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STANDING COMMITTEE

ON

HEALTH

Tuesday, June 8, 2021

Video Conference

IWK Programs and Services Across the Province and Atlantic Canada

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STANDING COMMITTEE ON HEALTH

Rafah DiCostanzo (Chair)
Hon. Leo Glavine (Vice-Chair)
Hon. Tony Ince
Hon. Ben Jessome
Bill Horne
Barbara Adams
Colton LeBlanc
Susan Leblanc
Kendra Coombes

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Karen Kinley
Legislative Counsel

WITNESSES

IWK Health Centre

Dr. Krista Jangaard, President and CEO

Dr. Annette Elliott Rose, VP Clinical Care, Chief Nurse Executive
Co-Lead, COVID Management Team

Dr. Doug Sinclair, VP Medicine, Quality and Safety
Co-Lead, COVID Management Team

Dr. Andrew Lynk, Chief of Pediatrics

Dr. Jim Bentley, Chief of Obstetrics and Gynecology

Dr. Alexa Bagnell, Chief of Mental Health and Addictions

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JUNE 8, 2021

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Rafah DiCostanzo

VICE-CHAIR
Hon. Leo Glavine

THE CHAIR: Order. This is the Standing Committee on Health. I'm Rafah DiCostanzo, the MLA for Clayton Park West, and I'm the Chair for this meeting.

Today, we will hear from the IWK Health Centre on the topic of IWK programs and services across the province and Atlantic Canada. Members, witnesses, and committee clerks and Legislative Counsel should keep their video on throughout the meeting and turn their microphones on mute unless I call on them to speak. All other staff should have their audio and video turned off.

This is a good time just to check your other devices, your cellphones, to make sure they're on mute; I'm checking mine at the same time. Please try not to leave your seat during the meeting unless it is absolutely necessary. If any members have any technical problems, please phone the clerk, not me.

I will now ask the committee members to introduce themselves, starting with the Honourable Leo Glavine.

[The committee members introduced themselves.]

THE CHAIR: For Hansard, I acknowledge the presence of the Legislative Counsel, Karen Kinley; and the Legislative Committee Clerk, Judy Kavanagh.

Now I would like to welcome our witnesses and ask them to introduce themselves and to also give us their opening remarks. We will start with Dr. Krista Jangaard. Please go ahead.

DR. KRISTA JANGAARD: Would you like each to introduce themselves, or me to introduce them when I start my remarks? Which would be appropriate?

THE CHAIR: Maybe if they introduce themselves, that would be lovely. Maybe I can go through the names.

[The witnesses introduced themselves.]

THE CHAIR: I welcome Dr. Jangaard to give us your opening remarks.

DR. KRISTA JANGAARD: Thank you to the committee for the invitation to meet with you today and to talk about our programs and services offered by IWK Health. I think I forgot to introduce myself - I'm Dr. Krista Jangaard, and I am the President and CEO at the IWK Health Centre.

I would like just to mention that Drs. Sinclair and Elliott Rose are here as the Executive Co-leads for Clinical Services, as well as the IWK Co-leads for the COVID Response Team. The physicians that you've met: Dr. Bentley is from our Women's and Newborn Health Program, Dr. Bagnell from our Mental Health and Addictions Program, and Dr. Lynk from our Children's Health Program. These are the three primary clinical programs at the IWK.

Often when people think of the IWK, they think of the hospital building that I happen to be sitting in right now on University Avenue. They think about it as a hospital where sick children get treated and where babies are born in Halifax. A recent community survey that we did actually confirmed that this is indeed how most respondents, who are your constituents, view the IWK. Far fewer identify our role in women's health, the work being done in the community, our advocacy and capacity building activities, our academic mandate for research and teaching, or even our Maritime mandate as a whole.

In fact, IWK Health Centre has a broad reach as an internationally recognized academic health science centre dedicated to patient- and family-centred care, research, and education. Although our main campus is here in Halifax, we also have 14 community

clinical and resource sites across Nova Scotia. In addition, we offer mobile clinics and services, as well as virtual care options for patients and families in Nova Scotia, Prince Edward Island, New Brunswick, and even some subspecialty care to residents of Newfoundland and Labrador.

With respect to our academic mandate, the IWK is a leader in research and knowledge sharing. Our research is supported by 13 research chairs, including a newly-launched quality and safety chair that Dr. Sinclair can tell you more about, a number of research institutes, and ongoing local, national, and international research collaborations. We are a strong educational partner with Nova Scotia universities, hosting more than 1,200 learners from many different health professions at the IWK each year.

To set the stage, because it's a broad topic, I thought maybe we could have a few recent statistics. In fiscal year 2019-20, our IWK team included 3,368 employees, 238 active facility physicians, and over 750 volunteers. There were 4,611 babies delivered, almost a little more than half of the babies delivered in the province each year. We had over 34,000 visits to our children's emergency department, we had close to 4,200 pediatric-based surgeries, 1,200 gynecology-based surgeries, and over 400 breast health surgeries in that year. We had close to 15,000 acute inpatient discharges, and over a quarter of a million ambulatory clinic visits. That's a lot of care.

To better understand the types of clinical services the IWK provides locally for HRM, provincially, and regionally, we thought it might be useful to review the terminology that we think of when we think of levels of care or tiers of service. If we think of primary care, or generalist care, that's care delivered in the community by family doctors, dentists, nurse practitioners, midwives, and other health professionals. At the IWK, we provide these services for the local HRM area, and they include things such as maternity services, newborn care, some of our emergency care, school health services, collaborative primary care, and breast screening for example.

Secondary level of care, or specialty care, is the level of care that's provided by specially trained physicians and clinicians who have training, in our case, particularly to care for children, women, and youth. Services that fall into this category are provided locally for HRM again, provincially where required, and even regionally if those services don't exist in the local area. They include such things as pediatric dental care, pediatric surgery, general pediatrics, obstetrics and gynecology, and some of our mental health services.

Tertiary care, which is the third category, is subspecialty care. This is the care that most often when people think of the IWK, they think about. It's that highly specialized, complex care that most often is found only at the IWK in the Maritimes. All three of our programs have services that fall into this category such as neonatal and pediatric intensive care, emergency care, high-risk maternity care, inpatient mental health, and a wide variety of pediatric and medical surgical services. I'm sure that my colleagues who are on the call with me today can better describe those in much more detail than I can for your questions.

Sometimes our services are program-based and they're broad. I want to just highlight a few areas of current focus, looking at how we're working to meet the needs of women, children and youth in our province and beyond.

Starting with the Women's and Newborn Health program, one of the major areas we work at is support for access to primary, maternal and newborn care, and that includes midwifery services. As half of the births are done outside the IWK catchment area of HRM, we do this in partnership and collaboration with the Nova Scotia Health Authority.

One of the big examples in the past year that has really been led by the IWK was some collaborative planning that happened at the IWK Department of Family Medicine where they looked at building a standardized funding model that would help support maternal and newborn care. This really has helped stabilize regional services so mothers and babies can be as close to home as possible for that first part of their care delivery.

We were happy to announce a number of weeks ago the development of Atlantic Canada's first multidisciplinary endometriosis and chronic pelvic pain clinic, and this was welcomed by the women who actually suffer from these conditions. It's a coordinated service that the IWK is leading.

Of course, the care at the IWK is provided in many different settings, and two that we're quite proud of are our state-of-the-art Neonatal Intensive Care Unit and our newly redeveloped Early Labour Assessment Unit.

When I move to Mental Health and Addictions, an area of great activity has been the launch and integration of virtual care services. These actually got up and running in a matter of a couple of weeks in response to the first wave of COVID last March and have continued to be adapted and utilized. The team has been able to use these services so that during the successive waves of COVID, we really have not had much disruption in access to care for mental health for our youth and children.

Looking at flexing resources, we've been able to meet some of the 15 to 20 per cent increase in recent demand that we're seeing, like many others, due to COVID. The most important thing, I think, with this, though, is that virtual services have been very well received by patients and their families.

Our mental health team is also involved in capacity-building across the Maritimes, supporting care communities and care closer to home. One example of this is the Learning Link project, and I'm sure that Dr. Bagnell will be happy to give you more information about that exciting project.

The mental health program has a subspecialty training program for residents, including a rural rotation so that we can expose our new practitioners to care settings across our province. And of course our Garron Centre for Child & Adolescent Mental Health has been a great benefit as a purpose-built place for children and youth in crisis.

