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STANDING COMMITTEE

ON

HEALTH

Tuesday, April 13, 2021

Video Conference

Health Care System Human Resources

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STANDING COMMITTEE ON HEALTH

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[Hon. Suzanne Lohnes-Croft replaced Hon. Leo Glavine]
[Hon. Brendan Maguire replaced Hon. Tony Ince]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dr. Kevin Orrell, Deputy Minister
Angela Purcell, Senior Executive Director, Health Workforce

Nova Scotia Health Authority

Joanne Stone, Senior Director, People Services/Human Resources
Geoff Piers, Director, Recruiting and Workforce Planning/Central Zone People Services
Colin Stevenson, Vice-President, Quality and System Performance

IWK Health Centre

Steve Ashton, Vice-President, People and Organization Development
Matthew Campbell, Director, Strategy and Performance and Director (Interim) People

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, APRIL 13, 2021

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Rafah DiCostanzo

VICE-CHAIR
Hon. Leo Glavine

THE CHAIR: Good morning, everyone. I call this meeting to order. This is the Standing Committee on Health. I'm Rafah DiCostanzo, the MLA for Clayton Park West and the Chair of this committee.

Today we will hear from the Nova Scotia Health Authority, the Department of Health and Wellness, and the IWK Health Centre regarding health care system human resources.

Members, the committee clerk, and Legislative Counsel should keep their video on throughout the meeting with their microphone on mute unless I call your name. Please wait for me when I call your name before you speak. All other staff should have their audio and video turned off.

If you have another device with you such as a phone like mine, please put it on vibrate or turn it off. Please try not to leave your seat during the meeting unless it's absolutely necessary. If you do, please leave your camera on just so that we know you're coming back.

If I need to confer privately with the clerk or Legislative Counsel, or if members wish to confer before a vote, I may call a brief recess. If any members have technical problems, please phone or text the clerk.

I will now ask the committee members to introduce themselves for the record, starting with Hon. Suzanne Lohnes-Croft.

[The committee members and witnesses introduced themselves.]

THE CHAIR: I guess I will let the witnesses start with their opening remarks. Dr. Orrell, please.

DR. KEVIN ORRELL: Good morning, Madam Chair and committee members. We appreciate the invitation to the department and to our Nova Scotia Health Authority colleagues to meet with you today. We're happy to be here to discuss the health care system human resources. I'll introduce my colleague Angela Purcell, who you just met. She's our department's Senior Executive Director of Health Workforce. Our colleagues from the Nova Scotia Health Authority have been introduced. I'll say a few words and then we'll look forward to the discussion.

The department works with our partners to ensure the province has the right mix and supply of health professionals to meet Nova Scotia's needs. That includes our health authorities, other government departments, post-secondary institutions, municipal and community partners, unions, professional association and colleagues, and many others. That work ranges from education and upskilling to credentialing, recruitment, and retention, and it encompasses many health care professionals.

While doctors and nurses often come to mind when we think of health care professionals, there are a host of other professionals who make up our health care system. Working together, we have put in place multi-year initiatives to ensure adequate supply of many health professionals that we need. In fact, recent data from the Canadian Institute of Health Information shows that in the last five years, the supply of most health professions in Nova Scotia has continued to increase.

From medical radiation technologists, dentists, physicians, paramedics, psychologists, dietitians, pharmacy technicians, licensed practical nurses, social workers, speech language pathologists, and many others. Despite this progress, some localized shortages and other challenges exist, and strategies to address these are under way.

I would like to take a few moments to talk about our nursing workforce. Our nursing strategy was developed to help Nova Scotia attract and retain nurses that we need. We have added new seats to Dalhousie University and Cape Breton University with a focus on First Nation and African Nova Scotian communities. The Nurse Practitioner Education Incentive helps RNs return to school to become nurse practitioners in exchange for working

in areas where it has been difficult to recruit. We've done these things with our partners and it has helped to enrich our nursing workforce over the last several years.

We have also worked to support continuing care assistants. CCAs are a key member of our health workforce, caring for our loved ones in their homes, in long-term care facilities, and in hospitals. We have worked to offer standard training through the NSCC and several private career colleges, and a bursary program exists that offers financial support for successful applicants. The Recognition of Prior Learning assistance program provides funding for people to have their skills and experiences assessed to become certified to work as CCAs. A new Continuing Care Assistants Registry Act will give us better data for workforce planning to ensure that we have enough continuing care assistants to meet the needs of Nova Scotians.

I know physician recruitment and retention remains a topic of interest, not only for this committee, but for many Nova Scotians. Doctor recruitment, like most things in our health care, does not have a simple solution. It's why we have a suite of programs, initiatives, incentives, and funding to train more doctors here, while working with our partners to attract physicians from other provinces and areas.

We have residency spaces for family doctors and specialists, expanded clerkship training programs, and added more undergraduate medical school seats with a focus on students from rural communities, Mi'kmaq and other Indigenous people, and African Nova Scotians.

We have launched a family medicine Practice Ready Assessment Program to help internationally trained doctors work here, added immigration programs specifically for doctors and other health care professions, and established a new fund to support community efforts to recruit doctors. While compensation is not the only factor in attracting and keeping more doctors, we have struck an agreement that ensures our family doctors are the highest paid in Atlantic Canada.

We are working with our partners to train and hire more providers, and ensure our trained professionals are working to their full scope of practice. An example would be pharmacists who can now prescribe oral contraception, and treat and order medication for urinary tract infection and shingles. They can renew prescriptions for 180 days for many drugs. Another example is our nurse practitioners who can now complete medical assessment forms for commercial drivers, licence applications, and drivers who have medical conditions requiring assessments.

The last year has clearly shown what we can accomplish when we work together. The partnerships we have developed extend beyond those directly involved with health care and have been instrumental in our provincial response to COVID-19. The pandemic has highlighted our ability to quickly mobilize the resources we need to work toward a common goal. The same approach will serve us well in terms of our health care human resources.

We are committed to continued collaboration with our partners to maximize opportunities to strengthen our varied and valuable health care workforce. Thank you.

THE CHAIR: Thank you, Dr. Orrell. Next we have the Nova Scotia Health Authority. I believe Mr. Colin Stevenson is presenting his opening remarks, correct?

[9:15 a.m.]

COLIN STEVENSON: Good morning, Madam Chair and committee members. Thank you for the opportunity to be with you this morning and to provide an overview of some of the important activities that the Nova Scotia Health Authority has under way to ensure health human resource requirements today and into the future.

As noted in introductions, with me today are Joanne Stone, our Senior Director of People Services; and Geoff Piers, the Director of People Services for the Central Zone and leader for our recruitment team.

This past year has been a very busy one for Nova Scotia Health Authority staff and I would like to acknowledge all of the dedicated employees and physicians providing services to Nova Scotians. Care providers are working to ensure the health of Nova Scotians in unprecedented circumstances, and we appreciate that hard work. We want to ensure that we have continuous planning to provide as much rest as we can with the summer months coming.

The Nova Scotia Health Authority is a large and complex provincial organization, even in non-pandemic times. We are Nova Scotia's largest employer, and we proactively plan for human resources based on service needs. We collaborate with our partners at the Department of Health and Wellness, the IWK Health Centre, Emergency Health Services, long-term care, academic partners, unions, professional associations, health care foundations, and communities to ensure that we have the right mix of providers at the right time, and in the right location.

The demand for health human resources is a national challenge that has been elevated by COVID-19. Our collaborative provincial approach in Nova Scotia has been one of the reasons we have been successful in employing and reassigning staff during this past year with COVID-19.

From establishing primary assessment centre testing in the early days to the vaccination rollout, mobile units, and regional care units for long-term care, we have successfully hired and managed resources to meet the changing needs of COVID-19. Working as a system, we have been able to reassign staff to new and different roles within zones, across zones, and to long-term care settings as needed.

