before we had any cases here in the province. We'll continue

to use those measures of strong restrictions, protecting long-term care facilities, having very close surveillance and then a response.

When we had outbreaks in long-term care during wave one, we had a whole system response. We were very rapidly able to mobilize public health along with the continuing care sector and other parts of the acute care sector, if necessary, to provide the appropriate response for long-term care.

We've been doing a review of the long-term care sector with a particular focus on infection control. I haven't been as involved in that as my other colleagues, so I'm going to turn to them to talk a bit more about that review.

THE CHAIR: Dr. Orrell.

KEVIN ORRELL: Long-term care in Canada: the standard of care is such that without a pandemic, we probably would have gotten by for hundreds of years as it was. However, I think the opportunity with this pandemic is that we have identified those aspects of long-term care and living in those facilities that make that population of people very vulnerable.

They're older people, their immune systems are old, they have other comorbidities, and they cohabit and share bathrooms. They are in situations where the spread of a virus can occur very easily. Now that we have witnessed how drastic this can become, we certainly have to do better. We have to do better right across the country, from one coast to the next. Certainly, that is true for Nova Scotia and it's true for every province in the country.

We're going to use the experience - as sad as it is - to improve our ability to look after this vulnerable group of people. The reviews that we have initiated at Northwood where the largest infection took place in a long-term care facility, and for the infection control and prevention review that we're doing in every facility across the province, we're going to use the information from that for short-, medium-, and long-term improvement. The short-term improvement would increase our ability to look after the next wave.

What can we do immediately that's going to help us to protect these vulnerable people? What are we going to do in the medium-term and what are we going to do over a much longer period of time? I think every province in every jurisdiction in the country will be looking at the same things.

SUSAN LEBLANC: I have to say that I'm a little surprised by your comments that without a pandemic we could have continued on in long-term care the way we've been going for hundreds of years. I think that is somewhat short-sighted, given that we have many reports that were written, long before this COVID-19 pandemic, talking about the terrible state of long-term care, at least in Nova Scotia.

We know that Northwood has been asking for years to have money from the provincial government to expand their facility so that people don't have to be in double occupancy or triple occupancy rooms anymore. There are many things that have been going on in long-term care, and one could argue that the issues of Northwood and other facilities in Canada have something to do with the fact that we haven't been looking after our long-term care facilities for many years.

I know that there's a review going on. I'm sorry it's not a public inquiry, which is what many people have asked for, like the families who had loved ones who died at Northwood; the NSGEU also have called for a public inquiry. I wish that were happening.

I'm wondering if you can share with us - given that you have short-term, medium-term and long-term plans - what are the learnings that you can share with us now so far? Do you know of any changes or will you be implementing any changes for a potential second wave?

KEVIN ORRELL: We know the things that make sense. The reviews are on schedule. They were slated to be finished and reported by September 15th. That will take place. They're on point to do them in the time frame that they've been given. That's one advantage of the review - that we will have some oversight and some suggestions that would be available to us as a department earlier than through other review mechanisms.

Basically, we know that the occupancy itself may not be the issue. It's more to do with the shared bathrooms. There is some way to manage that, perhaps with people who are mobile, who use the bathroom and maybe are roommating with somebody who is not as mobile and would not be occupying the bathroom and things like that. So there are some very practical things that we're able to look at.

We look at the staffing models. Cleaners are a very important aspect of care in a nursing home - how they do that and if we can isolate them to certain sections so that they're not travelling through the whole facility. Those are some of the things that we've intrinsically recognized and we are going to try to improve.

[1:45 p.m.]

The IPAC, which is the Infection Prevention and Control specialty - it really is. People are trained in IPAC to administer it as a clinical specialty. They can identify things that can help to prevent or to control infection when it does break out. We need more people trained and qualified to do that situated in our nursing homes, in residential care facilities, and in our hospitals. We need more of those people around to help when a situation like this pandemic exists.

We know those things. We're waiting for other recommendations that will come from the review which we will get in the time frame I spoke about, by September 15th.

SUSAN LEBLANC: Again, I'm a little surprised at your comments about shared rooms. I know that there are many experts in this field that do suggest that shared rooms and multiple occupancy rooms are part of the issue. Of course, you know that we have many situations in Nova Scotia, and particularly at Northwood, where there are shared rooms.

Speaking of data collection, we filed an FOI to try to understand how many residents in long-term care in Nova Scotia are in multiple occupancy rooms. According to the response, the government does not either have - or keep - that information, which I find frankly shocking.

The Nursing Homes of Nova Scotia Association has called on the government to create ". . . a multi-year infrastructure plan that eliminates shared rooms in older long-term care homes and creates an environment where residents can live with dignity, pride and privacy."

Is it a goal of the government to eliminate multiple occupancy rooms? Can you say that right now? If so, is there a date when they would be eliminated?

KEVIN ORRELL: I'm going to address the two areas that I surprised you with - your last two questions about long-term care facilities.

The shared occupancy is very interesting. Nursing home patients quite often feel very isolated and it's even more pronounced in people who may be on the verge of some dementia or early Alzheimer's. Their association with others is an important part of their socialization in the facility.

I've surprised you twice - perhaps I'm relying on my own personal experience. My mother ended up in a long-term care facility for the last year of her life. She actually enjoyed her roommate. When we had the opportunity to move her to a more modern facility - which was the original request we made for her placement and it wasn't available at the time she left the hospital - she did not want to leave. Her roommate was her friend by this point. She could have gone to a much newer facility with a single room but asked us not to do that. We didn't and she certainly finished her days with a friend and socializing and laughing and talking. They might have talked about the same thing every day, but it was important to them.

The other issue is that the change that's necessary for long-term care is going to be something that takes place over a very long period of time. This is very, very complicated the way continuing care has evolved. I don't know about the government's plan, but my personal plan and a legacy that I would hope to be able to leave as a deputy minister is that we take this sector on for change early enough in my mandate so that I can walk away at the end of my time as deputy minister and say that this has been changed. There are many things that can make it better. Regrettably it's expensive, but I think if it's planned well and initiated over many years, I think we can do the right things.

SUSAN LEBLANC: How much time?

THE CHAIR: About four minutes?

SUSAN LEBLANC: We could have a discussion on this for a while, but I will just say to your point: that's a good argument for increasing budgets in nursing homes and long-term care facilities for more staff and more social coordinators and those kinds of excellent programs where people can feel like they live in a community.