Finally but not last, a lot of our time, as you can imagine, has been spent in the last couple of years looking at the redevelopment of the Emergency Department at the IWK, and construction is slated to begin this Fall. You may be aware that we're the only tertiary and Level 1 trauma centre for children in the Maritimes, and we're the only Atlantic pediatric teaching site for emergency medicine for pediatric and subspecialty medical residents.

This new ED will provide a way in which we can have an environment to improve patient care pathways and flow, whether you're a mom with a two-week-old baby who's coming in for a feeding problem, to a child who's been in an accident, all the way to a youth who's in crisis for mental health.

Just like our mental health colleagues, our pediatric colleagues also have been exploring virtual care opportunities. We have a number of pilot projects that are currently running, and one exciting launch was our COVID virtual follow-up service that was implemented in this third wave that we're just coming out of now. That allowed our emergency medicine physicians to contact families who had had children who tested positive but were not sick enough to be in hospital but really needed some access to care.

We remain engaged across the province in cross-sectoral work and one example of this was the work that we did with the back-to-school plan. We continue to look at shared care models and provider networks so that we can help build capacity, help our patients transition, and have consultation services, again to support care as close to home as possible.

Internally, we remain engaged in continuous improvement and in initiatives in areas such as pediatric dentistry, orthopedics, and autism, where we know access to care is of concern to our communities. I was really happy that during the pandemic, we were able to open our brand new pediatric intensive care unit.

[1:15 p.m.]

Those are our three programs, but right now, of course, there would be no way to have a discussion of health services and delivery of those without talking about COVID, and talking about the IWK as a partner in the provincial response to the pandemic. We really had to balance our role and system capacity for COVID service delivery with the maintenance of safe, accessible core services for children, women, and families.

A lot of work went into this. We had adaptations in service focused on public health, we had to utilize appropriate virtual care and working from home. We had to understand how we could redeploy our staff, and then have staff that were responsive to the call for redeployment activities. We proactively scaled up resources in high-demand areas for pandemic care, we reconfigured our screening and navigation processes, we were successful in launching a COVID-19 assessment and testing centre with 811 as a partner,

and we piloted what was known as the swish and spit method for testing children, which was then rolled out across the rest of the province.

One of our great accomplishments, I think, was launching the prototype community vaccine clinic, and even more recently providing resources for pregnant and breastfeeding women and children aged 12 and above, who want to become vaccinated but have questions. So, some real resources in our vaccine clinic and rollout.

I have been very proud of the teams at the IWK for the contributions and for always using best evidence. Changing landscapes make this difficult, and sometimes you need to chart a course and then change direction as needed, and they have been able to do that. Who would have thought this time last year that the IWK would have had a team working at Northwood caring for elders, or being a site where our senior citizens first had access to their vaccine, or that we would share staff with Nova Scotia Health Authority for testing and tracing? But we did.

I'd like to close today by saying we don't do this alone. The IWK is a partner in the larger health system that works together not only to provide care to patients, but to create and support diverse communities, respond to health inequities, and advocate with the women, children, and youth and their families in the Maritimes.

At this time we'd be happy to take any of your questions.

THE CHAIR: I can't tell you how much this means to me, to keep hearing about the IWK. I worked for the IWK for almost 20 years as a medical interpreter and looked forward to every assignment, as I think we are so lucky to have such an amazing hospital in Halifax. I delivered my two daughters almost 26 and 29 years ago, and it was brand new at the time, the new centre. I'm just delighted that you are here to tell us more about this amazing hospital.

I will start by saying that we are now ready for the question and answer period. We normally hold it in 20-minute rounds, starting with the PC caucus, followed by the NDP caucus, then the Liberal caucus, and depending on how much time we have left, we will do the second round.

If I may ask everyone to wait for me to call your name, then you can unmute and speak, so that Hansard knows who is speaking. Thank you again, and we can start the question period at 1:18 p.m., and we will be starting with Mr. LeBlanc, correct? From the PC Party.

COLTON LEBLANC: Thank you very much to our witnesses this afternoon. It's a pleasure to welcome you to the Health Committee. I still cherish the opportunity that we had last, I think it was January, as a caucus to tour the new NICU. It was a wonderful opportunity to do so and amazing to see the hands-on work that your organization does, and thanks so much for the collective efforts over the past year.

I'd be remiss if I did not congratulate the foundation for another successful telethon this past weekend. It's just remarkable to have raised $6.6 million, so kudos to everyone for that success.

Obviously, mental health has come to the forefront during the pandemic, but there was a study that was published on Monday, and it was regarding new mothers and how there's data out there from particularly Ontario showing that the demand for more mental health services has increased since pre-pandemic, so certainly over a nine-month period. I guess from April onwards. It's quite alarming. Although I've noted that this data is exclusive from Ontario, there's been some interpretation that there could be some trends in other provinces.

Seeing that the emotions of the pandemic, the isolation, the uncertainty, the lack of interaction, the disruptions in our typical day-to-day lives and different support for families, I'm wondering if there have been any similar trends identified here in Nova Scotia.

KRISTA JANGAARD: I can give a couple of general remarks about that, but perhaps if I could suggest that Dr. Elliott Rose might be able to fill in a few more details. We have indeed actually had some research going on here looking at the stresses and the impacts of the pandemic, both on our families coming in for care and the impacts of the visitor restrictions with them, and then the long-term issues that people are facing as they take home a new baby when our ability to get together is more focused.

Perhaps if I could ask Dr. Elliott Rose to follow up with some more details that would be appropriate.

THE CHAIR: Dr. Elliott Rose.

DR. ANNETTE ELLIOTT ROSE: To add to Dr. Jangaard's comments, I'll touch on a couple of resources that we have for pregnant and new mothers. One is a provincial program, the Reproductive Care Program, which sets best practice and guidelines around perinatal care across the province. We work in partnership with the Nova Scotia Health Authority and provide capacity building, but also best practice information around many things related to perinatal care, including mental health.

In our Mental Health and Addictions program, we have the reproductive mental health service, and it's a very busy service, but I will have to say this is one of the times when virtual care has actually been a significant success. As we can all imagine, new mothers are very busy and very tired and have many competing demands, so it's often very difficult to get out to appointments, particularly in that new time postpartum. Virtual care options have actually been quite successful. We saw a 156 per cent increase, believe it or not, in appointments in reproductive mental health.

Some of that may be due to need, but some of it actually may be due to access. Previous to that, we actually saw a number of women have to postpone their appointments and weren't able to access services as quickly as they were before.

COLTON LEBLANC: In the study, it spoke that upwards to a 35 per cent increase in demand. Dr. Elliott Rose said that there was a 156 per cent increase, maybe because of increased access. Do we have any identified statistics collected perhaps by your organization that would identify that there was a clearer link or concrete link between the mental health impacts of the pandemic or the pandemic effects on mental health for expecting and - I guess, in this case - postpartum mothers?

THE CHAIR: I normally would pass it to Dr. Jangaard, but if you prefer another doctor or another member would like to speak, if you just raise your hand just quickly like this, and I know you would take that as well, whichever works better for you. I pass it on to you, Dr. Jangaard, and you can decide.

KRISTA JANGAARD: Dr. Bagnell may have some more information about that, having done some of the work on looking at the evaluation of our virtual care methods, so I would ask if she had anything extra to add.

DR. ALEXA BAGNELL: We've been following the data really closely through the pandemic in terms of demand, so I can speak to generally mental health and addictions, which I think is a good barometer in terms of Nova Scotia in terms of children and youth accessing service. I know reproductive mental health, which is under our portfolio, Mental Health and Addictions, has seen similar trends. We measure both emergency - so emergency mental health visits, crisis line visits - and then calls to our central referral line, and we collect data each month and really move our resources accordingly.

Interestingly, in the beginning of the pandemic, like other services, I think it was a shock to everyone and people didn't come in for help, so we didn't actually have a lot of use of our emergency services compared to usual for April of last year, or even our crisis lines at first. Then we saw a gradual increase heading into the Summer, young people heading back to school, uncertainty about what that was going to look like exactly.

So we saw sort of a gradual increase, but it was really in October and November that we started to see a more persistent change and this would be in the 15 to 20 per cent range if you look at it from years previous, comparing those. But we've seen that pretty consistently into now. That would be both our emergency visits and our calls to central referral.

Interestingly, most of the visits are requiring either crisis service appointments - but not necessarily coming into hospital, so we know that there's more distress but not necessarily mental illness, and that is an important differentiation. It means those young people and families still need supports, and that's what we do. But it's not coming into

hospital support, so our actual admissions have not changed, which is really interesting, but our emergency visits have definitely increased.