During the past fiscal year, we had approximately 9,200 hiring transactions including hiring approximately 1,500 new staff for COVID-19 activities, bringing our total

workforce to approximately 27,000. We have also developed a pool of more than 1,100 volunteers and 400-plus physicians ready to help. As a province, we are fortunate to have had so many Nova Scotians step up to help with COVID-19 by offering to volunteer, and retired physicians and nurses returning to their professions to work in vaccination clinics.

With that volume of hiring transactions in a year, we will always have a certain percentage of vacancies. As job postings are created, some existing staff are provided the opportunity to apply and move to new programs, new services, and new geographical areas, creating new vacancies within our organization.

Each year, we anticipate our nursing requirements for the year and offer full-time employment to as many new graduate nurses as possible, so that nurses either come home or stay in Nova Scotia. Our recruitment efforts are extensive and include job fairs, media outreach, and international campaigns.

For more challenging-to-fill roles, often in rural areas, we will offer recruitment incentives of up to $10,000 and relocation expenses with a return of service agreement. When there are specific professions such as nurse practitioners required, we have been fortunate to work with the department and our academic partners to enhance nurse practitioner training specifically to benefit rural areas. We are also fortunate to have foundations that have supported students with bursaries to return to a certain geographic area and meet future health human resource requirements.

We are proactively planning to meet the future needs of Nova Scotians. For example, with the Cape Breton Regional Municipality health care redevelopment project, we have worked with the Department of Health and Wellness and Cape Breton University to expand the number of nursing students in that program to ensure we have ample local supply for the long term.

We continue to look forward and strive to be better. Last month we launched the first Nova Scotia Health Authority People Strategy. We look forward to it guiding our health human resource activities and supporting the workforce in a number of key areas including development, mental health and wellness, and increasing the diversity of our workforce. We strive to be an employer of choice that engages staff and further ensures the sustainability of services to all Nova Scotians.

Thank you, and we look forward to the discussion today.

THE CHAIR: Does the IWK has any opening remarks, or can we move on to questioning?

STEVE ASHTON: Yes, we do, Madam Chair, if it’s okay.

THE CHAIR: Please go ahead.

STEVE ASHTON: Thank you very kindly, Madam Chair and committee members. We appreciate the opportunity to speak with the committee today.

As a committed partner in our health system with our partners at the Nova Scotia Health Authority and the Department of Health and Wellness, the IWK represents a community of over 3,200 staff, 400 physicians, 800 volunteers, hundreds of researchers, and also provides support to over 1,000 learners a year. Through the pandemic and in our post-COVID planning, we've learned the importance of being nimble, innovative, and responsive as a health system, not only to the needs of the patients and families we serve, but to the dedicated people who serve them.

Workforce planning in health care is a strategic imperative in our mind. As the boomers retire, the demand for health care grows. The competition for qualified staff and physicians will intensify. The IWK and our colleagues compete with public and private sector employers across the country and around the world. While many health care workers have stayed put to support each other through this crisis, we know that once the current pandemic subsides, people will seek new career opportunities and dust off the retirement plans. With that in mind, we believe that in this race for talent, we have to be committed to being proactive and innovative in this environment.

Over the years, the IWK Health Centre, along with our partners, have established a number of practices internally, and again together with partners not only in health care but with our labour, education, and community partners. That's done to anticipate the human resources needs and ensure that we can attract and retain the talented professionals we need to deliver on our mandate. This includes, as most of you would imagine, forecasting vacancies and retirements. We track attrition, our overtime rates, and our health and wellness data as well. We also learn lots through conducting annual employee and physician engagement surveys, as well as exit interviews, to understand what influences departures, and it also informs opportunities to improve our employment experience.

We hold listening sessions with diverse members of our workforce and our community to understand their experiences and address barriers in our workplace.

At the IWK, we hired a strategic recruitment consultant a few years back to focus on what we consider hard-to-fill roles and cultivating talent pools for the future. In partnership with the department, we developed close relationships with the education system and professional associations to ensure that we have an appropriate pipeline of new graduates and new entrants to the workforce. We fund select staff for specialized education to grow our own in those areas where we know there's a national shortage.

The arrival of COVID-19 certainly challenged us in extending our workforce planning even further. Through the past year, as with our partners in Nova Scotia Health Authority, we augmented our teams with recent retirees, temporary hires, volunteers, and in fact members of the provincial civil service who supported us throughout a number of areas, including testing, outbreak response, and our provincial vaccination program.

Our staff and physicians selflessly stepped into roles not only within the IWK but also in support of our partners at Northwood and within Public Health. We also pivoted to roll out virtual care this past year at record speed, and there's no better example of this than our community mental health and addictions team, who implemented virtual appointments within the first weeks of the pandemic. This dramatically changed the way we delivered care, especially in the early days of the pandemic, when mental health support was most critical. In fact, we saw over 30 per cent of our workforce also shift to working from home. This highlights the opportunities ahead to reimagine and improve the way we work and deliver care and services going forward.

As I close, there's one very important point that I think we all want to make, and that's this past year has highlighted that we cannot be effective in health care if our team members are not healthy, safe, and working in respectful and supportive environments. Despite the adrenaline and the commitment that has fuelled this historic response, our health care workers are tired and looking forward to the light at the end of the tunnel, as we all are.

To that end, we want to highlight our ongoing commitment to support the physical and mental health of our people, because their health and wellness is essential to providing the best possible care to our families and communities. As we work together through the pandemic and towards a new normal, the IWK remains a committed system partner to ensure that we have a health workforce that is ready to meet the challenges of today and the needs of tomorrow.

THE CHAIR: Next will be our question and answer period. If you don't mind, just make sure you wait. I see a hand. One second, Ms. Adams. If you don't mind waiting until I call your name before you unmute to speak. We will start with the PC Party for 20 minutes, followed by the NDP for 20 minutes, then the Liberals for 20 minutes. Depending on how much time we have left over, we will do the cycle again, either five or 10 minutes, again starting with the PC, NDP, and Liberal. We have to end at approximately 10:40 because we have committee business after that. I'm assuming Ms. Adams had her hand up because she's starting.

Go ahead, Ms. Adams, with your questions.

BARBARA ADAMS: I want to thank all of you for being here today. It's a really important topic. I also want to echo what Mr. Ashton just said. I've been a physiotherapist for nearly 40 years and I've never seen a year like this past year, and the extraordinary commitment that every health care professional made - not just at work, but the fact that they sacrificed their social life in order to keep their bubbles as small as possible.

Some of these questions are going to be a bit all over the place because we've just gone through several hours of budget debate, so I have a number of questions stemming from that. I want to start with a couple of local questions.

Ocean View Continuing Care Centre is in my constituency. Almost two years ago in June, the two physicians who were there - the medical director and another physician - indicated that they were leaving. They put in their resignation papers and it took a while to get a response. Up until now, there are three physicians - the two there and a third one - are doing very short hours there, and there is no end in sight as to whether there may be a full-time medical director there or full-time staff. Right now, we have a lot of health professionals at that facility who are working without really the oversight of a physician that they used to have.

It's difficult for me to know who to ask the question. We only have time for one person to answer so I'm going to direct them to the deputy minister, and then if he thinks there's someone else who should answer that question, I will allow him to direct it as to who he thinks is most appropriate.

Right now these physicians who are working part time, one is a medical director somewhere else, and so therefore their time is diverted. I'm just wondering how many long-term care facilities in Nova Scotia do not have a permanent medical director in place in addition to Ocean View.

KEVIN ORRELL: This is an issue that we are attempting to address here at the department. There are, in fact, many outside of the Central Zone that do not have doctors that oversee the patients and who are there on a 24/7 basis. We are currently in the process of developing programs that will allow primary care for each of the residents. It will be a combination in some communities of doctors who are willing to do that and can be supported to do that, along with nurse practitioners.