I want to go on to people waiting for long-term care. The number of people occupying a hospital bed because they're waiting for placement in a long-term care facility has increased by 35 per cent since March while the overall wait-list for placement increased by 23 per cent. I understand that part of the dynamic is extra capacity reserved, as you have mentioned, for COVID-19-positive patients during the outbreak and that the province is looking for an organization to add short-term capacity to the long-term care system over the next two years to deal with future outbreaks.

I'm wondering what the timeline for this capacity is - when this capacity would become available and what will it look like?

THE CHAIR: Dr. Orrell, you only have a couple of seconds.

KEVIN ORRELL: I think basically, we're going to look at other areas and arenas in which these people can be placed before they go to long-term care, so we have to improve . . .

THE CHAIR: Order. The time has elapsed for the NDP caucus. We'll turn it over to the Liberal caucus - Mr. Glavine.

HON. LEO GLAVINE: I first want to thank Dr. Strang, Dr. Orrell and Associate Deputy Minister Lagassé for being here today as we get our Health Committee work under way.

I had the good fortune as the Minister of Health and Wellness to work with you, Dr. Strang, just as H1N1 was nearing its end. I know how strong you are in terms of both caution and precautionary approach to keeping Nova Scotians healthy.

As we go into Fall and Winter, and flu season comes along, we do need to have hospital beds available should there be any kind of second outbreak. I know we've always been very significant in the province and a leader in the country in terms of taking the flu vaccine. What would you say in terms of its uptake this year right across the population? Is there any emerging research to tell us that getting the flu shot could be advantageous vis-à-vis COVID-19?

ROBERT STRANG: Thank you for the question, Mr. Glavine. We know that last year, our flu uptake in the general population was about 39 per cent. We'd been hovering anywhere between 38 and 40 per cent, if we're lucky, for the last number of years. Like other provinces and territories, we have taken the opportunity when additional flu vaccine became available. We will have enough flu vaccine for just over 50 per cent of the population. My hope is that we max out and use it all and get 50 per cent of the population immunized this year.

These are two different viruses, so being immunized against influenza will not protect you against COVID-19. However, what it does help is that it reduces the likelihood you're going to get influenza, which reduces the likelihood of getting sick and having an impact on the health system. What's going to potentially become very complicated this Winter when we get into flu season is that the symptoms of COVID-19 and the symptoms of flu are very much the same, so we're going to have to get into testing people for influenza, other respiratory viruses and COVID-19. The more people we have immunized, the less we're going to have this issue about whether they have COVID-19 or flu, which potentially makes things more complicated from a very clinical perspective.

What we have seen, fortunately - and I will say it's very limited experience - Australia had a very mild flu season because they were in the midst of their flu season while they had quite significant restrictions related to COVID-19. All the measures that we have - maintaining physical distance, masking, et cetera - will prevent the spread of influenza and other viruses. While we need to be prepared and have maximum uptake of flu vaccine, we don't know for sure, we can't rely on it, but we have a hope that if we continue to have all Nova Scotians following the personal preventive measures for COVID-19, that will have a significant positive benefit and reduce the transmission and the spread of influenza as well.

LEO GLAVINE: Dr. Strang, we're hearing a lot now about the possibility of a second wave. In fact, I've had people ask me when is it coming, how big do you think it will be? My view has been that in this province under your leadership, the Health Authority, the Department of Health and Wellness, government, and the collective effort of Nova Scotians - we've done a marvelous job, as we look across the globe, at containing COVID-19.

I don't believe there has to be a second wave. What would you say to Nova Scotians in the weeks ahead as to how we should be working to mitigate and perhaps keep it at the very seldom case that we're currently experiencing?

ROBERT STRANG: I agree with you that we don't know for sure. When some people talk about a second wave based on experience with previous influenza pandemics, that's more related to something inherent in the nature of the virus. We don't know for sure whether we're going to get a second wave of COVID-19 just because that's the way COVID-19 behaves. There may be some seasonal nature because of it.

When I talk about it, I don't even use the words "second wave". I say, "the possibility of a resurgence of COVID-19". That, frankly, we have a fair degree of control over. We really don't have any community spread of COVID-19 and we have not had for the last couple of months. We don't have COVID-19 here in Nova Scotia other than sporadic cases that all have had, as their original source, entry into Nova Scotia from somewhere else - another part of the country or somewhere internationally.

That's why we need to continue to focus on having fairly tight restrictions on our border - who gets in here - and the ongoing requirements for a quarantine. We continue to look at that. We have to be cognizant that we are seeing increases in COVID-19 in our larger provinces like B.C., Alberta, Ontario, and Quebec.

The other piece of that, which is under our control, is our collective behaviours. What we're seeing, to a large extent, driving COVID-19 up in other parts of the country is where there's been a relaxation and instances where there's been large gatherings. Other events which then spark community spread. That's why I keep saying my message to the public is that we have to continue to work together - all of us - to practise personal protective measures.

We will get some sporadic introduction of COVID-19 into the province. We have, and that will continue to happen. If we all work together with the two-pronged approach, which is early detection of cases through easy access to testing and then strong public health follow-up to isolate cases and quarantine contacts as well as everybody practising those measures: if you're meant to quarantine, quarantine; if you're meant to mask, mask; and everybody social distancing as much as possible. If we're all doing that well, that means even if there is a case, it's not going to have a chance to expose large numbers of people and have a big outbreak.

Much of this actually is within our control to manage and minimize the chance for a broad spread of COVID-19 in our province.

LEO GLAVINE: Thank you very much for that oversight. I did sort of want to start here, but I will go back to it. In the first days when COVID-19 came along, as we all know, there was no plan book for even you, Dr. Strang, as much as you're familiar with viruses and epidemics. Where were your sources of where we needed to go? Was it World Health? Was it Dr. Tam? Fellow medical officers? Where were you focused to get the best plan for Nova Scotians?

THE CHAIR: Dr. Strang, you have about 30 seconds.

ROBERT STRANG: Okay, very quickly. Actually, we did have a robust pandemic plan which was developed before and then revised after H1N1. That was a very good starting point which led us in a number of key areas that then had to be adapted as we learned more about the specifics of the virus. We started having the Council of Chief Medical Officers calls within the second or third week of January . . .

THE CHAIR: Order. Hold that thought. We're going to take a 15-minute recess as we had planned. We'll start up with you continuing, Dr. Strang, at 2:15 p.m. sharp.

[2:00 p.m. The committee recessed.]

[2:15 p.m. The committee reconvened.]

THE CHAIR: We'll come to order. We will let Dr. Strang finish his remarks.