We have a wonderful emergency mental health crisis team at the IWK who have done a phenomenal job of supporting families and getting them connected to either an urgent care appointment, if they need it, within seven days or into our regular services in our community mental health.

COLTON LEBLANC: I'm happy to hear of the success of virtual care for your organization. It's something that's been echoed at our first Health Committee meeting back - I believe it was the first or second one - with Doctors Nova Scotia. It was an overwhelmingly positive experience for doctors and physicians, and also for the majority of Nova Scotians. It's something that as a Party, we've come out strongly in support of pre-pandemic and it's unfortunate to have had to have a pandemic to see it come to fruition, but it seems that we're on the right track with respect that there are some limitations, of course, to virtual care.

I do want to pivot to another topic on the same lines, though. It's a topic that doesn't get talked about quite often and I think it's a challenge and a very difficult time - a topic for expecting mothers and their families to discuss and probably even more so to go through. It's those who are experiencing pregnancy loss. I've seen it in my own social circles, of moms who have suffered a pregnancy loss coming out and discussing it a little bit more. I can't imagine the loss that they're going through and the roller coaster of emotions that it plays for them. Certainly with the pandemic, with the visitor restrictions, that probably has had even that much more difficult challenge for them.

There was a story on the CBC back in March and it talks about pre-20-week gestation versus post-20-week gestation treatment. I understand it's more of a unique situation in the HRM area, because in rural Nova Scotia, you go to the regional facility and then there would be the variety of services. I was a little bit frustrated and saddened to hear of the experience that Ms. Lauren Howe had to go through of being brought to one hospital, told to go to another hospital and essentially brought back to the IWK. It wasn't her first time going through this very difficult time, so I empathize with her and the difficult situation.

How can we as a province improve that type of system, not only for the efficiencies within the delivery of health care, but more so for the individual who's going through both a physiologically difficult time or condition or process, but even more so for their mental well being? How can our health care system, when it comes to the IWK and NSHA, come together and ensure that there are efficiencies when we can avoid this bouncing around for mothers who are going through a difficult time. Perhaps Dr. Jangaard can start off.

[1:30 p.m.]

KRISTA JANGAARD: Certainly working as part of the system and making sure that the services come to the patient rather than the patient having to find the services when you're looking at shared care delivery is really important. I think Dr. Bentley and Dr. Elliott Rose could talk a little bit about some of the planning for services within HRM, as you note, it is a little bit different than the rest of the province. If you were in Yarmouth, you would go to the regional health centre and the team would be the same team.

If I could ask Dr. Bentley perhaps to lead on that question, I think he could give you some of better ideas of what the team is doing to work on those kinds of issues.

THE CHAIR: Dr. Bentley.

DR. JAMES BENTLEY: I've been head of the department of three years, and even before that, this has been front and foremost of how we're trying to change this. This is a problem and a concern and we are working towards rectifying that.

The problem is that if you're less than 20 weeks gestation and you're having a problem, that may be a pregnancy-related problem but it may be something else, and we also might need to go to the operating room very quickly. We do not have the facilities at the IWK for that sort of care to be given that quickly. We don't have an emergency room for adult women to deal with that, so it's appropriate that they go to the Central Zone and the QEII emergency. It does become a problem when we're going back and forth with interaction between the two hospitals.

We have a committee where we're working with some of the emergency room doctors who are very committed to sorting this problem out and to actually work some processes that allow us to get people to where they need to be quickly and to react to this so that we can deal with things. As you've said, it's to allow the whole patient to be dealt with - not just the medical problem that is in front of us with the pregnancy loss, but there's also the psychological aspect of that. If we can actually bring them here, we can get the reproductive mental health services that came up in the last question involved as necessary rather than being stuck in the emergency room.

The article was very moving and has allowed us to focus our energy and actually work together with the emergency room at the Central Zone to actually come up with some plans, which are slowly being put into place. This has all gone on in the midst of COVID and the third wave, so the fact that when we checked and they actually managed to do this in the last few weeks - that was quite amazing to me. We are moving in the right direction. There are things happening.

COLTON LEBLANC: I appreciate that there's lots of work going on behind the scenes, particularly as Dr. Bentley noted, amidst a pandemic, so I'm glad to see that there's

progress and system improvements for the betterment of health care delivery for patients like the one noted in the article.

I do want to take another path regarding mental health and access to youth mental health, especially when it comes to those trying to access services in rural Nova Scotia. Unless a youth presents to an emergency room during business hours - so Monday through Friday - there may not be access to a child psychiatrist, which poses a challenge for consults after those business hours.

There was a story that came out in the local newspaper that outlined last fall a situation where a youth was presenting with suicidal ideations and was unfortunately unable to get to the Garron Centre at the IWK because there was no room. They were admitted to the regional facility for a couple of days.

How can we ensure - and maybe perhaps virtual care is part of that solution - that those who may not have direct access to IWK services in the HRM can continue to have the proper psychiatric consultation and evaluation and treatment in rural regions, especially in the after-hour scenarios?

KRISTA JANGAARD: I'm of course going to send this over at some point to Dr. Bagnell, who is our expert in this. But as I highlighted, one of the really important roles of the IWK is around capacity building and helping build strength within the tiers of service that are in local communities. Some services are in a community, some services are in a region, and some services are only here at the IWK, so it's having strength in all of the different tiers of service to make that happen. As well, to have a plan when there is an urgent, out-of-hours patient who shows up in one of the regions - how we can best and most smoothly move that patient to the level or tier of service that they require.

I think, Dr. Bagnell, if you'll allow, can give you much better detail about how that actually rolls out and is made operational.

ALEXA BAGNELL: It's a great question, because we've actually worked with the Nova Scotia Health Authority to put together a policy around child and adolescent presentations to emergency departments in the province and then how to flow into the IWK and how to use our expertise and resources. So it's very timely, because we completed that, I think, within the past two years. It really is a collaboration.

We have child and adolescent psychiatrists in the Northern Zone, in the Western Zone and really great news of one of our three graduates this year from our subspecialty program in child and adolescent psychiatry is just in the final phases of signing with the Eastern Zone. So there will be a child and adolescent psychiatrist in Cape Breton, which is just phenomenal for that region. We're really, really excited about that.

We work with all of our colleagues in the province, and there's an actual on-call rotation for the Northern Zone, where emergency departments in the Northern Zone can

actually call. That's their first step - to use their crisis services so that every youth who comes in sees a crisis worker as long as they're in an emergency department that has that service, and most of our emergency departments in the province do. Then they determine if this does need a psychiatric consult, and the first step in the Northern Zone is actually to call the on-call child and adolescent psychiatrist for Northern Zone to determine whether this is something that can be managed with the consult with the child psychiatrist by phone, or does it need further evaluation at the IWK.

You're correct - we are the only 24/7 child and adolescent psychiatry emergency service, so we operate 24/7 all year in our emergency department and we do consults from across the province who need an emergency psychiatry face-to-face assessment. Those assessments are really specialized and detailed and they do require young people to be present because it's usually a risk assessment. It's when we're most worried about young people and really assessing what's going on with them, how is their family doing, and what's the best next step. Sometimes that best next step is coming into hospital and sometimes that best next step is connecting them with services quickly in their community afterwards, and we work with our provincial colleagues around that.

There was a time this Winter where I think people probably saw the notices where our inpatient unit was at capacity and kind of beyond. We worked, actually, with all of the health centre to support our youth and have as many be able to come in to our hospital who needed it. We did have a few times - and I will say there were a few, thank goodness - where young people did have to be hospitalized for a few nights with our support, so we were available 24/7 to that team waiting for a bed at Garron. I'm going to knock on wood right now and say fortunately that has passed and we are now maintaining what I would say is our regular census, our regular admission rate, and we haven't had that happen - I think it was in January.

I will say that was a time when we were really collaborating across the province in a pandemic, in a time when we were at capacity. That's the first time we've had that - and I've been doing this job for seven years - where we had to actually hold young people and ask that hospital to keep them overnight. I hope it doesn't happen again, but we now do have a really good process in our province to do that, and so hopefully we'll continue to do a better job with that too.

THE CHAIR: Thank you, Dr. Bagnell, and you did it just on time. We're at 1:39 and we now move on to the NDP caucus and Madame Leblanc.

SUSAN LEBLANC: Thanks to everyone for being here. I just wanted to start also by asking some questions about children and youth mental health. We know that there are wait times in the dozens and even hundreds of days for children seeking non-urgent care across the province. For example, at the industrial Cape Breton clinics, most people wait 66 days for their first appointment and then 133 days for the second. At the IWK, the wait times website lists 59 days for the first appointment and 55 days for the second

appointment. We know anecdotally that there are families in HRM who are only able to get an appointment for their child for three months from now.