Several homes do have primary care offered by nurse practitioners - some by doctors. There is a care group in Halifax that looks after almost all of the homes here in Central Zone. This is an issue that we recognized and that we are attempting to address. Exact numbers - if that's a statistic you'd like, I can get that, but it would take some time.

BARBARA ADAMS: I would, in fact, like those numbers. Two years seems like a very long time to wait. There is a requirement in the legislation that there be an RN on duty at all times. There are some nursing homes - I won't say which ones - that have entered into contracts with LPNs to be in charge of the facility because there is no physician or RN. It's a trend that I'm concerned is increasing.

In addition to the numbers of how many physicians are missing as in long-term care facilities, I'd also like to know how many have a written agreement to allow an LPN to be in charge of their facility. I know of a couple, but if there are others out there, I would like to know that as well.

In the Homes for Special Care Act, 19(k), it says, "prescribing staff requirements and qualifications for a facility, a nursing home and a home." One of the things that I know for sure - because I worked at Ocean View for six months during the pandemic because

they lost their physiotherapist because of the pandemic - the staffing ratios of how many RNs, LPNs, CCAs, physiotherapists, OTs, rehabilitation therapists, and social workers are not in any way consistent across the province.

[9:30 a.m.]

I'll just pick a particular number. The unions have all called for 4.1 hours of care per resident per day in nursing homes. The PC Party of Nova Scotia has committed to that in our plan. The unions and the Nursing Homes of Nova Scotia Association have called for that. I'm just wondering if the deputy minister can comment on - given the fact that you were supposed to prescribe a staffing level in the regulations and it's not there - whether he agrees with 4.1 hours of care, which is up from 2.6 and 3.1, or if he thinks a different staffing level is more appropriate.

KEVIN ORRELL: Currently, the average would be about 3.6, and we have undertaken investigation. We had the experts from Mount Saint Vincent University, at the facility they have for aging, do an assessment and provide recommendations. They could not come up with a number, and the reason that the staffing ratio is different is because each home is different. They have a different set of patients. The acuity of patients certainly makes a difference as to the staff-to-resident ratio.

In a facility where there are a large number of mobile people who are not profoundly demented, who can get up and do their personal care and go to a dining room to eat, they need less staff than a place that has quite the opposite. Even within one facility, a unit that manages more patients with higher needs would have a higher staffing ratio than a unit that does not. Many of the administrators of the homes have stated that they did not want to be legislated a higher number than they currently had because that would commit them to more when in fact they didn't feel they needed it.

Having said that, we are interested in doing what is correct for each home. The geography of the home makes a difference as well. We are going to be introducing an international assessment tool called interRAI this year, and interRAI has been used in many countries to evaluate and to make assessments on that issue. It evaluates people at the time of entrance into the facility and will establish a care need, and then can be used throughout their stay as a resident of the facility to change it as appropriate, given that their condition may be different during the time they spend in the long-term care facility.

BARBARA ADAMS: I feel the need to comment on a couple of comments that you just made. The interRAI system was supposed to be here a couple of years ago, so we're a few years behind. Actually, it was 2018 when that was all started to talk about, so we're a few years behind on that. You also mentioned about how Janice Keefe and the expert panel were supposed to identify appropriate staffing levels, and what they indicated was that they didn't have sufficient data. One of those pieces was CCAs. It was something I called for, it was in our plan to have the CCA registry, but it took two and a half years from the time the expert panel said you needed to have a mandatory registry for CCAs,

which I don't understand because they're the second largest health profession in Nova Scotia behind nurses, yet they're the one profession we haven't a clue how many we actually have.

The other thing that you commented to is you said the average staffing level was 3.6. That's not my understanding. My understanding is that it's 2.6 in some facilities that were legislated or negotiated more at the residential care level of frailty levels 6 or 7, and 3.1 hours of care in the long-term care where the frailty level is 7, 8, or 9. If it is in fact 3.6, that's new information that the Nursing Homes of Nova Scotia Association is not sharing, so it would be really interesting to see, of all the long-term care facilities, what each staffing ratio is. It is negotiated and that's one of the frustrations by the Nursing Home Association when they get together, one that has the exact same acuity level as another has a different staffing ratio.

You also mentioned that you had some nursing homes that said they didn't want more staff. I'd like to know who that is because that's not anyone that I've ever talked to. They're all claiming that they need more staff, so I think that's a concern.

The next question I have is a really basic one. Two or three years ago, we got funding for a clinical nurse practitioner. It took us 18 months from the time we got the funding for that to actually getting someone hired. Something that came up during that was that they weren't actually advertising.

At Ocean View, for example, the physiotherapist who left and I took her place for six months on a casual basis as a volunteer - they have physio there only working maybe 10 hours a month, supervising two physiotherapy assistants.

I'm just wondering what happened over the last few years in terms of allowing staff to have shorter hours so that they can supervise staff who have a lower level of training? How much does that happen in the Nova Scotia Health Authority where we have allowed someone to work very casual hours in order to be able to supervise those who have a lower level of training?

KEVIN ORRELL: A few things - you base a great deal of your observations, of course, on the home that you actually worked in and extrapolate, I guess, to the whole system.

I, on the other hand, have had a great deal of experience in Cape Breton at the Cove Guest Home and at the Harbourstone and other facilities. As an orthopedic surgeon, when people became too frail to come to my clinic for injections for arthritis and things like that, I would go to the home and do them there and certainly ramped it up in the early stages of the pandemic before I started.

I have a little bit of a different experience based on homes that I've had some experience with, as well. They are certainly not all the same. There is a delegation of

authority in many homes. For example, because of the situation with CCAs and the need to hire more and to fill the vacancies that exist, we created a position of a long-term care assistant. In fact, the CCAs are able to supervise the long-term care assistants and they're able to do much of the work that frees up the CCAs for other duties.

The same thing exists in hospital environments and other long-term care facilities where nurses can delegate and supervise LPNs to do some of the work that they formerly did. There is a hierarchy of delegation that does exist in all of our health care facilities.

BARBARA ADAMS: Thank you for that answer, and I will clarify. As a physiotherapist who ran a home care physiotherapy and OT company, I've worked physically in all of the long-term care facilities in metro and I have toured around the province. As the critic for long-term care, I have heard from quite a large number of staff and directors from other facilities. It is not just based on Ocean View - I use that as the example because I'm protecting the anonymity of those who have come forward from other places.

I want to ask a very practical question because I see that it's still an issue. When you go to the NSHA's employment website for the public - if you're a CCA and you want a job in the NSHA, you type in "continuing care assistant" - and it comes up with 339 jobs. The majority of them are not CCA positions. There's care team assistant, care coordinator, continuing care, it goes on, where you have to go through pages of tabs before you actually find a job for continuing care assistants.

We brought up this issue a few years ago when we were talking about accreditation. One of the issues that was highlighted in accreditation was the delay in hiring. The search feature here doesn't seem user-friendly and I'm just wondering if there is any interest or plans to streamline it so that it's a little easier to actually find a job in Nova Scotia, if you are looking for a particular job.

KEVIN ORRELL: I think I'll refer that to Colin or the Health Authority.

COLIN STEVENSON: I'm going to ask Geoff Piers to speak from a recruitment perspective to the application from an online process and some of the work that we've done to try to speed up the recruitment and placement process.

GEOFF PIERS: We use SuccessFactors recruitment module products that a number of different government organizations use across Nova Scotia. The search function is somewhat limited, as you note. It just searches for all the words you type in, so if you put in more words, it's going to take you to anything where those words exist.

With regard to how we're trying to improve it, we have a working group with governmental partners and external contracted vendors where we're constantly trying to improve it. We meet monthly, actually, to do so. This search function is something that

we're looking at within the restrictions or the functionality of the systems we have to use, so we intend to do that.

We also offer a number of other ways that people can contact us if they're struggling with navigating through the system. They can contact us directly for supports in trying to find positions as well.