ROBERT STRANG: As I was just starting, we have two regular groups that bring together the chief medical officers and other senior public folks. We have monthly conference calls and meet twice a year - that's the Council of Chief Medical Officers of Health and the Public Health Advisory Committee.

We were meeting. We began talking with the Council of Chief Medical Officers of Health in the middle of January. We do have a mechanism in the event of an emergency - we did that with H1N1, we did it for Ebola - where very quickly we brought those two groups together and created the Special Advisory Committee on COVID-19. We began having regular conference calls. We're now down to twice a week and for a period of time during the peak we were three times a week.

Those groups of all the Chief Medical Officers of Health is a key way that we link in to our colleagues across the country. We take advantage of some of the big provinces: Ontario has Public Health Ontario; British Columbia has the B.C. Centre for Disease Control; Quebec has INSPQ, their public health research agency. They bring information to the table. A key role for the Public Health Agency of Canada and Health Canada is that they bring international information to the table.

So we're well connected through that mechanism of a special advisory committee to understand what's happening around other parts of the country and evidence of what's happening internationally. There are other structures as well like the FPT Conference of Deputy Ministers and the Council of Ministers of Health, and there are a number of other structures that were stood up, so we certainly weren't doing this in isolation.

LEO GLAVINE: One of the big areas is the importance of testing. It has been diminished probably in some discussions, but I know you and the Premier have been big on testing. When we hear of 700 or 800 tests per day, is it also a bit of a form of surveillance testing in that we get some sampling from across Nova Scotia - which I think it is important to the whole evidence-based decision making?

ROBERT STRANG: Testing always performs two functions. It's a clinical function for that individual, but the broad testing - the aggregate information of the testing is a critical part of our surveillance. We continue to have testing based on symptoms. People need to have some type of symptom, but we've kept a very low threshold.

This is one of the areas where we've actually continued to be informed by our national conversations: what is the group of symptoms that you would trigger somebody to actually have a COVID-19 test? We broadened that back in May. We just now narrowed it back down again. The purpose at that time was to make sure we had a very low threshold of somebody being tested. We wanted to make sure we didn't miss a test. We looked at that for the past three months and we've been able to refine our symptom list again because now we have good evidence in Nova Scotia - enough cases of how COVID-19 likely presents.

You're absolutely right, and we continue to refine our testing approach. We are now testing all university students who are coming in from outside Atlantic Canada. We're looking at ways - once we have gone through that testing of students while they're quarantined - of using that lab capacity, if you will, on the testing capacity for other ways that we may monitor.

We're looking at different ways you may use it at the border, for instance. One example may be moving into people who don't have symptoms at all - just giving them an opportunity. For instance, long-distance truck drivers who are in and out of the United States may have a higher risk - we're looking at how we might test them.

We also always have to be aware that our first priority is always people who are symptomatic. As we get into the Winter, we'll see more people with just respiratory symptoms. We also know that we're likely to see more people needing testing as we open up schools, et cetera. We're very cognizant of making sure that we maintain the capacity for people who might have symptoms and get them tested in a timely manner, even if we might want to do some of these special populations.

LEO GLAVINE: I have one question that kind of intrigues me a bit in that the cases now that we're experiencing across Canada, we're seeing far fewer people going on ventilators. Is that due to the fact that many are in that 20 to 40 - that healthier population - or is it the use of viral medications that is perhaps a help in dealing with COVID-19 if you have the virus?

ROBERT STRANG: As we shift and we have more people, unfortunately because of some of the behaviours that are not following public health measures - we have younger cohorts of people who are much less likely to get severe disease. We don't yet have any direct antiviral treatments for COVID-19, so that's not the reason. It's simply because we have a greater proportion of people who have a lower risk of severe disease.

LEO GLAVINE: I know what I've been hearing, especially over this past month. My title of Minister of Communities, Culture and Heritage has been a bit of a camouflage and I'm not so much in the direct line of sport questions, but I'm starting to get them more and more.

As children return to school and we know that sport and athletics is an important part for many of our students, can they hopefully look forward - if the landscape stays as it is - to having some sport? School sport does have very special meaning for many of our students.

ROBERT STRANG: This is one of the areas where it's important that we focus on what the right balance is. Right now and we've had since in late June, I believe it was - whether it's a sport or a theatre event or some kind of cultural event, you can have up to 10 people that can be together and don't have to keep physically distanced. Your total number can be up to 50, but they have to maintain that physical distance.

We've had lots of conversations. In August, we actually had a big conversation with people from your department, minister, and from Sport Nova Scotia. We looked at what it would take to kind of open up sporting activities. The decision we came to at the time - and the recommendation I then took to the Premier's Office - is that our priority needed to be to open up educational opportunities first for children and youth and even adults in universities and schools.

We needed to get through the first few weeks of school opening. If we opened up lots of recreational and sport opportunities at the same time for kids, we're adding significant risks to them both from school as well as after school and weekend activities.

I just saw it earlier at the break; I have a meeting coming up on the sport and the cultural arts activities again in the third week in September. We've said, we've got to get through these first few weeks and then we'll revisit that. I certainly recognize the importance of various recreational and sport opportunities for children, youth, and adults. How can we do that safely? We're going to be re-looking at that and whether we can increase that number beyond 10. It's that number 10 that right now restricts things like hockey, basketball, and also puts some limitations if you're going to have a theatre event or whatever.

We have active plans to look at that, but my focus will always be on finding that right balance and what is an acceptable level of risk that we can take on - and always knowing that whatever we do to open up, we can restrict again. It would be one of the first things we would look to restrict if we started to see increased COVID-19 activity again.

THE CHAIR: Mr. Glavine, you have about eight seconds.

LEO GLAVINE: I'll just say thank you for your leadership and for the teams around you that have supported the province over the last months.

THE CHAIR: Order. Time has elapsed. We'll turn it over to the PC caucus. Mr. Houston, 12 minutes.

TIM HOUSTON: Dr. Orrell indicated that COVID-19 was an opportunity for the long-term care sector to identify issues. Many of those issues had already been identified by the sector. In fact as my colleague had mentioned, for three consecutive years Northwood submitted requests for capital funding to Minister Delorey that would have seen the building of new floors to eliminate some of the double- and triple-bunking of residents.

I'd like to ask Dr. Strang: Had Minister Delorey or the government acted on the proposal and implemented it, there would have been fewer multiple occupancy rooms. Knowing what we know now, would that have made a difference in the spread of the virus at Northwood if that proposal had been accepted and acted upon?