These numbers have jumped from earlier this year, and there could be a whole bunch of reasons for that, but it is also the case that there are virtually no private clinics that are taking on new children as patients, which adds another layer of complexity for those who are fortunate to have extra coverage to pay for private care. Of course, all of this creates incredible stress for families.

I'm wondering first of all, Dr. Bagnell, in terms of those non-urgent appointments, if you might be able to talk about what the issues are there and what the factors are.

ALEXA BAGNELL: It's a great question and it is what we have been observing, which is January-February, we were able to what we call meet the demand, so even though the demand had increased, we were able to flex our resources. Right into March we were still meeting 98 per cent of the wait times for the bands, and then really since April-May. Our system is designed in a really great way, but it's also very productive and everyone knows what everyone is doing.

At a certain point, you've flexed all the resources and you hit a point where your wait times do start to increase. That's what we're seeing right now. They seem pretty consistent, but it depends on the week you look at, but they're anywhere from 40 days right now to about 55. I think if you're waiting for a very specialized service, then they can be up to 90, so some of our services that are non-urgent but very specialized might have a bit longer wait.

We are looking at that data all the time and discussing where we need resources, and what we need to do to try and meet that demand. I'll tell you from working with my colleagues across the country, this is something that everyone is working with. The virtual care option has helped a lot, because we're able to actually Zoom in to other clinics and help out a family physician or help out a pediatrician who is managing a young person or family, maybe outside of the IWK to be able to support them.

We also have a great telephone consult service that's really had a lot of uptake recently where physicians can get an appointment with a child psychiatrist within three to four days to run a case by them. We all go on the rotation for that - the child and adolescent psychiatrist - to be able to answer questions, trying to address things earlier, and also give them some suggestions on how to manage in the interim.

We've been doing those ways to try and support while people are waiting, plus our emergency room of course is always open. We do encourage people to reach out to central referral at that point if things do change, and we also recommend that their family physician or pediatrician does as well, because those things do make a difference. If someone is non-urgent when they first call but things change, we want them, so they're told at that time, please call back if something changes.

Those are the ways we are trying to manage, and we just got our recent data, which is exactly what you said. We're meeting about that this week, about how we make sure we try and manage that and use our resources wisely to help kids who need that help right now.

I think you asked a question just around what they are presenting with. I will say it's full range - it's not one thing, but there is a lot of distress. Some people simplify it by saying not coping as well as they usually do with regular stress - that's one of the ways to put it - but there are also others presenting with more trouble coping at home with learning difficulties.

So there are many different presentations - I would put it under distress and needing some more support.

SUSAN LEBLANC: Listen, I know that the mental health system, especially for youth - when I think about it, it's like a puzzle and a labyrinth. It's just so complicated and there are so many issues, so I don't pretend to understand it at all, but I hear lots of stories about people engaging with the system. I know of one family whose child has interacted with the emergency room many times and now is in care, I guess, of the Minister of Community Services. They were receiving treatment through the Department of Community Services at the Wood Street residence in Truro, and now has to move to another part of the province as they await a neurological assessment. Apparently there is only one doctor in the province, this person has been waiting for months and months, but in order to get that to happen faster, they're moving to the Waterville centre.

[1:45 p.m.]

Is there a metric that is followed where a child has to be removed from parental custody in order to receive some of these treatments? I know that is a DCS thing as well, but is there a contribution from the IWK or collaboration? That's my first question. The second question is: For these very complicated neurological assessments or psychological mental health assessments, why does it take so long to get those done?

THE CHAIR: If you could wait for me to call your name the next time, Ms. Leblanc, I'd appreciate it. Is that question for Dr. Bagnell as well, or Dr. Jangaard?

SUSAN LEBLANC: For Dr. Bagnell.

ALEXA BAGNELL: I can start. I think that Dr. Elliott Rose may be able to speak to some of the system issues, and I think she would do a great job of explaining some of that.

It is complicated. We work really hard around trying to simplify things and helping people navigate, and we have great trained access navigators, but it's still complicated. Mental health is one of those areas that when people reach out, we really do want to be responsive because it takes a lot for people to reach out in the first place.

I think your question is around how systems talk to each other from the Department of Community Services, the Department of Justice, the Department of Health and Wellness and mental health. I think that's what you're getting at, and then if there is any health reason where IWK would weigh in and say they need to be in Community Services or in Justice.

I can speak generally, I can't speak to that situation, but I can speak generally, which is we do all work together. We have really good relationships with Community Services and Justice, and in fact Waterville is actually an IWK and Justice partnership, so we're the Mental Health and Addictions care at the youth facility. We have very good relationships there. The Nova Scotia Health Authority has child and adolescent psychiatry and mental health services that support the Wood Street Centre, which are from Northern Zone. Mental Health and Addictions is definitely integrated in both those services that you talked about.

Mental Health and Addictions, generally may say, this is what we would recommend, but we would never be making recommendations on where someone lives. We may say this current environment has these stressors, but that would be about the limit of that, so it's usually a systems decision, and I think Dr. Elliott Rose could speak to some of the tables that comes to in terms of what I would consider youth who are really either high-risk or complex across our systems, and how we work together around that.

ANNETTE ELLIOTT ROSE: Building on Dr. Bagnell's comments, she spoke really about the clinical partnerships across the system. There are several tables where we meet on a regular basis. One is senior partnership committee, so DCS, Health and Wellness, Education and Early Childhood Development, and Justice meet on a regular basis that has been paused off and on during pandemic, but certainly that is the ongoing table where we talk about [Inaudible] policy changes, how we're going to work differently together, and all the various strategies required for that.

Then reporting into senior partnership, one of the committees is Integrated Service Delivery, and Maureen Brennan - our Director of Mental Health and Addictions - is a member of that committee. They have very specific conversations, obviously with patient and family permission, around cases and where there may be gaps in services and where the various departments can work together differently to advance care.

I would say for Wood Street Centre, too, to add to Alexa's comments - we actually work in partnership with Nova Scotia Health Authority and with the Wood Street team to inform their service model, and so they're looking at various service models to meet the needs of youth. We're involved in that as well.

SUSAN LEBLANC: I'm going to move on from that for now. According to a freedom of information request filed by our office, there were twice as many Code Census calls at the IWK in 2020 as there were in 2019. I'm wondering if someone can talk about some of the factors that would have contributed to that increase. I guess I'll direct that question to Dr. Jangaard.

KRISTA JANGAARD: That's a really good question. Code Census, of course, is a time where our clinical team would raise the flag and say that they were at capacity. That doesn't necessarily mean at capacity for beds. That can be together with the number of patients who are there, how complex the patients are, what the acuity is, and what the needs of those patients are.

The areas that most often we look at as having Code Census would be, as Dr. Bagnell described, the period in January where we had Code Census within our Garron inpatient mental health facility. We have Code Census in our pediatric and in intensive care areas - that also would make up some of those numbers. And on one occasion, on a very, very busy evening in the emergency department during COVID, when we were split up, we also had a temporary Code Census within our emergency department.

So most of the time when you're looking at what leads to those and why you have them, it has to do with the patient population that's presenting. In some of these areas, we see differences that are seasonal. So it is not uncommon that our Neonatal Intensive Care Unit has to respond when people are having babies, and often we get our Code Census in the Neonatal Unit a couple of months before we usually see our little birth surge, which happens in the Spring and in the Fall fairly regularly every year. So some of it is around tying in patient population.

Some of it is by other factors for what's going on. So if we have a particularly busy influenza season, which we actually did just prior to the pandemic. We were coming out of a very busy influenza season that impacted our pediatric intensive care unit, for example. So patients with influenza who are very ill can stay a number of days and then that affects how many other patients you can have through the unit.

Much of it is based on the patient flow, and in the areas that I've mentioned, those are all urgent and emergent services. You can't put a pre-term baby on a wait-list or a child who needs to be admitted to Garron on a wait-list and say, sorry, we can't deal with you today, come back tomorrow. What you heard Dr. Bagnell talk about is, how the system then works together to make sure that you can have the capacity for the sickest patients.

When you're in a Code Census, it doesn't always mean that you don't take another patient in. It means that you need for each case to look and see within the unit is there someplace else within the health centre for some of these patients to go? Is there some place else within the Nova Scotia or Maritime system, since we do care for the three Maritime provinces, where these patients can be repatriated if they come from away? And are there other places within the health centre we can admit some other patients to work on?