Commenting more broadly on things to improve recruitment, there are all kinds of efforts. For now, I guess I'll stick to the search function question. It is somewhat challenging. There are limited numbers and we do offer alternatives to support people.

BARBARA ADAMS: My last question perhaps then is - we know that there was a huge shift in creating collaborative health teams around the province. The NSHA's By the Numbers report shows that there are 88 collaborative health teams in the province. It's a two-parter. One is: Is there a collaborative health centre in every constituency in Nova Scotia? There are 51 constituencies and 88 collaborative health teams.

The other says - the other intent was for a ratio of 10,000 citizens. The collaborative family practice team metric included four to five physicians, one to two nurse practitioners, two to three family practice nurses, and one to two community members like dietitians, social workers, and physiotherapists. I'm wondering if there is a document that summarizes or lists every collaborative health centre, and then the actual staff who work there - maybe not their names, but how many actually have a physio or social worker?

Those are my two questions. Is there one in every constituency and is there a list of all of them, including what additional staff they have there besides a physician?

KEVIN ORRELL: I will tell you that because of the commitment to primary health care access, the government did support the establishment of these collaborative care practices. The goal was 70 new or enhanced collaborative family practice teams. Currently, as you mentioned, there are 88, but there are actually 89 in the province. So 174,000 people have found a family practice since the inception of this.

It does involve some of the professions that you mentioned, but not every collaborative team would have the same composition. With 89, I would imagine there would be some in every constituency, but perhaps, Colin, you might have a better feel for where the collaborative practices were established across the province.

[9:45 a.m.]

COLIN STEVENSON: We can provide that separate for you in the sense of the list of locations and the actual team composition. I don't know the exact location of every team or have it in front of me at this time.

Part of the movement in the sense of the building of the teams really was based to some degree on appropriate location and the need for support to primary care, but the readiness of the team. There would be some sort of variability in the sense of the locations of those, based on interest of the primary care providers themselves, and the type of team composition does vary across the province - again, based on what was identified as the need within their particular practice and how they felt that they could have some of those additional resources to augment what they were currently delivering.

I'm happy to provide a full listing of the locations of those practices and the team composition.

THE CHAIR: You did it just in time. We now move to the NDP. Go ahead, Ms. Leblanc.

SUSAN LEBLANC: Thank you to everyone for being here this morning. I also would like that list, Mr. Stevenson, so if you could just provide it to the committee, that would be great.

I want to start off with a question about the government's fiscal projections for the next several years. We are in the middle of our budget session. As part of the back to balance plan, the government is anticipating a $208 million drop in departmental expenses between this year and 2022-23. Given that the Department of Health and Wellness and the Nova Scotia Health Authority represent almost half of those expenses, this could be extrapolated to mean a significant reduction in health spending.

My first question is: Have you been asked to prepare for those reductions, and have you been asked to consider any cuts to human resources? I guess I will direct that to Dr. Orrell and to Mr. Stevenson.

KEVIN ORRELL: Just as an aside quickly, I have a list here of all the collaborative family practice teams that are located in Nova Scotia by zone and each individual one, so that's very easy information to get to Ms. Adams right away.

I think we dealt with some of this type of questioning during Budget Estimates. As you are aware, and as we've discussed, the expenses for COVID-19 are large. They're very big expenses. PPE, testing, contact tracing, the staffing for filling the primary assessment clinics for the immunization program, et cetera. We anticipate that there will be, as we proceed and God willing as we remain safe and our epidemiology is good, that there will be less spending in the next fiscal year for COVID-19.

Those expenses should decrease, and that will allow us to save money. We do not anticipate there would be any reduction in any of the health human resource spending that is planned in the budget.

SUSAN LEBLANC: I wanted to speak a little bit about Northwood again. In a freedom of information request that our office received back from the Nova Scotia Health Authority during the first wave, we saw that at least one point during the Northwood outbreak, continuing care assistants were the most numerous among the infected staff at the facility. In the documents, Nova Scotia Health Authority staff contemplated whether CCAs might need enhanced personal protective equipment training.

I'm wondering if somebody can talk about that issue in general. Has there been more analysis about why that particular group of workers had the most infections? Were there critical shortages in staffing at that time? How is it that health care workers didn't have enhanced PPE training?

I will say that I am one of those volunteers you talked about and have trained in swabbing at the asymptomatic pop-up testing sites. I got one hour of PPE training for my three-hour shift, so I had a lot of awesome training. I'm wondering if somebody - I guess Mr. Stevenson - could talk about that whole situation, and then I might have some follow-up questions.

KEVIN ORRELL: If I could start it off - I think we have to take ourselves from today when we know much more about COVID-19 than we did back when COVID-19 hit Nova Scotia, and when we were entering the first wave.

At the time that we were seeing a ramp-up of infections around the world, around the country, and in Nova Scotia, we didn't know what was going to transpire with this pandemic. We did not know all of the details. There was no playbook. There was no doctor ever trained in any residency program who could open up a book and come up with a recipe about how to manage this pandemic, so there were challenges. There were challenges from the point of view of providing PPE equipment to our health care workers. There were challenges about how it was used and where it was available, and when it was available.

I would say that the Public Health Agency of Canada did give us direction as to when to introduce PPE. Initially, it was for gloves and they didn't recommend masking. Of course, then that changed and as it became obvious, masking became a very important part of the management and restrictions in association with COVID-19. In fact, at Northwood, we introduced masking in Nova Scotia several days prior to the recommendation from the Public Health Agency.

There is an assumption, I guess because it's a simple device - a mask and gloves are very simple devices - and we were scrambling with all of the aspects of the pandemic to deal with it. I would state that there was probably an assumption that everyone knew how to put a mask on and everyone knew how to put gloves on. I think that what we've come to learn is that, in fact, is not the case. There are techniques that are very important when you're donning and doffing personal protective equipment. There are also very significant considerations when you're getting rid of it in garbage and disposing of it on a permanent basis. We've come to understand and to know more about that.

The staffing issue at Northwood - and I'm glad you raised this because at my last appearance at the Public Accounts Committee, I directed some comments about staffing. Staffing at Northwood was a challenge. My remarks were taken out of context and it was deemed that the remarks were a reference to the overall death rate and the mortality rate that occurred at Northwood. That was not the case.

I made comments that staffing was a challenge and we at the time had closed down the acute care side of our health care system, so we did have the advantage of being able to re-deploy people who normally worked in our hospitals and who worked on the acute care side of things to re-deploy to Northwood, so we did not see the type of situations that existed in Ontario and Quebec where the military had to be called in, where we looked at the national news every night and saw that there were people who were reported as being neglected - not changed, not fed, not given water for days on end. That didn't occur at Northwood. Staffing was ramped up through re-deployment and we met the challenge.

Did we learn to do it better - I mean for PPE, as well as for staffing. We wouldn't be scientists, we wouldn't be practising in health care if we didn't improve our ability to understand things and to make it better as time goes on.

Yes, things have changed. We undertook the IPAC review in tandem with the Northwood review and we were very careful about addressing all of the recommendations from both of those. Those recommendations have helped us to recognize where we could do better. That included the provision of the PPE and the education of people who were going to be using it and how to dispose of it properly.

It also helped us with staffing and to recognize where the most important people and staff should be redeployed and what type of staff should be redeployed, and how the Department of Health and Wellness and our health authorities could work together. It was only, I think, through the synergy of that collaboration that we were able to do a job during the second and, arguably, the third wave that is being described now so that we fortunately have not had an infection in our long-term care facilities since that time.

Remembering, if we go back in time, when we started all of this, we didn't have all the information we have today. Fortunately, I think we've spent a great deal of time learning and applying that learning to make things better.

SUSAN LEBLANC: Thank you very much for that answer. It's really helpful.

Before I move on, I will just say that I agree with what you're saying about the lessons learned. That was going to be my B part, so I'm glad you addressed that about how lessons have been incorporated and how as scientists and health care professionals, you've incorporated the learning, which is awesome.