ROBERT STRANG: That's one factor. We also have to understand that we had outbreaks of COVID-19 in a number of other long-term care facilities - some of which had the same infrastructure issues that did not spread. I don't think you can pin it down to any one specific factor. We certainly know moving forward, across the country, that we need to look at how we do things differently in long-term care.

These have been long-standing problems. We have these same issues every year with influenza. As I said, I've been around here for 20 years that all three Parties have been in government. These are long-standing issues around long-term care that we need to - as the deputy said earlier, COVID-19 has highlighted the need to pay more attention to this sector. There aren't easy solutions and I think we have to be careful not to pick one issue and say, that was the cause of the outbreak at Northwood. I've been in depth in looking at that, talking with Northwood - it was a combination of a large number of factors which led to that situation.

Again, look across the country, there's no doubt that COVID-19 has highlighted long-term care as an issue. It's not unique in any way, shape, or form in Nova Scotia.

KEVIN ORRELL: That's a critical question. We identified early for the review team that we would specifically like them to consider that problem and whether or not an expansion would have made a difference. They will address that in their report.

TIM HOUSTON: Thank you both, gentlemen, for your responses. I don't know how much there is to address. It seems pretty obvious that if you have fewer multiple occupancy rooms, that's a good thing for controlling the spread of the virus. This was an issue that Northwood had identified and in three consecutive years asked for help on.

Dr. Strang, in your role, were you aware of the requests from Northwood for assistance from the government in limiting the number of multiple occupancy rooms?

ROBERT STRANG: In my day to day work, I'm not directly involved in those kinds of policy conversations around long-term care and potential investments in long-term care.

TIM HOUSTON: If somebody had asked you in your official role, would more rooms - and therefore fewer multiple occupancy rooms - be a good thing for infection control, you probably wouldn't have said there are a lot of factors. You probably would have said, yes, it would - because it is on its face.

ROBERT STRANG: I would have said that it's one of a number of factors. I'm well aware of a lot of other challenges around infection control in the long-term care sector. We'll hear much more about that in the review. Again, I always look at things in a comprehensive package and not try to pull out one piece versus another. Knowing that with all of the things we do, we're going to be investing in something. Therefore, there's not resources invested in something else. Everything has to be looked at in a big context.

TIM HOUSTON: I appreciate that, but the room constitution is obviously very significant. I guess another significant factor would be access to PPE for infection control.

On April 8th, Public Health Canada announced guidelines for long-term care facilities. One guideline called for all long-term care providers and visitors to wear surgical masks. British Columbia had, in fact, instructed that to happen a couple of weeks prior to that - back as early as March 25th. It took the Province of Nova Scotia four days after that Public Health Agency of Canada recommendation to actually institute that guideline.

When you were asked in a press conference on May 5th, why the four-day delay, you indicated that there's no point in having a directive if you don't have the supply. I interpreted your comments that day to mean that the PPE just didn't exist to do it. Is that the case that we didn't have adequate PPE as late as April 8th, April 9th, April 10th, April 11th - we just didn't have the PPE to fulfill the directive of Public Health Canada?

ROBERT STRANG: I'm going to answer that a couple of ways. First of all, we have to understand that B.C. had the first cases of COVID-19 in late January. We didn't get COVID-19 until March 15th. So they were a number of weeks ahead of us and therefore all their actions were appropriately ahead of us.

I was part of conversations looking at the evolving evidence and was well aware, and part of the discussions that led to the conclusion from the Public Health Agency of Canada.

[2:30 p.m.]

My answer at the time was not that we didn't have supplies. We had been working on a PPE supply for a period of time before that in anticipation that we might need to have further distribution of PPE. It was making sure that we had the ability and the right supplies and were going to be able to distribute that in a timely manner.

What we didn't want to do was come out with a directive that then left long-term care facilities or other health care facilities without the necessary supplies, then we'd put

them in a really hard position. That four days was really to make sure that the work was done appropriately and we had supplies and a mechanism to distribute. I remember that very clearly.

We came out on the Monday with a directive under the Public Health order, but what people don't know is that the Sunday and the Saturday before that was a large amount of work - people working over the weekend - making sure that the PPE that we had was distributed and actually in the hands of long-term care facilities before we brought out the directive.

TIM HOUSTON: I better understand your answer to be that the province had adequate supplies, but it hadn't been distributed to the places that would need it to fulfill the directive. Is that a fair summary?

ROBERT STRANG: We didn't want to be premature in distributing it into sector X when we may have needed it somewhere else. When we got the directive, I think that the period of time is a relatively short period of time to get it out and to get it into places where clearly the evidence was now telling us it needed to be.

TIM HOUSTON: In terms of B.C. being ahead, I always thought that was an opportunity to learn some lessons from what was happening there. On March 25th, they said everyone in long-term care should be wearing a mask and the Public Health Agency of Canada ultimately agreed, then we implemented after the Public Health Agency of Canada. There are three spots in the timeline there.

Did you ask the minister, or did the Minister of Health and Wellness inquire of you, maybe some time in late March, about having people in long-term care facilities wear masks? Is that something that the minister was asking?

ROBERT STRANG: I don't recall him asking the direct question. I was involved in lots of conversations at the FPT table. B.C. did that because they were actually having active outbreaks in their long-term care facilities.

What drove the Public Health Agency of Canada directive, and then our directive provincially, was more the growing evidence around asymptomatic spread. Based on our influenza, and then our COVID-19 adapted response plans, people were wearing appropriate PPE if they were dealing with somebody who was symptomatic. That was in place for a long period, from the very beginning of our infection control.

What shifted was as we got more evidence around people who could be asymptomatic - meaning that you then have to have everybody, whether they're dealing with a resident who is symptomatic or not, have the appropriate PPE. It was not the B.C. situation. We had the same thing in place that if there was an outbreak back in February or January, we would have used masks like B.C. did.

It was an evolution, and that occurred over time and it came together very quickly in early April where there's enough evidence now that people could be asymptomatic spreading. This then resulted in the federal directive, and then the uptake by that in a very timely manner, provincially.

THE CHAIR: Dr. Orrell, you had something to say?

KEVIN ORRELL: The fact is our department recommended and supplied masking to Northwood on April 5th which was two days before the Public Health Agency of Canada recommended it. We were 48 hours earlier than their recommendation. Then by April 13th, it was mandatory. Everybody had to use it in all long-term care facilities.

TIM HOUSTON: That's helpful. So you had the department saying everyone at Northwood should be wearing masks, but it didn't happen. Then the feds came after that, and then the province came after that but the department apparently recognized earlier than anyone else that the masking was required, I guess. That's what I take from those numbers.