So it's patient load, patient volume, sometimes equipment, sometimes beds, sometimes staffing, but it is a complex kind of combination of all of those things. We have been more in tune with the fact that for patient quality and safety, we need to make sure that our staff are not saying, hey, we can just tuck another patient in. We really need to be

aware that as we get more busy in our units, that can impact the quality and safety of the services we provide.

We've been much more open to saying, here are the processes, here's when we do it, and here therefore is what we can do when we get to a Code Census to help manage it. I hope that answers your question reasonably well.

SUSAN LEBLANC: Madam Chair, you're on mute.

THE CHAIR: Actually, if I may just let you know that the system chucked me out and brought me back without me touching the computer and when it brings me back, it puts me on mute. So if that happens, just wait two seconds and I'll be back.

Ms. Leblanc, you have four minutes left.

SUSAN LEBLANC: Thank you. I'm going to come back to that, Dr. Jangaard, in a second, but I do want to ask a couple of more questions about emergency departments. I understand that the IWK did not keep statistics on emergency room overcrowding prior to 2019. Are you able to provide a general picture of what capacity trends have been like over the last several years? I guess this does tie into what was going to be my B part for the previous question, which is: In general, as the CEO of the organization, are you concerned about the capacity of the hospital?

KRISTA JANGAARD: I'm concerned about everything about the hospital. That's my job. That's what they pay me for. I will answer some of your questions but we have Dr. Sinclair, who also happens to be an emergency department physician, so he may give you a little bit more answer to what I'm going to say about the ED.

What we do know about the emergency department over time is the number of visits. So when our emergency department was built and opened in 1992 as a state-of-the-art emergency department at that time, there were just over 22,000, I think, visits to the emergency - 24,000, maybe. As I said in my opening remarks, we're up to about 34,000 and there are a variety of reasons for that. Some of it is around the number of children and the population that we have within the health centre, and these are non-emergency visits for non-urgent things. When we look at what's called our CTAS levels - these are emergency visits for things that need to come and be seen - we actually have an increased demand.

One of the very big drivers of looking at the new emergency department redevelopment is the fact that we have more kids coming through, we have more youth coming through, and we have a wider diversity coming through. As we took on the youth mental health to the age of 19, that changed the access and the use within the emergency department. It's very different to be an 18-year-old having a mental health crisis sitting in the same emergency department waiting room as a four-year-old who's got a sore ear.

So there have been changes in how we deliver care. There are changes in our population and there are increases in demand for our emergency services that have led us to where we are. We keep very close statistics of how many patients leave without being seen, how many patients actually get admitted, and I'll ask Dr. Sinclair to comment on that if there is time.

Am I concerned about our capacity? That's what you pay me for and that's what I have my team keep their eye on: What are the priorities? Where are we seeing increases? What are the wait times? How can we continuously look at continual improvement in activities to make that access better and make the flow better?

When we do that, then we can get to the point where we say, okay, now we can tell you what our new emergency department needs to look like, because we know who's coming in, what's projected to come in, what we need for best practice for that, and then you build something like we did with the NICU, like we did with the PICU, like we did with Garron, that the environment lets our staff do the best care.

THE CHAIR: Thank you. Dr. Sinclair. You have less than a minute, so please go ahead and maybe I can extend it if the members are in agreement. Go ahead.

DR. DOUG SINCLAIR: Thank you, Madam Chair. Emergency department overcrowding is an international problem, of course. I would say at the IWK, it's simply really not a problem. Most emergency department overcrowding is caused by admitted patients waiting hours or days to be admitted. We simply don't have that issue at the emergency department at the IWK.

Some of that is because obviously we don't have frail, elderly patients, but frankly, it's because of the commitment to the patient experience and flow and admission of the children. Some of our longest waits are from the mental health patients who require complex interventions and often don't get admitted, and our new emergency department is going to have a fabulous new section of the facility to improve the experience of the mental health patients. Our staff are great, but the physical appearance is just not set up and it will be much better in our new emergency department.

THE CHAIR: Thank you, Dr. Sinclair. You did it in very good time.

The time has elapsed for the NDP caucus. Now we move on to the Liberal caucus and I believe the Honourable Leo Glavine is starting with questions. Go ahead, Mr. Glavine.

HON. LEO GLAVINE: I want to thank Dr. Jangaard for her team being present today and above all, her leadership at the IWK and especially through COVID - as you said, chart a course, but then perhaps have to change very quickly.

[2:00 p.m.]

In terms of the overall IWK and its future, do you work on a five-year plan - whether it's the personnel, equipment, programs? How is that larger picture seen now that you have some experience as the CEO?

KRISTA JANGAARD: It's very interesting. No one would certainly have picked a global pandemic to be the time that you were doing your strategic planning, but like most organizations, the IWK has in the past had a five-year strategic plan that looks at priorities and looks at initiatives within the priorities. Our strategic plan, called ASPIRE, was due to actually expire - if that makes any sense - in 2020. We had started in 2019 with our board and with our senior management team to start looking at what we would need to do for strategic planning.

Even before the pandemic hit, what became very clear to myself and to our leadership team was that so-called strategic planning that looked in five-year blocks perhaps was not as responsive to the changing landscape that you had in health. We had put forth and were working on a new way of looking at strategic plans that was much more agile and looking at strategic themes and directions that would be reviewed every three to five years. Within those strategic priorities, which we would review annually, some of them would be two- to three-year-long priorities, but they would be looked at annually, and then initiatives which would be reviewed quarterly.

We were all set, and in fact at our board meeting in January of 2019, I presented this to the board, who were very supportive of that. We were going in March to have our first discussions about where that would take us and what it would look like, and then COVID came.

I think what COVID really showed us is our thought about needing to be agile and responsive with strategy was really important. Knowing what your purpose is and redefining that, and we've done some work on that this year, knowing what your big buckets of work need to be. For us, it's about our system, leadership, our partnership, and advocacy; about really good access to care and flow; about taking care of your people; about research and innovation; and of course, about being responsible stewards of the money that is provided to us on behalf of Nova Scotians to provide good care. Those buckets we were really happy with, and we did some work on priorities.

That work for my team, along with all the COVID activities, has been continuing onward and forward. Supporting that one layer down, you asked how we think about our people. We actually have a people strategy, which is linked to that strategy, to the bigger ideas. We have a quality improvement plan, and Dr. Sinclair is the lead for that, he could tell you a little bit more about that. Then we have a way in which all of the items on those plans have someone attached to them that is accountable for looking at what the goals are for this, and whether we're meeting the goals.

What you would see if you went on our website right now is our quality improvement plan for quarter two of 2020. It hasn't been updated because we have been doing the work in the background and we have it - it just hasn't been posted because of some of the other COVID complications that we've been working on.

Thinking about how we hear from the front lines what's important, and that includes some of our discussions today - what you hear from your public, what you hear from your constituents, what we hear from our physicians. What our clinicians tell us is the best practice standards that are coming down and then it's looking at what the Nova Scotians are telling elected officials their need-to-be priorities are.

We sit in the middle of what the priorities of Nova Scotians are as brought to us by government, versus what are the priorities that we're hearing - and there are many of them - and spend some time asking, what are the top priorities in those buckets of work that we need to do now that are front and foremost of getting us forward?

Much of the work that Dr. Bagnell talks about when we look at the quality improvement activities within community mental health started because they were identified in that priority as something that we needed to measure, for example. Then you take all of that and you link it to your business planning, which is the annual cycle that informs what we're going to be looking at this year as well.

That's kind of how we've been approaching it, and I'd love to say that it's because I'm more comfortable in the position than the last time I was in front of you at one of these meetings. But it really is all down to the executive team who look in their portfolios, to our directors and managers and to our frontline folks who keep us honest about what it is we need to do here.

It all ties back to our purpose of providing care, doing good research, and teaching people so that sometime when I want to retire, we'll have people who can replace me.

THE CHAIR: I just want to take an opportunity to welcome Dr. Andrew Lynk, who just joined us. He's the Chief of Pediatrics. We were aware that he was joining us a little later, so welcome again.

Mr. Glavine, go ahead please.

LEO GLAVINE: With that response, Dr. Jangaard, I don't think I've missed your AGM this year.

I think one of the great areas of work of the IWK are the 14 satellite centres across the province. I'm just wondering if you could outline for this committee how that is orchestrated. Is it delivered through hospital settings? Does it connect to school health centres? What are some of the supports provided? I think bringing care to people is a great strength, so if you could just outline some of that work.

KRISTA JANGAARD: This is why I bring all these experts with me that are on the panel. The 14 sites are a combination of primarily our community mental health sites, which Dr. Bagnell could tell us a little bit more about, and they're about getting services delivered where kids go to school and where they live.