Let me just say that it does beg the question about minimum standards for staffing - and I don't want to get back into this. I'm just going to make this as a comment, not a

question. Earlier when you were speaking with the member from the PC caucus, you talked about the interRAI system and how the current average is 3.6 hours. If that's the average, then that means there's a lot of people getting way less time than that with staff and a few people getting more.

Experts from all over the country are calling for minimum standards. I totally understand if some people need less time or less care and some need more, but a minimum standard is the minimum standard. That's all it is. It's saying, let's raise the level up to 4.1 hours and we'll go from there. If someone doesn't need 4.1 hours of nursing care or feeding and bathing, then there's probably other stuff that could happen that probably couldn't happen right now with the level of staffing that we have.

I will also say that in terms of your hearing from facilities where they don't want that minimum standard because they don't need that staff, I would suggest that if the government was willing to provide funding for that staff, organizations would happily take extra staff. There's lots of things that could happen. Like I said, I'm not asking a question about that - I'm just talking.

I'm going to move on to paramedics, though, if I can find my page. I understand that there are around 200 paramedics who are currently off on stress or sick leave. Can Dr. Orrell talk about some of the challenges facing paramedics at work and what work is taking place in the organizations that are represented here to address that?

KEVIN ORRELL: Our paramedics have been a very critical part of our health care system for years, even prior to the COVID-19 pandemic. They have been a group that has had difficulty in terms of injury and being off work with musculoskeletal problems that have occurred. We do pay the Workers' Compensation benefits. We are trying to participate to help to reduce that type of work-related events that result in injury and people being off work with the workforce safety planning that's being done.

[10:00 a.m.]

There are a number of initiatives that the employer, EMC, would have in place in collaboration with that safety work, including education and some devices that help to reduce back strain and musculoskeletal injury. This is something that's being rolled out and advanced. We have had several meetings with the unions and stakeholders, and this is something that we hope to translate through the entire health care system - specifically, the paramedics and also the people in home care who have been subjected to a lot of workplace injuries as well.

SUSAN LEBLANC: In May 2017, Doctors Nova Scotia partnered with Dr. Michael Leiter from Acadia University to conduct a comprehensive study on physician burnout. The report concluded that physicians are struggling to manage workload, and participants scored extremely high on exhaustion, cynicism, and efficacy indicators. Physicians felt a profound lack of respect for the professional expertise and autonomy and

only 40 per cent agreed that it was, "possible to provide high quality care to all of my patients." The report concluded that the most impactful way to improve burnout in Nova Scotia was to improve physician relationship with the Nova Scotia Health Authority.

What concrete measures have been taken to improve the relationship between doctors and Nova Scotia Health Authority? That's my first question.

COLIN STEVENSON: I can speak to some of the issues the question's going to raise. Yes, I would say that we're completely aware of the report and also within our own organization have completed an engagement survey to understand from physicians what the opportunities are for improvement within our organization. We took similar strides to look at the relationship that we have as an organization with our staff.

Through the course of the last 18 to 24 months, as mentioned in my opening statement, there was work done to actually devise a people strategy for us as an organization to help provide guidance and direction for us moving forward. It really is based on the feedback we received as an organization from physicians and from staff about what the most important things are for us to be focused on to improve that relationship and to improve how people see us as an employer; to really kind of not just create an environment where people want to come to work - that's really important - but for us to create an environment where people see that their needs are being met and they're satisfied in wanting to stay and work within Nova Scotia, either as an employer or as a partner, as physicians are.

So that report really identified a number of key pillars for us to tackle and focus on, which I think gets to some of the core components within a physician's specific engagement report and study as well. Some of that really is that opportunity for people to develop and be supported within the organization. It has a focus around ensuring that we're creating a workplace which is safe both physically and mentally for people to be able to come and work.

A lot of focus, obviously for us as an organization and others within the province, nationally and internationally, is around diversity, inclusion, and equity within the workplace. There will be a specific focus and pillar for us as an organization around that. We have started to build a network within our organization to take a very specific focus around the work that we do as an organization and how we support others to feel safe and supported within their work environment.

In addition to that, really, is that sort of continued workaround collaboration with physicians, physician leaders, and Doctors Nova Scotia in areas such as recruitment and retention and support. There has been a collaborative committee that has been established and that has been considered to have good success in the sense of building that relationship.

The other thing - and this is something I think Dr. Orrell sort of alluded to - is some of the things that have changed for us as an organization as a result of COVID-19. The

communication to physicians changed substantially and increased significantly, I would say, over the past year as a result of COVID-19 and how we responded as an organization and communicated with physicians. There has been more timely, focused, and dedicated communication out to our physicians across the province to try to keep them engaged and informed in the work that's happening within the province and specific to our organization, and different ways for us to engage the physician leaders within the province to make sure that we're addressing what their needs are. Our Health Authority medical advisory committee, for example, meets on a weekly basis now to try to address the needs within different programs or departments led by physicians.

SUSAN LEBLANC: Would you say, Mr. Stevenson, that the relationship has improved in general? I mean, this was three years ago. How are you feeling today?

THE CHAIR: The time has elapsed. I apologize. We'll move on now to the Liberal Party. We are starting with Mr. Jessome.

HON. BEN JESSOME: Thank you, staff and folks who are here to support us today. I have a question related to - I guess I'll start with a subject that has certainly got some attention publicly and operationally related to paramedics. Off-load challenges have been cited as one of the pinch points for our paramedic operation. I'm just wondering if - I'm thinking perhaps Nova Scotia Health people might have some comments to add to that or perhaps it would be more appropriate for the deputy minister, but one of those two entities. What's the work that's being done to assist specifically what the off-load challenge is experienced by the paramedic system?

KEVIN ORRELL: I think I can start off and then some of the operational issues could be discussed as well by Colin and his team. Firstly, this has been a very long-term problem. This has not been something that we've just witnessed over a few years. This has been far back to the turn of the century. The issue was addressed in 2019 by a former minister of the Department of Health and Wellness with a directive. Then in March this year, our new minister issued another directive to attempt to address this issue.

I always compare the health care system to an accordion. When one side moves, there is a reaction on the other side. The issue is that we can't treat it as simply an emergency room problem. It goes back into the community for family doctors. If there are not enough doctors seeing patients and these people have to go to the emergency room at night and they're taking stretchers and places in the emergency room to be seen, when an ambulance arrives, there is a physical issue about space.

It has to do with the number of people who can be discharged from the emergency room into the hospital to become in-patients. It has to do with the number of people who are present in the hospital on an alternative level of care who are waiting to be discharged to another facility. The whole system has an access and flow problem.

For the most part around the province, other than the Central Zone, the standards of off-loading are fairly close to national standards. We have kept the standard to 30 minutes with the new contract with Emergency Health Services in order to acquire the information and data that we need to fully address this problem.

The Central Zone and the Halifax Infirmary site becomes the most problematic and we're currently looking into ways in which patients can be off-loaded before they're actually admitted to the emergency room so that it doesn't tie up the ambulances. It's one part of the equation, but as I said, you have to address the entire system in order to address the off-load issue.

Colin, you may have some more specific operational things to comment on.

COLIN STEVENSON: Maybe just to augment the deputy's comments, I agree that it really is sort of a broader system issue and really focuses on the movement of patients through the system. It's not really specific to the ambulance at the time, although that certainly becomes an indicator at the tail end of the patient access flow initiative. As an organization in partnership with the Department of Health and Wellness and other system partners, we are really trying to find the different strategies to address the input, so, the need for patients to come into the system in the first place, and there are ways to actually support that different throughput, which is really the process of moving a patient to the appropriate location of care within our organization.

Do we have the right supportive services and availability of beds, and/or are there other means of being able to support the care of the patient without them needing to be admitted within the hospital? As the deputy indicated, that focus around the output, so it's placement of people and supporting people when they go back to home, wherever home is, whether it's their individual dwelling or, for example, a long-term care facility.