I only have one minute, so I am interested in making sure that we learn these lessons around single rooms. We have put out a long-term plan as to how that can happen in this province. I'd be happy to share it with the department if they're interested.

The access to PPE is certainly one that is on the minds of a lot of Nova Scotians. We made a lot of offers during the early days to help source supply. Now today, we're back to school, and ventilation - which I guess would be another factor in it all - is a consideration in the schools.

The Minister of Education and Early Childhood Development suggested that opening a window will provide the same protections and keep COVID-19 out of the classrooms. Is that advice that your office provided to the minister, Dr. Strang - to just open windows to improve ventilation in the classrooms?

ROBERT STRANG: If you look at any of the Public Health guidance . . .

THE CHAIR: Order, the time has elapsed for the PC caucus.

We'll move on to the NDP caucus and Ms. Coombes - and welcome to your first Health Committee meeting.

KENDRA COOMBES: Thank you very much. You will be aware that staffing shortages are another critical challenge for the long-term care sector. You may remember that CUPE's submission to the Expert Advisory Panel on Long-term Care stated that 75 per cent of the LTC workers surveyed in 2018 reported working short either daily or weekly. How did this change during COVID-19? Has this ratio gone down or up?

KEVIN ORRELL: There were problems, again, with the regular staff at Northwood and other long-term care facilities becoming ill or becoming afraid and not showing up for work. The minister then initiated the Act that permitted redeployment and we were able to get very close to or better than the staffing models that were in place. So it did improve after the redeployment of people to the care facilities.

KENDRA COOMBES: I am going to go with another question now and it's a different take. This question is for Dr. Strang. We know that in order to curb the impacts of the second wave, it will be critical that people who are experiencing symptoms of COVID-19 be able to stay home from work, take time to get tested and self-isolate if necessary. It is also part of the back-to-school plan that an entire cohort of students and close contacts might be required to isolate for 14 days. Younger students, of course, would require supervision during this time.

These requirements are impossible decisions for people who cannot afford to miss any pay. There are many of these in our province. Many of my constituents have been, and will continue to be, faced with this conundrum. Can you explain the importance of staying home when people are unwell and the role that paid sick days have in this equation?

ROBERT STRANG: Certainly, from a public health perspective for not just COVID-19, it's a long-standing challenge, whether it's salmonella in a restaurant or influenza every year. There are a lot of reasons why people don't stay home or are unable to stay home. We need to recognize that we need to work together with government, with businesses as well as with communities, individuals, and families.

The policy decisions around that are beyond my scope in Public Health or beyond the scope of the Department of Health and Wellness. It is absolutely important that we work together to recognize the barriers that are there that may limit people's ability to stay home and find ways to collectively reduce those barriers.

KENDRA COOMBES: I will concede my time to my colleague, the member for Dartmouth North.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: I am going to go back to long-term care for a moment. In July this year, the Nursing Homes of Nova Scotia Association released a paper that described what is needed in the sector. I'm going to ask you a couple of questions about that. The first one was compensation for front-line staff and management in long-term care can be as much as 30 to 40 per cent lower than the same or equivalent roles at the NSHA.

The Nursing Homes of Nova Scotia Association has asked the Department of Health and Wellness to conduct a full compensation review of long-term care roles. I'm just wondering if this is being considered or if it's under way.

KEVIN ORRELL: It isn't immediately under way at this point in time, based on our other considerations for looking after COVID-19, but I can assure you that it is a discussion that we've had and that we will be moving on.

Over and above the pay differential that we have recognized and would like to do something about, I think there has to be an elevation, if you will, in the status of those people who are employed in the long-term care sector. They should be recognized as specialists, just like an ICU nurse or an emergency room nurse or somebody who works in a very specialized area of the hospital. There are geriatric or elder care people across all of the occupations and I think the way that we can improve their situation and improve the respect that we should have for them, based on their experience during COVID-19, is to recognize that.

SUSAN LEBLANC: That's great to hear. I'm just going to revert back to another question then. The starting wage for a CCA with a diploma is $17.47 an hour, but we've just been updated that the current living wage in Halifax is $21.80 an hour. Do you see any need for changes in the wages of CCAs or personal care workers in long-term care?

KEVIN ORRELL: Well, I'm going to rely on my newness to the job and the fact that I am an orthopedic surgeon taking on a health care administration job. Those things are all important to consider and we obviously have to take advice from people who play with numbers and do those things. I can assure you that they work very hard and it would be my goal to make sure that hard work is recognized.

SUSAN LEBLANC: Going back to the paper from the Nursing Homes of Nova Scotia Association, since 2016 we have heard that a blueprint for continuing care is under way, but a vision has yet to emerge. The Nursing Homes of Nova Scotia Association is calling on the department to lead a sector-wide engagement process to build a vision and a framework for long-term care. Is this being considered?

KEVIN ORRELL: Absolutely.

SUSAN LEBLANC: Any timelines on that?

KEVIN ORRELL: There is a great deal of effort and a great deal of manpower that's engaged in managing what we've done. It has been across every branch of our department. It has been across every department in government. The facility of time to sort of engage in one or another project at this point has not been real because of our concentration on looking after Nova Scotians.

Once we get through the resurgence and create what has come to be commonly known as the new normal, I think then we get back to looking at some of these points that have been identified and that we would like to further investigate and work on.

SUSAN LEBLANC: Operational funding for long-term care homes has been significantly reduced in the last several years. The needs of long-term care homes have grown, particularly since the COVID-19 pandemic, but the resources have not - nor has their distribution been revised to create equity across the system. The association has called on the department to revise funding models and ensure equitable access across the system. Is this being considered?

KEVIN ORRELL: Yes, and again, do I have a time frame? I do not. We are going to get through and look after these facilities. I can assure you that anything we needed to do in terms of staffing, procurement of PPE, extra administrators, IPAC, et cetera, has all been done without consideration of budget or deficit. So we've moved on those things without any reference to the deficit. We are $368 million deficit at the Department of Health and Wellness, and we will still do what we have to do for the people of Nova Scotia and for the vulnerable people in these nursing homes.

SUSAN LEBLANC: In 2016, the government cut funding transfers to long-term care by 1 per cent, which had the effect of worsening shortages in the sector. During the pandemic, your department spent an additional $45 million as you talked about on COVID-19-related costs in long-term care. I am absolutely confident that spending has been warranted.

Can you provide us with a breakdown of how and where the money was spent? Can you tell us what permanent investments will be made in long-term care as a result of learnings from COVID-19?