They also include an obstetrics and gynecology community clinic, which is based in Dartmouth, that Dr. Bentley could tell people more about, our midwifery service, which is in Dartmouth as well, situated in the community where we know midwifery services are helpful and supportive of those who are in need of them.

Dr. Lynk can certainly talk about the activities that happen in our school settings - between he and Dr. Bagnell and our SchoolsPlus program - that actually meet the needs of children in their schools, because we want them to go to school. We know that treatments offered closer to home in their community, where your sports are, by and large are better situated whenever possible.

I don't know, Madam Chair, if there was one of those people that I mentioned that Mr. Glavine would like to hear more from.

THE CHAIR: If you would like to speak just raise your hand and I'll call your name, if you have something to add to what Dr. Jangaard has just said. If you don't, I just move back to Mr. Glavine.

LEO GLAVINE: I was wondering if there is a link in fact to the school health centres, which again can be a deliverer of proactive health, meeting those mental health issues that students have, and developmental issues, which are part of the IWK's work. I was wondering if we could have perhaps Dr. Bagnell outline those connections.

ALEXA BAGNELL: As Dr. Jangaard outlined, we have school mental health clinicians, IWK clinicians who work in schools. They are on the ground in the schools and they liaise with the health centres, also guidance counsellors, administration, and SchoolsPlus. SchoolsPlus is a really great province-wide service that really supports kids with different learning needs, both mental health related, but also can be specific learning or developmental needs, and they really work closely with us. It has been a great partnership.

We really have close relations with the Department of Education and Early Childhood Development, and we did a lot of work in the back-to-school plan together with them, and putting together information for both educators and parents in getting back to school and getting kids ready for school, as well as talking about the transition and trauma informed care principle.

Our trauma informed care team with the IWK works closely with the Department of Education and Early Childhood Development, so we've been really fortunate. I've seen that really grow in the last decade in particular - the teamwork, the working together to

help kids who have different mental health difficulties and other areas and being able to really share skills and knowledge on the ground in the schools, so kids don't have to go anywhere else. They can get the help they need in the school setting.

LEO GLAVINE: I had the good fortune to tour and be at the opening of the Garron Centre, and also get to the new NICU - both of which I would class as world-class. In terms of the emergency department and the kind of numbers that move through there currently - I know perhaps you can give us a little bit of a timeline if it gets under way, and it should this Fall. What would be some of the advantages that it will bring to child care and adolescent care in our province? I know the IWK, from my experience, is in fact of the highest calibre. What will that new addition have to offer?

KRISTA JANGAARD: It is very exciting. I have to say I'm as excited about the new construction of the emergency department as all of you knew I was with the NICU, which is clinically where I came from.

Really what we're talking about is moving to a way in which our facility can meet the needs of the patients we serve. As I said, over time we have seen a significant increase in emergency visits. When you look, it's across everything. It truly is from the baby who's a few days old whose mother is really worried because they're not feeding very well and they haven't gained weight, through everything you can imagine that would take you there as a toddler and young child, to all of the stuff that happens when you have people on playgrounds and playing hockey and skiing, up to children who have infectious conditions, all the way to our youth mental health. Starting in childhood and going to youth.

The facilities that you need and the environment that you need to care for each of those different groups of people is a little bit different. Gone are the times when you build a box and the same box does the same thing for many things. You have to be flexible to ask, how can we have the space that can meet the needs of certain people?

As Dr. Sinclair alluded to earlier, thinking about having a designated area and space within the emergency room that is really focused and built, quiet, has the right kind of offices and things to de-escalate a youth who is in mental health crisis, is far different than the space that you need for the four-year-old who has stuck jelly beans up their nose and needs to have them out - which happens not infrequently, unfortunately.

This new emergency department will give us more space, but also will give us the space to lay it out so that it can be used for a variety of different things. We are excited at the thought of getting the shovels in the ground in the Fall, and we've been doing a lot of planning for that.

The team actually has been working for the last two or three years, because just like in our NICU and our PICU and our Garron redevelopment, before you think about what you want to build, you have to think about the services and how you're going to deliver them and what the model of care is. That work has largely all been done. It has

accompanied continuous improvement work that looks at patient flow so we can be efficient and best use the space as well.

This is going to be a game-changer. Really, when it's open, it's going to allow our staff the space that they need to do their work in the very best environment. One of the things I can say that COVID has really revealed to us is that not everybody who comes into the emergency room has an infectious disease, but many do. In the first wave of COVID we actually had to split the emergency room into two, so we had one stream where children who had infectious symptoms could be and one stream where they didn't. The new emergency room will allow that to happen within one space.

[2:15 p.m.]

That's just one example of taking what we now know about care and emergency and turning it into building the space that we need to do it. It is a game-changer, we're really excited. We like to show things before and things afterwards, and we're looking forward to the next four years - not without all of the stress that happens when doing a major reconstruction when you're delivering care, but there you go.

I think the other thing Mr. LeBlanc would be very happy with is the new place for the ambulances and the paramedics to be able to come and drop off their kids in a flow that makes much more sense than trying to back in and out of a busy parking garage, for example.

LEO GLAVINE: I don't want to miss the opportunity to ask Dr. Lynk a question. Like him, I am concerned about the total well-being, and certainly the physical health and the movement of our children in order to grow strong bodies as well as minds.

I'm just wondering how his work in the IWK will be a leader connecting to our schools, where they are a captive audience, and how we can increase the participation level of children and activity.

DR. ANDREW LYNK: Thank you for the question, Mr. Glavine, and I want to thank you. You've been a great champion formerly as a school principal and now as a provincial politician for keeping kids healthy and active and well. Thank you for that.

I would say one of the star programs that we've had in the province is the Kids Run Club, which Mr. Glavine will know quite a lot about. Just about all of our schools now have it, which encourages just running - not just the child, but also getting their families involved in moving. The Canadian Paediatric Society says we should be getting at least 60 minutes of aerobic exercise at least three times a week. We just know that's not happening. We know a lot of teenage and adolescent young women don't take gym classes. We surveyed that before because the change rooms aren't very pleasant and there's all sorts of different reasons.

We have a lot of work to do on that part, but I love that Kids Run Club, and it starts early, and I know the government has helped with some funding for that. Doctors Nova Scotia has been helping with funding for that. Let's keep something like that going too.

I think that I would just remind everybody that, and this is probably well known, that about 50 per cent of our health comes from our genetics and our physical environment and our health care system. However the other 50 per cent comes from the social determinants of health: our family income, our level of education, our housing security and food security. Those things weigh heavily on the long-term outcomes for children and their families in terms of being overweight or underactive or not being able to participate or afford to get into sports.

I would just remind us all that we still have a lot of work to do in Nova Scotia to address family and child poverty here. About one in four children and families live still in relative poverty depending on which measure that you use, and compared to the rest of the provinces, Nova Scotia is not doing as well in terms of improving that. Things got a little better a year or two ago when the feds came in with the Canada Child Benefit, and Nova Scotia increased the eligibility, which was great. But still, there are lots of people and families and kids who are living in deep poverty.

We have to remember we have the beautiful IWK and lots of fantastic regional centres to do some of the health care part, but it's incumbent on all of us to do the health part, and that comes down to having a clear action plan around child poverty with measurements and indicators, which other provinces have done and have gotten their rates down. We really need to focus on this much more, and I just refer people to the *2020 Report Card on Child and Family Poverty* report by Lesley Frank from Acadia if you want more details.

THE CHAIR: Thank you, Dr. Lynk. The time has passed for the Liberal caucus.

I had counted that we're going to have seven minutes each for the second round, starting with the PC caucus. I may have to cut our Liberal one by one minute because we went over.

Ms. Adams.

BARBARA ADAMS: I worked at the IWK as a student on the cystic fibrosis unit in NICU, so this is near and dear to my heart.

I only have six minutes and I have 20 questions, so we're going to do a rocket round. Very briefly, poverty we know is a major issue, and lack of housing. Out of the 66,000 Nova Scotians without a family doctor, do you have any sense of how many of them are children? Also, when someone comes through the IWK - either emergency or for any kind of outpatient or surgical care - what is the impact on them when they don't have a family doctor for you to liaise with when they leave? That's for Dr. Lynk.

ANDREW LYNK: I asked for that information as well, and I don't think they record it on the 811 whether there's children or families, but I can tell you from personal experience, there are quite a few children and youth who don't have that. That goes to Mr. Glavine's point before, some of the importance of having youth health centres at our high schools to have access for adolescents who don't have access to family physicians.