One of the things that we're taking on in the sense of this as an activity within our organization is really not dissimilar to how we had to focus around COVID, and really that is treating it as a need for a dedicated incident management response. So there are teams that have been established within each of our zones largely focused on the ability to improve flow and improve off-load time and time for a patient from arriving at the ED requiring admission to the hospital to actually having that admission.

Those teams are reporting through for provincial success and activities so we have the ability to share those across the organization, supported strongly by research and innovation teams, which can look at what the leading practice is and the results of that leading practice, both across the province, but really sort of nationally and internationally. Also, how do other care models and technologies actually help to support that and improve that?

BEN JESSOME: I can appreciate that when we see it sometimes, it's expressed as an isolated element, but it seems reasonable to me that there are many moving pieces, particularly in the health care system.

I believe it was Mr. Stevenson or Mr. Campbell who talked about the usefulness of virtual care during what has been a challenging pandemic scenario and appreciating that we don't want to base all of our decision-making on things that might have worked well on the fly during the pandemic. I get the impression that with respect to accessing mental health care, accessing primary care in parts of the province, that it becomes a challenge to recruit and maintain human resources in those communities.

The virtual care is going to be something that is utilized as one element of the health care system ongoing, so I'm wondering if - for example, I've gotten some calls to my office from constituents who may initially be uncomfortable utilizing that as a primary care scenario. What would the department and the Nova Scotia Health Authority be doing to socialize or reinforce the value of that as part of the overall health care operation for patients who are potentially a little uncomfortable about making use of virtual care?

[10:15 a.m.]

KEVIN ORRELL: This is a very important discussion right across the country, across all the health care systems in the world, I think, at this point in time. The fact is that virtual care existed even before the COVID pandemic. There were ways in which patients could be followed, could be seen in consultation, and looked after virtually prior to COVID-19. COVID-19 has certainly accelerated our use of it.

In mental health, for example, the mental health clinicians feel very strongly that they have had a very good experience with it. They report their patients are very pleased. They have not had many missed appointments or as many missed appointments as they sometimes get when people were coming to a clinic and having to sit there. That had to do with stigmatization and things like that. They've enjoyed a great deal of success and we're certainly very interested in their experience on an ongoing basis.

However, they are a specialty that doesn't have to sometimes lay their hands on people's bellies or listen to their heart or listen to their lungs, so the next group that has used it extensively have been the family doctors. We recognize that during COVID-19, patients were very happy to have contact with their family doctors in some way - virtually, when in-person care was considered to be less attractive because of contact, et cetera. Their experience has influenced the way in which we would like to evolve this system of care.

We have a report that has been commissioned by InfoWay that will be shared with us and with the health authorities this month. It has been completed. There is some suggestion that it does provide access to people especially for follow-up, but may not, in fact, provide access to people who have never been seen before. It can replace an in-person visit, but it's very important to remember it is not a replacement for it on a long-term basis.

My brother had a patient who called about psoriasis and an itch on his scalp and wanted him to order a medication for the itch. He tried to do that virtually. He's an experienced family doctor with 27 years under his belt and he recognized the patient did not have psoriasis in any of the contact he'd had with him previously, and insisted he come in for a personal visit and diagnosed a melanoma. So there are dangers with trying to do everything virtually.

We have a year now that has been approved by the Treasury Board to offer virtual care. We've set the fees for virtual care. At the end of that year, there will be an evaluation of the utilization of it and what we have learned from it in terms of what it can offer patients and what dangers and what regulations need to be robust on an ongoing forward basis.

BEN JESSOME: I think a couple of my other colleagues want to ask some questions here. I do appreciate everybody's willingness to be nimble over the last year in particular. Deputy, I appreciate those comments that virtual care is part of the overall system and we need to remind Nova Scotians that if they need to get seen in person that they can access that type of service. That's it for me, Madam Chair.

THE CHAIR: We'll move on to Suzanne Lohnes-Croft.

HON. SUZANNE LOHNES-CROFT: Thank you all for being here. Recruitment and retention are very important here in Nova Scotia. I appreciate all that you're doing to make a difference in this. Can you talk a little bit about the unattached patient clinics that are available in the different zones? I don't know a whole lot about it. It's fairly new to me. I understand they are placed in the zones, but they're for people who are unattached. I'd like to know the uptake, where they're located and whatnot, because we MLAs, we get calls on a regular basis from unattached patients looking for primary health care.

KEVIN ORRELL: The unattached patients, I think in the past they were called walk-in clinics, but that name has changed over time. These people are able to make appointments. If they don't have a family doctor, they still require an appointment to go into the clinic to be seen, and they can be looked after for the problem that they're coming to see the doctor about. There are several in the province that take place. There are some nurse practitioner clinics that also provide some care to unattached patients. In fact, there are about 42,000 people who have had access to nurses at one level or another for primary care.

I do have a list of some of the places where they occur, but at this point I think the Nova Scotia Health Authority may have some further comments about that.

COLIN STEVENSON: There are a number across the province based on availability of providers and where there are some gaps in the sense of individuals looking for or requiring support for primary care. It's indicated that the intention around it was to augment and be able to provide that level of support.

We did see sort of a shift in the change in the ability of how people could access care through COVID, so again this is linking back to the previous comments around virtual care. Some individuals who would have been unattached or still looking for a primary care provider were also able to access services through virtual care and providers that were willing to provide that type of support, so it's another approach that was augmenting what that need was in the past.

We'd have to pull a list and provide for you the actual location and the number of those. We'd be happy to do that.

SUZANNE LOHNES-CROFT: Do I tell people to call 811 for the information?

COLIN STEVENSON: Call 811 for information on how to access our locations of primary care?

SUZANNE LOHNES-CROFT: Yes.

COLIN STEVENSON: Yes. 811 has been an opportunity to be able to identify where there are services located in the province, including those, so that would be one avenue, and I'll also make sure you have the list.

SUZANNE LOHNES-CROFT: Is it possible to arrange a virtual appointment with the clinic?

KEVIN ORRELL: I could address that. Sometimes the decision about what's virtual and what is in-person is based on what the person identifies as the problem, but there is a pilot program in the Valley that is doing a virtual evaluation of people for primary care needs, so that's a pilot to just see how that works in terms of looking after some of these patients.

SUZANNE LOHNES-CROFT: You said that these have sort of replaced the walk-in clinics. My understanding of the walk-in clinics is they were for people who were unattached but also for a lot of people who wanted to avoid going and waiting at outpatients, were going to the walk-in clinic, at least in my area, and getting signed up on the list for appointments. Does this happen any longer at these unattached patient clinics? Many people who use the walk-in clinics were actually attached to a primary caregiver.

KEVIN ORRELL: That's correct. There are clinics that are set up to look after people who are part of a group, perhaps, who already have a family doctor. They have a less acute problem and don't require an emergency department, but they require that their child or they themselves be seen.

The initial rollout, at least in Cape Breton where I work - these walk-in clinics did both. They saw unattached and attached patients. I think some practices defined it more as a walk-in for their own group of patients with the doctors who work there for off-hour

urgent appointments as opposed to the unattached clinics, where they don't have a family doctor. I think it's just separated in the nomenclature.

THE CHAIR: Order. The time has elapsed for the Liberal Party. Now we are going to have our second round, but just because of time - we only have about four minutes - and we will start with the PC Party for four minutes ending at 10:30. Mr. LeBlanc.

COLTON LEBLANC: I'll dive right into the questions with a few moments left here.

I have some concern with how sometimes data are perhaps presented, particularly when it comes to differentiating between head counts and actual full-time equivalents. I'm interested to hear from the department how they're doing so to differentiate between the full-time equivalents and head counts when it comes to collecting, analyzing, and presenting that data when it comes to health care professionals.