[2:45 p.m.]

KEVIN ORRELL: We can provide that. I would defer to submitting that to the committee afterwards. We do have a breakdown of where our funds were spent and what COVID-19 expenses were entailed, yes.

SUSAN LEBLANC: How much time?

THE CHAIR: You have under three minutes.

SUSAN LEBLANC: I'll try to keep this short. We know that many, many families who have loved ones in long-term care facilities have been heartbroken about not being able to visit for long periods of time. We know that many of the residents in long-term care have suffered in a social way because of that. Many families have been talking about the decline that they witnessed in their loved ones because of not having lots of visits, et cetera.

We know now that this morning it was announced that up to two designated caregivers per resident can be trained to provide support, which is a great announcement. Caregivers will need to be trained in infection control measures, but staffing shortages are

already acute at many facilities. Can you explain what resources will be provided to long-term care homes to be able to train and facilitate the designated caregivers?

ROBERT STRANG: Recognizing some of the staffing issues, we've got to understand these family personal caregivers are not going to require intensive training in complicated or complex infection control. It's very much basics around hand washing, wearing a mask, and those kinds of pieces. They're not going to be doing the kind of care that would require more intensive infection control.

I think, without being on the front lines, I don't see this as being a huge issue for long-term care facilities to take on. Part of what they will be working with is around what capacity they have within each facility over time to do the necessary training for family caregivers. At the same time taking on the family caregivers will help with some of the other staffing pressure that they have. We've got to remember that family caregivers are doing basic care. They're not doing much more of the complex care that would require higher levels of infection control and personal protective equipment.

SUSAN LEBLANC: Outside of those designated caregivers, I'm wondering if you can describe more resourcing for facilities to be able to support more visits and longer visits with loved ones?

THE CHAIR: Order, time has elapsed for the NDP. We'll turn to the Liberal caucus and Ms. DiCostanzo, for 12 minutes.

RAFAH DICOSTANZO: I just want to start by thanking Dr. Strang. I want to tell you that you have an admirer in Ontario in my sister, who is envious of our situation here and would like to have the same numbers in Ontario. She's always watching you and wanted to send her regards to you and the work that we've done here in Nova Scotia.

My question is about testing. In your remarks, you said we started with under 200 and we went to 1,500. Can you explain to us what that meant in staffing? Is it the quality of the testing that improved or how did you move staffing in order to do seven times the volume?

ROBERT STRANG: I'm not the lab person and I don't know all the details, but there's been efforts in several areas. They purchased another piece of the appropriate testing equipment. They redeployed another piece of equipment so there was more testing capacity.

Certainly, Dr. Hatchette and his team have been very proactive. They thought well ahead and purchased and stockpiled the reagents and necessary lab supplies to give that enhanced capacity. They have certainly redeployed staff from other parts of the laboratory which has added to that.

I think one of the key things in my discussions with them - they went to a 24/7 staffing model. That maintains today and in my conversations with Dr. Hatchette, they may stay with that. There are efficiencies within that. People have to now go to shift work, et cetera.

All those pieces together, that's the kind of level of detail I can speak to. I think they deserve a lot of credit for the work that we're doing to go from that 200 a day. If we had a real surge, we could go beyond 1,500 and we're pushing that 1,500 in the last week with all the university capacity. That, to me, has been one of the hallmarks of our success: the ability to rapidly ramp up our lab through-put.

RAFAH DICOSTANZO: Probably a lot of the staff who were doing other tests were moved and deployed to use COVID-19 testing and that's why maybe we stopped some of the non-urgent procedures that my colleague was asking about. Could that have been some of the staff who were moved from one section to help with the other section?

ROBERT STRANG: That's certainly my understanding. One of those components is redeploying, like we've done in other parts of the health system. To meet the demands for COVID-19, we've redeployed within the Health Authority and the lab is no different.

RAFAH DICOSTANZO: My other question was about 811. Can you explain to us how they manage the number of calls and what did they put in as a process and would that stay for the next? Does anybody have the 811?

JEANNINE LAGASSÉ: Very early on, when the decision was made to have 811 field the calls for screening and testing, we worked closely with them as a partner to increase their capacity. Very early on, they made the decision to put out a call for additional workers - retired nurses in particular, who do the screening calls and other staff who do the initial triage.

Our initial work with them was to ramp up on staff, and then subsequent to that, we did lease some additional space, bought additional technology, and invested in all of those things to allow them to ramp up their staffing so that they could increase their call period over a longer period of time than they would in normal times during the day - we extended the call period as well.

RAFAH DICOSTANZO: Has it really slowed down right now? Do you plan it monthly - as November, you're planning your staffing? Are you deploying people? It is just the staffing that I would like to know about.

JEANNINE LAGASSÉ: They continue to have the staff to be able to increase as required. They have the location and everything that we've maintained knowing that there may be a resurgence that they are able to staff up or staff down as required.

RAFAH DICOSTANZO: I'll pass it on to my colleague.

THE CHAIR: Ms. Miller.

HON. MARGARET MILLER: I welcome this opportunity to actually say thank you for all the work you've done. I think I passed this on a little while ago too - just the sense of confidence you gave to Nova Scotians every day with the press conferences with the Premier. I think it was a great opportunity to be able to share what was going on. There's nothing worse for Nova Scotians than to fear something that they don't know - and the department always keeping them on track, knowing what was going on, what was expected. I think that helped towards the calm in the province and where it was going.

I did want to mention a little personal experience we've had during this COVID-19 time. My husband was diagnosed with colorectal cancer in February. Because of his comorbidities, he was able to have his surgery - a very successful surgery - in April. My daughter - of course it was a result of the family history - was able to have a colonoscopy just two weeks ago. Certainly, there were no delays at all involved.

I just want to say that I was quite surprised by both - that the surgery would be handled as quickly as it was and how it was handled, and with my daughter's testing as well - how quickly that was done. There didn't seem to be too much of a wait there at all. Certainly, we're dealing with the northern areas for further testing. It was a very positive experience for my family, so I want to pass that congratulations on to the department for continuing to do the work that you're doing.

We've seen a lot of negative things that have happened during the last six months with COVID-19, but some of the good things that have come have been in doctors' practices, and that has been the virtual care. Do you expect that to continue in the future?

KEVIN ORRELL: Virtual care has always been here. What we did during COVID-19 was facilitate virtual care - we made it easier to use. We reimbursed for the same fee that would have been given for an in-person visit and encouraged people who were afraid to go to their doctor's office, who were afraid to go to a hospital or a clinic to participate with their health care provider in that way.