Yes, it is an issue for a percentage of the population, and it's a concern, because we often don't have someone to send back to in terms of a family physician or a nurse practitioner.

BARBARA ADAMS: Years ago, because I represent the military, CFB Halifax did a pilot where for the families of military people who get posted and can't get a family doctor, they gave them a subscription to Maple, a telemedicine service where they could follow up with medications, referrals, and test results that they may have ordered.

The PC Party a year and a half ago announced that we would give telemedicine services for every Nova Scotian without a family doctor. Would that make your jobs easier when you're sending somebody home with medications, or you've ordered a test that they may have to go for, and you know that there's somebody that that patient or family member will be able to talk to about this when they don't have a family doctor. Dr. Lynk?

ANDREW LYNK: Certainly we've learned a lot about the virtual world, and we've been doing virtual medicine now intensely for the last 15 months. We're much better at that. It's always better to have a human being who can lay on the hands when you need to lay on the hands, so that would be my first preference, and often we will keep those young people coming back to our own clinics at the IWK if they don't have family doctors.

I don't feel like people are - hopefully not falling through the cracks. Could virtual care do this as well? It would certainly be another alternative that we're going to need to consider in the new world while we wait to get our family physicians and nurse practitioners up to 100 per cent.

BARBARA ADAMS: This is to keep them going until such time as there is a family doctor, because no doubt that's the preference, but we need that person to coordinate the care. I appreciate that.

I have put in concussion legislation to coordinate the process that we use across the province, because I used to work at the Atlantic Balance and Dizziness Centre. I'm just wondering if you can comment on what the top three reasons are coming through emergency. I know you said that it's an appropriate emerg visit, but I'm wondering, given that it has been a dramatic increase in the number of emergency visits, we get the number of kids has not gone up, in fact it's come down since the IWK opened. Can you tell me what the top three issues are that are bringing kids to emerg?

THE CHAIR: Is that for Dr. Lynk or Dr. Jangaard?

BARBARA ADAMS: Dr. Lynk - well, sorry, I guess Dr. Jangaard.

ANDREW LYNK: Maybe Dr. Sinclair because he actually works in emergency sometimes.

DOUG SINCLAIR: In general, the variety of illnesses really are the same at the IWK emerg as any other emergency department. Really it's respiratory illnesses by far the number one, followed by injuries. One might argue, could those be seen in another area? Again, if you look at the concentration of X-ray facilities, we can do all the follow-up, it's actually the most efficient actually to be seen in an emergency department, rather than a walk-in clinic. So it's actually a pretty comprehensive service. And of course the population of children is actually rising in HRM - although the over number may not be. So we actually are seeing increased volumes and also complexities of children who are seeking care 24/7. So it's quite a variety of things.

Again, we have to be careful about the top list of complaints. We know that mental health is actually a small volume when we look at the total numbers, but has high impact and long length of stays and complexity. We have to be careful looking at just kind of the top numbers.

Your point about concussion is an excellent one, and we do have quite a bit of outreach from the IWK and also from the Emergency Department. There is an organization translating emergency knowledge for kids that actually has a number of recommendations and outreach around the province that will help, I think, care beyond the IWK, which is part of our mandate.

BARBARA ADAMS: I'm wondering what your flow of care is for children who have autism. I know that the ability to get tested has been a particularly big challenge, especially for those kids to get extra resources in the school. I'm just wondering what the wait time is like now to get that autism assessment done in order to get kids on the path towards care.

THE CHAIR: Dr. Jangaard, go ahead, please.

KRISTA JANGAARD: Actually, I was pointing to Dr. Elliott Rose, if we might.

ANNETTE ELLIOTT ROSE: The current wait time for pre-schoolers for the IWK for diagnostics is still around 300. We did have a slight improvement just before the pandemic - we increased our capacity by about 20 per cent. Then we're looking at various models where we - you'll hear this as a common theme in the conversation today where we're working in partnership particularly with the community pediatricians, so Dr. Lynk can speak about this as well, to advance the knowledge and skills of community pediatricians across the province to do diagnosis. So we're looking at rolling out some of that in the short term.

THE CHAIR: The time has passed for the PC caucus. We are now at the NDP and Ms. Coombes. Go ahead, please.

KENDRA COOMBES: First of all, I want to thank Dr. Lynk for bringing up poverty and its connection with health.

I have one question about midwifery care, which has huge potential to improve primary care outcomes of pregnant people who might not otherwise be integrated in the health care system. It is considered to have the best outcomes for low-risk pregnancies, but it is not available in every part of the province.

What is the wait-list for midwifery services at the IWK and are there people who would like to access the services who cannot be accommodated?

KRISTA JANGAARD: When we talk about primary level services, midwifery is indeed one that we believe is an important part of the delivery of maternal and newborn care.

At the IWK, we house a program that Dr. Elliott Rose referred to as the Reproductive Care Program of Nova Scotia. The IWK and the Nova Scotia Health Authority working together have really put forward a plan for how we could expand midwifery services over the next coming years. I don't have the statistics for how many are on the wait-list right now - Dr. Elliott Rose may and if we don't, we could get those to you.

When I mention the midwifery clinic placement in north Dartmouth, the community clinic is situated there because it is an area where we know that not all people feel comfortable accessing services in the same way in our regular services. So our midwifery services do have within them a component of working with those in the community who are more disadvantaged and may not have the ability to work with a family doctor or don't feel comfortable coming to our services for a variety of reasons. There is real benefit in that and we have a very active midwifery group here.

[2:30 p.m.]

The other thing I can say about maternal and newborn services though is, we're really proud that in a tertiary-secondary level hospital like the IWK, almost 50-plus per cent of the deliveries are still done by midwives and family physicians, so primary level care for primary level patients and families. That really is, as you say, associated with better outcomes, less interventions, and so forth. When you need an obstetrician, you need an obstetrician, but if you don't, having access to that is really important.

Whether it's midwifery services by themselves or well-put-together primary services - midwifery, nurses, nurse practitioners, and family physicians - supporting the

community to do that, I think, is what we would be trying to get at. It's to make sure we have those services available at the right level.

KENDRA COOMBES: This question is going to go to Dr. Bentley, I think. As someone who has experienced two pregnancy losses, it's a thing very near and dear. I was wondering if he could elaborate on the changes he mentioned earlier to a question my PC colleague asked. What are those changes that are coming with regard to women in 20 weeks of pregnancy being moved from hospital to hospital?

JAMES BENTLEY: This is in the preliminary stages of being rolled out fully, so I really can't give you specific details, but we're looking at streamlining the process to try to avoid that repetitive visit and to continue the initial point of contact being the adult emergency which we feel is the most appropriate place for that, but then transitioning care as rapidly as possible and as efficiently as possible to the IWK. It's in the process of being worked out at this point in time.

KENDRA COOMBES: I want to ask a question on reproductive support. One in six families will have trouble conceiving when they decide to start their families, and fertility support is considered an equity issue when it comes to the 2SLGBTQ+ communities and families. Could you explain what work is under way to expand the fertility supports that are available at the IWK?

JAMES BENTLEY: I should say that fertility services are not provided solely by the IWK and are partly done by a not-for-profit organization run by the university department to the Atlantic Assisted Reproductive Therapies Clinic. That is outside of the hospital setting.

Within that setting, we have three reproductive endocrinologists who provide IVF services. There certainly are challenges in the equity that is provided there and we are constantly lobbying for equity for marginalized individuals, whether they be cancer survivors or the LGBTQ community to be able to get access to that care. Also, I think to be equitable, that everybody in society has access to that care through some system that is not yet provided in this province. For example, New Brunswick has a tax incentive, P.E.I. has a system, as does Ontario and Quebec.

I understand that is a big issue, and equity across reproductive services and access to care is very important. We as the hospital department are working closely with our colleagues who work here and the AART, working together to try and facilitate that care and respond to the needs of the community as best we can.

THE CHAIR: The time for the NDP caucus has elapsed. We move on to the Liberal caucus. Mr. Jessome.

HON. BEN JESSOME: I did have questions related to the miscarriage incident with Ms. Howe, so I appreciate my colleague bringing that up. At this point I won't dive into that. It sounds like we got a pretty fulsome response.

To Dr. Lynk, please and thank you - I guess in the past year, we've made an effort to maintain a situation where students are back in the classroom and the IWK through you has been kind of charged to weigh in on why that's important.

Could you, for the benefit of the committee and those watching, reiterate why the emphasis is placed on putting students back in the classroom given the circumstances that we're challenged with in this pandemic?