KEVIN ORRELL: You're exactly right. There have been difficulties in tabulating exactly how many people have been working in different professions.

If we take that group that had been identified earlier - the CCA group - where we know we need personnel, that group is made up of people who do work on a full-time basis and there is a large number of casual workers as well. This is why the mandatory registry will make a big difference.

We will be able to acquire the information in a more accurate way as to how many are working full-time and how many work part-time or casual and then do our workforce planning based on a more accurate number. Right now, with the voluntary registration, we really don't have useful information that will help us to plan that particular profession.

COLTON LEBLANC: I guess the point I'm trying to partly make is that when we're analyzing data per capita, when it comes to the number of professionals per capita, that measurement may not be reflective. More doesn't always translate to more services and more care at the end of the day, whether we're talking about doctors or paramedics - whatever health care professional.

I guess what might be one of my last questions is: Who's ultimately responsible for the collection and analysis of data when it comes to the health human resources in the province of Nova Scotia?

KEVIN ORRELL: The information is broad and it certainly is complicated sometimes to acquire that information. I think, ultimately, the department has to workforce-plan and take the initiative to look at the workforce over an extended period of time - perhaps five or 10 years - and then to work with our stakeholders to do more immediate planning.

For example, recruitment was with the department until about 2016 and then was transferred to the health authorities. Ultimately on a recruitment basis, we're sharing information and supporting them in the operations of how they're recruiting doctors, for example.

We have a workplace for physicians that we are looking at to 2025 to do some longer-term planning. I think it's only rich in that all the stakeholders are involved would share in the ability to participate and to contribute their information.

[10:30 a.m.]

THE CHAIR: The time has elapsed for the PC Party. We move on to the NDP. Ms. Coombes, go ahead.

KENDRA COOMBES: I would like to continue with staffing. At the beginning of June last year, Quebec's government launched a recruitment drive backed by the full power of the government and funded fully to get 10,000 personal support equivalent workers and pay them $21 per hour for training, increased wages to $26 per hour, and worked to deploy these workers into nursing homes.

British Columbia's government took action at the very outset of the pandemic to provide full-time work and increased the wage to $21.75 per hour for personal support workers in long-term care to stabilize the workforce.

My question is: Was the compensation for health care staff - other than the federal top-up - looked at by your organizations and departments in the outset of the pandemic?

KEVIN ORRELL: I would start it off by identifying that Quebec, prior to the pandemic and for all of the years that I've practised medicine in Cape Breton, had always been short of staff - short of doctors, at least. I had occasion that always amazed me that people would come from Montreal and from other parts of Quebec. I was identified as a French-speaking surgeon and I had a large number of people, even with the private clinic there - of course, that's not for everybody - who would come looking for hip and knee replacements in Cape Breton. They had enormously long wait-lists and they did require augmentation of their workforce in order to address basic needs of their population. That always surprised me.

Sixty-nine per cent of the money in the budget for the Department of Health and Wellness goes to paying employees and doctors for their services. It's a very large amount of money that is paid across the sector for all the professions.

There is always a need and there are always groups that - there's a discrepancy between rural and urban. We have pockets of places where there are shortages and we've tried to address that. There are incentives. We've offered a great deal of educational incentives to improve our workforce across many professions.

KENDRA COOMBES: With all due respect, deputy minister, incentives don't really help when someone is in the workforce. For retention and recruitment, people do need proper compensation for their work. That includes better wages in order to retain and recruit.

THE CHAIR: Order, the time has elapsed for the NDP. We move on to the Liberal Party. Mr. Horne.

BILL HORNE: I'm pleased to be here and ask some questions. I want to know a little more about Dr. Orrell's discussion on nurse practitioners, the nurses strategy, and the CCE program. I want more detail on whether it has been successful, how many may have graduated, where they're working, and that sort of thing. That should take up a few minutes.

KEVIN ORRELL: Currently in Nova Scotia, we have 238 nurse practitioners who are practising in one way or another in this province. That represents an increase of 89 per cent since 2011. They work in different capacities. Some are associated with collaborative care clinics, there are some who are associated with work in a physician's office that is not a collaborative care office, and there are some who are working in nurse practitioner clinics.

We have evolved, and this went I think back to the - it makes reference to the question that Ms. Adams asked about the supervision of people that takes place in our system. Doctors initially had to supervise our nurse practitioners, and with time it has evolved so that they are able to be more independent. They can write prescriptions without having them co-signed. They can do assessments of people for medical reasons. They can work on their own with other nurse practitioners and provide primary care.

We have recognized their value in addressing some of the rural areas where it's difficult in getting family doctors to take over for doctors who have retired or left practice or unfortunately have passed away. These nurses have been very significant in the provision of primary care in rural areas that traditionally would do without otherwise.

BILL HORNE: Just quickly, we're in the House and approving an Act about the CCAs registry, and I'm wondering what you feel about having a registry and what do you see it doing to help the health professions?

KEVIN ORRELL: The CCA registry, again, is important for us in terms of acquiring the information we need to plan forward and to get accurate information about the state of that profession.

There is an umbrella legislation that's going to be submitted to bring in all of the unregulated professions. That would include nurse practitioners among those professions and the opportunity to have them registered and then evaluated so that there is some overview of how they are performing, and there's an avenue for the general public to identify any safety or care concerns they may have. That's part of it.

THE CHAIR: Order. Sorry to interrupt, Dr. Orrell. The time has elapsed for the Liberal Party as well, and I think it's time to have some closing remarks. I believe all three of you would like to say a few quick remarks, and if you could keep it to one minute, that would be great. We can start with Dr. Orrell.

KEVIN ORRELL: I would like to thank you, Madam Chair, and the committee for this very rich discussion about our health care human resources, which is very pertinent to all Nova Scotians. I want to thank those who are working in our health care system, from the frontline nurses and doctors, technicians, pharmacists, paramedics, and the countless others. It goes without saying that our hospitals couldn't run without the cleaners, the kitchen staff, and those who work in the laundry as well. They've been very important and their value is certainly very much identified during this pandemic.

I think we've witnessed through the pandemic a great deal of unprecedented reassignment and redeployment of staff and workers, and it goes to point out their versatility and their ability to meet the needs of the system. In fact, if the truth be known, I think every citizen who has participated in protocols and restrictions placed by Public Health has actually become a health care worker in keeping themselves, their families, their neighbours, and the entire province safe. We've enjoyed a great deal of success from the vigilance of people who in one way or another have actually contributed to the work of our health care workers.

We've also seen an unprecedented co-operation between the Department of Health and Wellness and our health authorities and all those other people who work in synergy to keep the province looked after and safe. We look forward to that ongoing co-operation as we move forward beyond this. Thank you.

THE CHAIR: Thank you, Dr. Orrell. Next we have Mr. Stevenson.

COLIN STEVENSON: I do want to acknowledge that a number of members of the committee and my colleagues have noted the challenging year that has been experienced within Nova Scotia and our teams at the Nova Scotia Health Authority and other health care organizations.

In the midst of a pandemic, we also faced an unimaginable tragedy that led to the deaths of 22 people and countless others being in pain and shock and grief. These events have really left many of us struggling to cope, and in particular, we know it will be challenging for many people in the weeks and months to come.

There's a lot of grief and trauma being experienced by our staff and our physicians and members of our community. It's important for us to acknowledge the support that's available for our physicians and our staff and our communities during this time and into the future. I really want to encourage everybody to focus on each other, reach out, and get the support that they need.

THE CHAIR: Thank you, Mr. Stevenson. Mr. Ashton.

STEVE ASHTON: Great follow-up and I appreciate the comments, Mr. Stevenson. Again, thank you, Madam Chair and the members of the committee.

I think as we've talked today, and the subject being what it is, it's really important to have the right people in the right place with the right skills. That's critical for having a functioning and successful health system. We need those people, as Colin just said, to be healthy and engaged in the work that we're doing together.