We have discovered a great many things that are useful and valuable about it. I would say that it's here to stay and I think we will be using it increasingly more common than we did prior to COVID-19. The issue, of course, will be quality, safety, and control. We'll have to make sure that it is improved and made more popular with the restrictions for safety and control.

There has been a great deal of satisfaction with it from the people who used it during the pandemic. I think that was largely because they were fearful they'd lose complete contact with their doctor or their nurse practitioner. Now, when they have the ability to engage personally, they may not have the same level of satisfaction, so we have to make sure we do that carefully and people still have options.

The mental health and addiction sector and the paediatric sector have used it extensively in the past, and we're looking to some of their experience to see how we proceed with it carefully.

MARGARET MILLER: I want to thank you again for taking your time. I know you're all very busy. It takes a little while to get ready for these committees. Thank you for being here. I'll pass it on to my colleague.

THE CHAIR: Mr. Jessome.

BEN JESSOME: I'll try to be concise here. I'm mindful that over the past several months, people who are not trained medical professionals have had the burden of triaging people in their workplace, visitors to their restaurant, employees. The one that comes predominantly to mind today are teachers who are going to have to triage their students and create some disruption in families.

I'm just trying to ask perhaps a question for Dr. Strang. What message would you send to teachers in triaging their students who express symptoms? Beyond that, what message would you send to families in support of teachers who have to make these decisions?

ROBERT STRANG: I think maybe it's the word "triage". We are not expecting people without a health care background to be doing any clinical assessment. We have produced some fact sheets late last week for principals and teachers on this. The overall message - whether it's for teachers or for families - is quite simple and succinct: If you're not feeling well, stay home or go home.

What we're asking teachers to do if a child presents to them and says they're not feeling well or making some judgment - especially younger children just don't look well - we said, you don't have to do a clinical assessment, isolate them within the school as quickly as you can, then call the parents or the caregiver and get them home. Then it's the responsibility of the parents or caregiver to take the next step, which we say, if somebody is unwell, they should, if possible, do the online 811 assessment. If they don't have internet, then call 811 and then get further direction from 811.

The basic message is you don't need to assess symptoms if somebody is unwell. That's all we're asking of teachers in the school system, is to recognize if somebody - a younger child especially - is unwell, or if a child comes to them and says they're not feeling well. We said, always err on the side of caution. We'll get some experience with this as time goes on.

BEN JESSOME: I guess in the 30 seconds I have left, I would just say that the consequence of having to trigger the sequence of events, as a society perhaps we need to be more mindful than ever that our schedules may become disrupted and our day-to-day is

going to be challenged in terms of relying on a particular schedule because of instances such as this where . . .

[3:00 p.m.]

THE CHAIR: Order, the time has elapsed. We will ask for brief closing remarks. Do you have any, Dr. Strang?

ROBERT STRANG: Thank you for the opportunity.

THE CHAIR: Dr. Orrell.

KEVIN ORRELL: As Dr. Strang identified in his opening remarks, this COVID-19 virus was an unprecedented global event. It's a dangerous, sometimes fatal infection, and particularly devastating for the most vulnerable. There's no playbook, and without a drug protocol or cure or in the absence of a vaccine, we will require to manage the disease based on scientific and public health principles.

What was done early in the pandemic was based on information and experience at that time. We have learned much in the interim and we will rely on that knowledge as we move forward.

As I told you, I came to the department as the deputy minister on April 1st - perhaps the worst April Fools joke in my life. This was after 31 years as an orthopedic surgeon. Based on my clinical experience on the operational side of the system, I was impressed with the measures that had already been initiated. I felt that the communication with health care providers and the general population was impressive. Had I continued to practise surgery instead of taking this job, I would have been very confident in the actions that were taken to protect Nova Scotians. The travel restrictions, PPE procurement, stabilization of the workforce for physicians, redeployment of essential workers, and the guidelines from Public Health were critical in the management of this wave.

As the curve flattened and our epidemiology improved, appropriate steps were put in place to re-open the health care system and to address issues such as wait time and the issues we have discussed about long-term care facilities, and as well, to open the economy.

The department has worked broadly across government to do this to create a new normal, while at the time maintaining the capacity to handle the resurgence that we anticipate. There is, and should be, a great deal of focus on the long-term care sector and its facilities. To that end, we have two reviews. As I stated, they'll be on time for report on September 15th.

Northwood was a tragedy that we have identified and would like to do much better. The IPAC review across the province will help us as well. These were undertaken with the lens of how we can move forward on a short, medium and long-term basis to improve the

entire sector. The national standards of care in Canada are all subject in every jurisdiction to improvement and we will do what we can in Nova Scotia.

We continue to improve our ability to look after this population with clarity, PPE procurement, improvement in IPAC principles and practice, and increased human health resources. So we're prepared as we move forward based again on scientific and public health principles as we manage a disease that continues to put the world at risk. Thank you.

THE CHAIR: Thank you to our three witnesses for keeping us safe. We're doing the business meeting later. I thank you for your attendance here and for all the answering of questions. Go back and take care of Nova Scotians again. Thank you.

We will start with our business meeting. We go to our correspondence. You received all the correspondence previously. To save paper and not have as much paper in the Chamber here, we ask that you know about them. We received one from Joanne Thomas in response to a request for clarification of a February 3rd question. Are there any comments?

There is a March 10th memo from Sam Hodder, Mental Health and Addictions program from NSHA; a March 11th letter from committee member Barbara Adams; a March 13th letter from ADM Jeannine Lagassé, Department of Health and Wellness in response to a request for information; and a May 6th letter from Tim Houston of the Progressive Conservative Party of Nova Scotia. Are there any comments?

There is a June 2nd letter from committee members Susan Leblanc and Kendra Coombes with the Chair's response; a June 15th letter from committee members Barbara Adams and Colton LeBlanc; and an August 13th email from Sarah Roberts. Are there any comments?

Organizational charts also were distributed from NSHA in April. We did the same process - they were forwarded to members on receipt but not printed.

We have an agenda-setting meeting in October. Each caucus has already submitted a list of proposed topics to the clerk in March for an agenda-setting that did not take place. The meeting was postponed because of House hours and later cancelled because of COVID-19. Do members wish to update their topic list and submit new ones before the October meeting? Is there an agreement for that? When would the clerk like to receive your topic ideas?

JUDY KAVANAGH (Legislative Committee Clerk): If I could get them from each caucus by the end of this month - Wednesday, September 30th - then I'll compile them and distribute a full list to all of you.