ANDREW LYNK: A couple of key things. One is that schools are a place of learning, obviously, and socialization and not all children will learn equally. There are some children - maybe 10, 20 per cent of children - who require educational support for learning and that's not easily done virtually at this point. It can be done to an extent but it's often done better in the classroom.

The other issue, and my colleague Dr. Bagnell, Chief of Child and Adolescent Psychiatry, alluded to this as well, is that schools are cocooned around other services: mental health services, and free breakfast or free lunch programs sometimes for kids who come from those poor families as well. Also, it's an opportunity for children who might be in abusive households where they are detected, actually, in the school when teachers notice bruises or behavioural changes or other things. So schools really are more than just a place of straight learning for everybody. They have so many more support systems.

Of course, the other issue is a lot of parents work - two parents are working - so to be at home and supervising your Grade 2 or Grade 4, or even your teenage students and kids to work online isn't always easy when you're supposed to be at work as well and you have to work.

For all those reasons, we've always said that we need to balance the benefits and the risks during the pandemic not just to students, which is relatively low, but also we recognize that staff and teachers would be concerned - especially prior to them being immunized - and making sure that we have layers of protection, however imperfect. As long as we had reasonable layers of protection, we felt if there wasn't community spread, it would be safe and best for kids to be in school.

I appreciate that the government and in particular Dr. Strang, whose team have been very flexible about this, have been able to pivot quickly, and I also have to give my heartfelt appreciation to the teachers and the administrators and the staff. This has been a stressful 15 months for them as well as they pivot back and forth, worried about their own families and their own health. They've stood up and they've really done a very good job at this as well under not easy circumstances.

I think we've had a very flexible, good plan and hopefully kids haven't fallen through the gaps. There obviously have been concerns, and there are ongoing concerns about how much further some kids who are struggling are going to be behind because of the last 14 or 15 months in education, but we'll see if we can catch them up.

BEN JESSOME: In this year's budget, we enabled $5 million to help the Province's support system be more inclusive and accessible - the biggest investment in community amateur sports in recent history. Is that something that your shop has been engaged in terms of deploying or how might we best use that type of funding stream?

THE CHAIR: Dr. Jangaard, would you like to take this one, or somebody else?

BEN JESSOME: I think Dr. Lynk is . . .

THE CHAIR: Oh, Dr. Lynk. I apologize. Dr. Lynk, go ahead.

ANDREW LYNK: Unless my boss wants to. Any extra resources clearly are important. I think some of our best people to know how to do this are our volunteer coaches and our Phys. Ed teachers throughout the province. They have a pretty good handle on this.

Ben, you will know that it's one thing to pay for registration fees for kids to play soccer or tennis or ice hockey but to afford the equipment or to even get a drive back and forth to practice and to games can be an issue too. It really needs to be well thought through, so those kids who really need to be involved and whose families can't manage it otherwise, we really need to include them.

We have a lot of smart people in this business across the province. If there are resources and we get the people together, I know we can improve things. We can make things better.

THE CHAIR: That brings us to the end of the question and answer period. I would like to ask Dr. Jangaard if she has any closing remarks.

KRISTA JANGAARD: Again, I'd like to say thank you for allowing the IWK to present to you and to talk to you about some of the things that we're doing on behalf of women, children, youth, and families in Nova Scotia. We're first to say we're not perfect. We know that there's work to be done, but we are dedicated to the continuous improvement activities you've heard us talk about while getting input and hearing where we can get better and then working to get better - all with the aim of improving the health with our communities.

Part of that is the health services deliveries that people think about us doing as a hospital. Much of it is around the kind of work that we've been talking about and about advocating for and with our families, our women, our children, and our youth. Thank you

for allowing us to come and talk a little bit about that, and we look forward to continuing our work for our people that we serve.

THE CHAIR: Thank you all on behalf of the committee members. You can leave at the moment while we have some more committee business to take care of. Thank you again for all you do for us at the IWK. Wonderful to have you today.

The first item on the committee business is a letter from the Department of Health and Wellness re: the organ donation, in response to the motion passed at the meeting of March 9, 2021. This one was forwarded to members on May 26th and again this morning. Any discussion? All is good? I'll move on to the next item.

Next, there was a letter from the Nova Scotia Health Authority referencing the witness availability for the June 8th meeting - today's meeting took place with the IWK.

The next item was the date and topic of the July meeting. I believe there is a time, and I'll get Judy Kavanagh to enlighten us on this, because we may have to change the date from the 12th to the 15th.

Judy, I'm going to keep it in your hands, because I have a lot of notes here to read fast. I can't remember, I believe you texted me that the fourth witness was available for the Thursday the 15th. Go ahead and inform the members.

JUDY KAVANAGH: You can see at the bottom of your agenda, the topic that I've been trying to arrange for next month's meeting. That's the one on medical students from and training medical students in rural areas.

One of the witnesses can't make it on the regular meeting date of July 13th, but all four of the witnesses have confirmed that they could make it if you held the meeting two days later, on Thursday, July 15th. I guess we're just looking for the committee's agreement to that.

THE CHAIR: Is it agreed?

It is agreed.

We will move it from the 13th to the 15th to accommodate our witnesses. Thank you, Judy, for trying. That covers that item on the agenda, our meeting in July.

JUDY KAVANAGH: One more note. I think I called this item the date and topic title or something.

THE CHAIR: The title was a little long, and I agreed with you, whatever you shortened it to sounded perfect. I have no problem with that. If you'd like to read it to us, that would be great.

[1:45 p.m.]

JUDY KAVANAGH: Okay. In its motion, the committee approved the title "Recruiting Medical Students From and Training Medical Students in Rural Areas," and I would suggest something more succinct such as "Recruiting and Training Medical Students in Rural Areas."

THE CHAIR: Yes, sounded perfect. Honestly, when I read that, I said, yes. Thank you, unless anybody else has any complaint on that? Okay.

The next item on the agenda is - sorry, the business is the date for the August meeting. Would you like to speak to that as well, Judy?

JUDY KAVANAGH: Sure. I've been trying to arrange this meeting for Dr. Robert Strang and Dr. Brendan Carr to come in and talk about the ongoing COVID-19 response, and you can imagine what their schedules are like. They're both willing to appear at the August meeting.

Dr. Carr is not available during the week of August 10th but he has confirmed he would be available on the following Tuesday, August 17th. I've just this minute sent out an email to Dr. Strang asking him if that date works him for as well. If it does, would the committee agree to holding its August meeting a week later?

THE CHAIR: Is it agreed?

It is agreed.

Any other business? I believe Ms. Adams had something to add here.

BARBARA ADAMS: I'd like to follow up on two motions that were made. The first one was made by me at the April Health Committee meeting about writing to the Minister of Health and Wellness to ask the IWK Health Centre to produce the IWK By the Numbers report the same way that the NSHA By the Numbers report was produced.

My understanding is that the letter has been sent, but I'm wondering, since it was back in April, if we've had any response from the Minister of Health and Wellness.

JUDY KAVANAGH: No.

THE CHAIR: I believe she said we have not heard, but she will continue to follow up on that. Thank you.

BARBARA ADAMS: Okay. And the second is we made a motion at the last committee meeting that the committee write to the Minister of Health and Wellness and the Minister of Education and Early Childhood Development requesting that they meet

with early child educators who had concerns. My understanding is that that letter was written, but I'm wondering if there has been a response over the past month.

THE CHAIR. Ms. Kavanagh, any response on that one?

JUDY KAVANAGH: I'm sorry, I was taking notes on the last one.

THE CHAIR: There was apparently another letter. Ms. Adams, could you repeat that, maybe?

BARBARA ADAMS: Yes. Last month at Health Committee, I put forward a motion for the committee to write to the Minister of Health and the Minister of Education and Early Childhood Development to ask them to meet with the ECEs and I know you did that letter. I'm just wondering if there has been any response from either the Minister of Health and Wellness or the Minister of Education and Early Childhood Development.

JUDY KAVANAGH: No, not yet.

BARBARA ADAMS: All right, thank you.

THE CHAIR: Thank you, Ms. Adams. That concludes our committee business for today. The next meeting, we have decided, is July 15th instead of July 13, 2021 from 1:00 p.m to 3:00 p.m. and the witnesses will be the NSHA and Dalhousie Medical School regarding recruiting and training medical students in rural areas.

Thank you, everyone. The meeting has now adjourned. I think it was a wonderful meeting and we heard a lot of wonderful things about the IWK. So thank you again and enjoy this hot, hot day.

[The committee adjourned at 2:48 p.m.]