While the challenges have been there, we're also excited about the opportunities to innovate and improve the ways we work as we emerge from the current crisis. I think, as everybody has mentioned, there's probably not a Nova Scotian who hasn't contributed in some way over the last year.

Our health care workers, who include our physicians, our health professionals, our support, our administrative staff, our researchers, the teachers, volunteers, learners, and of course the retirees who came back and stepped up, everyone has been incredible through this. They deserve all of our thanks and support. We greatly appreciate your support today and your interest in this topic. Thank you.

THE CHAIR: Thank you again to all three presenters today. On behalf of the committee, I truly want to thank you. I've seen our health system. I've worked as a medical interpreter for 20 years and I couldn't be prouder of the care that people receive here in Nova Scotia.

This last year, we were the envy of so many other provinces and other countries. I thank you from the bottom of my heart and from all Nova Scotians for the hard work that you've done over this last very difficult year. Thank you. You may leave so we can do our committee business. Thank you so much, again, for answering all the questions.

I just want to let everybody know that we have another meeting at 11:00, so I will not be able to extend the time. If we can just move on with the committee business, we're starting with a letter from the Department of Health and Wellness regarding the ambulance system in response to our request for information made at the February 9th committee meeting. This was emailed to the members on March 12th and again yesterday. Is there any discussion? I see none. Thank you.

We'll move on to the next item on the agenda, which was another letter from the Minister of Health and Wellness re: the Minister's Expert Advisory Panel on Long-term Care in response to our request for information, again, made at the February 9th meeting. This was emailed to the members on March 26th and yesterday. Is there any discussion?

Everybody received it. Thank you so much.

[10:45 a.m.]

The third point that we have on our business here is the organizational chart for the Nova Scotia Health Authority. It includes correspondence from the Nova Scotia Health Authority arising from committee decisions made at the meetings of January 12th and March 9th. This was emailed to members on March 31st and again yesterday. Any discussion? Wonderful, thank you.

Our last item is agenda-setting for our next meeting, which will be on May 11th. Please send proposed topics and witnesses to the clerk by Monday, April 26th. Is that okay?

The next meeting will be Tuesday, May 11th from 1:00 p.m. until 3:00 p.m. via video conferencing. It will be an agenda-setting meeting. If the House is still sitting on this date - I hope not - the meeting will take place from 9:00 a.m. until 11:00 a.m.

If there is no other business, I would like to adjourn our meeting so we can make it to our next meeting. Oh, I see a hand - Ms. Adams.

BARBARA ADAMS: Madam Chair, I would like to put forth a couple of motions for consideration by the committee to vote on. The first motion reads as follows: The Nova Scotia Health Authority publishes the Nova Scotia Health Authority *By the Numbers* report each year that outlines staffing, beds, and other statistics for the number of departments. This level of transparency in health services is important. Unfortunately, we do not get the same information from the IWK Health Centre. I move that the Standing Committee on Health write to the Minister of Health and Wellness to request that the IWK hospital be required to submit and publish online a similar IWK *By the Numbers* annual document.

THE CHAIR: Any discussion?

Ms. Leblanc.

SUSAN LEBLANC: I think that is a great idea. I think that the *By the Numbers* information is super helpful to not only our work as MLAs, but also to Nova Scotians in general. All that we would be doing is asking the minister to consider it, so I think it is a good idea.

THE CHAIR: All in favour? We are all in. We will write a letter. Ms. Kavanagh, you will take care of that. Thank you so much.

Ms. Adams, next.

BARBARA ADAMS: Thank you very much. It says: The Minister of Health and Wellness indicated during Estimates yesterday that the significant reduction in acute care beds from 3,503 beds in 2016-2017 to 3,113 beds in 2019-20 was due to a reallocation of acute care beds in rural areas to long-term care. It is not clear where these beds were closed

in the province in acute care nor where their facilities increased their stock of long-term care beds.

I move that the Standing Committee on Health write to the Minister of Health and Wellness to request a complete list of acute hospital beds by hospital and a complete list of long-term care in residential care beds by facility, both private and public, for each year over the past five years.

THE CHAIR: Any discussion?

Mr. Maguire.

HON. BRENDAN MAGUIRE: Madam Chair, may I have a few minutes to have a discussion about this offline?

THE CHAIR: Sure. Your volume is very low. Mr. Maguire is asking to take a recess for five minutes. We will be back at 10:53 a.m. We can turn videos off, if you wish.

[10:49 a.m. The committee recessed.]

[10:53 a.m. The committee reconvened.]

THE CHAIR: Order, please. We had a motion on the floor. Any further discussion? We can take it also to a vote. Any discussion?

Mr. Jessome.

BEN JESSOME: Just a friendly reminder that it is nice to have these things in advance if they are available so that we can consider them, but I have no problem supporting the motion.

THE CHAIR: All those in favour? Contrary minded? Thank you.

The motion is carried.

Do you have any other motions?

Colton LeBlanc.

COLTON LEBLANC: It is more a comment and asking the committee to consider looking at the timelines of the meetings. Meetings are structured to start 9:00 a.m. to 11:00 a.m. Looking at opportunities to maximize the opportunities to question the witnesses, recognizing the importance of this committee, and recognizing the time and energy that the witnesses dedicate to preparing and coming before this committee. Despite starting a few moments late, without any motions put forward today we would have been done at 10:46

a.m. today. I just think that even with my few comments here, we are still going to be done before 11 o'clock.

Those are just a few comments that I wanted to share with the committee today.

THE CHAIR: Mr. Horne.

BILL HORNE: With all the discussion that is going on, the preambles by the members asking questions are way too long. If you want answers to questions, allow them to ask questions that they have time to answer would be my say on that.

THE CHAIR: All right. Ms. Adams was next, then Ms. Leblanc. It will take us to the end of this and Ms. Kavanagh recommended that I end it at 10:40 a.m. That was the appropriate time. I ended it two minutes before that because I did not have enough for a minute for everybody.

Ms. Adams.

BARBARA ADAMS: Given the comment that was just made about our preambles, I feel compelled to respond to something that was said by the Minister of Finance and Treasury Board last night about how great it was that the government didn't have to recall the Legislature to talk about certain things because they had the authority to go ahead and make them without discussing them with Opposition.

We went almost an entire year without this Legislature sitting. You shut down this Health Committee for seven months. The fact that Opposition MLAs want to take a few extra minutes to ask questions on behalf of our constituents is our job and our right. If we are going into a preamble, it is because we had an entire year where our voices were not heard and our constituents' voices were not heard.

The other thing is there was a commitment to also limiting the preamble statements to only 10 minutes and we went over that. I would like to suggest our preambles might be a little shorter if we started right on time, if the committee guests were kept to their 10 minutes and the Legislature actually sat for the length of time that most other provinces are doing.

THE CHAIR: You mean the opening remarks?

BARBARA ADAMS: The opening remarks were longer than 10 minutes. They were, in my calculation.

THE CHAIR: All right. Ms. Kavanagh will figure that one out for us.

Ms. Leblanc.

SUSAN LEBLANC: Yes, that was what I was going to say, as well, about the opening remarks. I think at one point - it may have been in Public Accounts, I cannot remember - one of the committees that I am on, we discussed asking witnesses to limit their opening remarks so there was more time for questions.

The other thing I would suggest is I know sometimes motions from the Opposition are politically planned for surprise, but sometimes they are not. The ones that Ms. Adams proposed today, I think we could have had those in advance of the meeting, then the Chair and the clerk would know about how much time to budget.

I think, if possible, we could bring our motions ahead of time, acknowledging that I am in the Opposition and sometimes it is good to have an element of surprise.

THE CHAIR: Thank you. We appreciate that.

If I may adjourn and thank everybody for being here. We had a wonderful discussion and wonderful witnesses. I thank everyone. Have a wonderful long day ahead of us. Thank you. Bye-bye.

[The committee adjourned at 10:58 a.m.]