THE CHAIR: Is that satisfactory for everyone? Thank you.

Our witnesses at the next meeting will be Doctors Nova Scotia, we're hoping. The clerk has been reaching out to them. They've had a change of leadership, so she is working on that. We will know more about it as time progresses. We will go ahead with the business part of the meeting if they're not able to come.

Mr. LeBlanc.

COLTON LEBLANC: I would like to make a motion. This important committee began meeting back in January 2019 and discusses important matters to Nova Scotians, matters regarding access to and the delivery of health care. Both Opposition Parties have made a number of requests since our standstill back in February 2020 to meet either in person or through virtual means - those requests were not accepted by the government.

Therefore, I'd like to make a motion that the Standing Committee on Health be required to meet monthly either in person or via virtual means, to ensure that in the event of a second wave or resurgence in cases, we do not have to wait another seven months for a meeting of this important committee.

THE CHAIR: There is a motion on the floor. Ms. DiCostanzo.

RAFAH DICOSTANZO: Could I call for a five-minute recess to discuss it? Could we have it in writing as well? Not possible?

THE CHAIR: I don't know if there is time to have it in writing. Mr. LeBlanc.

COLTON LEBLANC: Yes, we would have to make a motion to extend the meeting since we have less than six minutes left to conduct this business.

THE CHAIR: We've already extended it. I'm supposed to be somewhere already. Ms. DiCostanzo.

RAFAH DICOSTANZO: Maybe three minutes?

[3:09 p.m. The committee recessed.]

[3:11 p.m. The committee reconvened.]

THE CHAIR: Order. Mr. Jessome.

BEN JESSOME: I am not sure exactly what the distinction is between this motion and the status quo. This committee is in most cases mandated to meet on a monthly basis. Given the current emergency circumstances that have prevailed, I guess outside of my purview, decisions have been made to focus the attention of health professionals on providing health care to Nova Scotians, so I'm not sure. Perhaps the decision to focus the

attention of health care providers across the province on providing health care, that decision could come forward again in the future.

Again, I don't know what the distinction is between what our committee shoots to achieve on a given day and what the honourable member's motion is that's on the floor today.

COLTON LEBLANC: If memory serves me correctly, this committee is not mandated within its rules to meet monthly, unlike other committees. Our role as MLAs - and especially Opposition MLAs - is to bring a level of accountability and transparency to government. That's why we're bringing forward this motion.

We hear on a daily basis through our constituency offices questions regarding various access to care. We discussed it this afternoon regarding preventive measures. Females are struggling to get in for a mammogram, for example. I'd be appalled if we haven't all heard about the challenges to get a blood test done.

It's our responsibility here to ensure that despite what may come, hypothetically, that we take appropriate measures at this time to lay the stonework that we can continue to work through this committee. So whether it be virtually, in person, it's incumbent that this committee make this decision today.

THE CHAIR: Just to be clear, we do not make policy at this committee, so we can't change things that are in the department. Ms. Leblanc, quickly.

SUSAN LEBLANC: I would move that we extend the meeting by three minutes so that we can finish this important discussion - or four minutes even, until 3:20 p.m. That's six minutes.

THE CHAIR: Is it agreed?

It is agreed. Ms. Leblanc.

SUSAN LEBLANC: I think that everyone understands the spirit of this motion. I think we all generally get what the member is trying to do here, but what I would like to propose is an amendment that would say that the Health Committee, which meets 12 times a year, would need unanimous consent to not meet at a given time.

That would mean that everyone would have to agree that the meeting is cancelled. If we don't get unanimous consent, then the meeting would have to go forward either in a virtual way or in an in-person way, which is the same way that I believe the Human Resources Committee functions, or one of the other committees functions.

That is my amendment - that the Health Committee would need unanimous consent to not meet at one of the regularly scheduled monthly meetings, which are scheduled 12 times a year.

THE CHAIR: I would like to weigh in with Mr. Hebb on this one.

[3:15 p.m.]

GORDON HEBB: I'm not sure that the amendment is necessary. The Human Resources Committee is mandated by the rules to meet monthly. I've given the opinion that in order for them not to meet requires unanimous consent. If this committee were to provide by the original motion that the committee must meet monthly, then that would follow that they would not have to meet if there was unanimous consent - which is, I believe, the nature of the amendment.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: If that's the case, if our colleagues from the Liberal caucus have said we are mandated to meet monthly, the question is, well then why haven't we met monthly for the last seven months? It would be great to know for sure if we are mandated, in which case Mr. Hebb's advisement would make sense.

THE CHAIR: Ms. Miller.

MARGARET MILLER: My concern here is we don't know what's going to happen in the next while. We don't know if there's going to be a second wave or if there's going to be a third wave or the economy's going to be shut down again or what. I think there's too many variables in play here to be able to say that we have to have unanimous consent.

I think we should continue the way we are and barring any unforeseen circumstances - like another outbreak of COVID-19 or a serious outbreak that actually shuts down things in the House again - that we would normally meet. I don't think there's any need for any of these motions. I call for a vote.

THE CHAIR: Mr. Houston.

TIM HOUSTON: The member is actually citing the reasons why this committee should meet monthly. It's because we don't know what's happening. Health care is a big issue in the minds of Nova Scotians. It's half of the budget. This committee should be meeting.

I will just offer that during this pandemic, families found a way to communicate through Zoom and Microsoft Teams. Companies found a way to communicate. The national Parliament found a way to communicate. This Health Committee can find a way to communicate and it should meet monthly.

THE CHAIR: Okay. There has been an amendment by Ms. Leblanc. We need to vote on that first if there's not unanimous agreement with that. No, okay.

There has been a request for a recorded vote.

YEAS	**NAYS**
Kendra Coombes	Rafah DiCostanzo
Susan Leblanc	Ben Jessome
Colton LeBlanc	Margaret Miller
Tim Houston	Leo Glavine
	Suzanne Lohnes-Croft

THE CHAIR: We'll vote on Mr. LeBlanc's motion. There has been a request for a recorded vote.

YEAS	**NAYS**
Kendra Coombes	Rafah DiCostanzo
Susan Leblanc	Ben Jessome
Colton LeBlanc	Margaret Miller
Tim Houston	Leo Glavine
	Suzanne Lohnes-Croft

JUDY KAVANAGH: Five Nays, Four Yeas.

THE CHAIR: Time has elapsed for our meeting. We will now adjourn, with our next meeting being on Tuesday, October 13th. Hopefully Doctors Nova Scotia will be here. Thank you all.

[The committee adjourned at 3:19 p.m.]