HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, May 17, 2022

LEGISLATIVE CHAMBER

Government Initiatives of Ambulance Availability and Offload Delays, and DHW Response

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HEALTH COMMITTEE

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[Hon. Patricia Arab was replaced by Braedon Clark.]
[Kendra Coombes was replaced by Lisa Lachance.]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Karen Kinley
Legislative Counsel

WITNESSES

Department of Health and Wellness
Craig Beaton, Associate Deputy Minister
Jeff Fraser, Executive Director - Emergency Health Services Branch

Emergency Medical Care Inc.
Charbel Daniel, Executive Director - Provincial Operations
Jan Jensen, Executive Director - Medical Communications, Patient Flow and System Performance

International Union of Operating Engineers, Local 727
Kevin MacMullin, Business Manager
Michael Nickerson, Business Agent

HALIFAX, TUESDAY, MAY 17, 2022

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Trevor Boudreau

VICE CHAIR
Kent Smith

THE CHAIR: Order, please. I call this meeting to order. This is the Standing Committee on Health. My name is Kent Smith. I'm typically the Vice Chair of the committee, chairing today. Today we will hear from witnesses regarding government initiatives of ambulance availability and off-load delays, and the Department of Health and Wellness response.

We have a few housekeeping items to address before we begin. I would ask everyone to please turn your phones off or put them on silent. In the unlikely case of an emergency, please exit through the back door of Granville Steet, walk down the hill to Hollis Street, and gather in the courtyard of the Art Gallery of Nova Scotia. Please keep your masks on during the meeting. As the Chair, that doesn't apply to me because I have to talk a lot.

Before we get to the introduction of the witnesses, I would ask the committee members to please introduce themselves for the record, stating your name and your constituency. We'll start to my immediate left with MLA Leblanc.

[The committee members introduced themselves.]

THE CHAIR: For the purpose of Hansard, I'd also like to recognize the presence of Legislative Counsel Karen Kinley and Legislative Committee Clerk Judy Kavanagh.

With that, I'd like to welcome the witnesses who are here today. I'll ask everyone to introduce themselves, and offer any opening remarks that you may have. We will begin with Mr. Craig Beaton.

[The witnesses introduced themselves.]

THE CHAIR: I'll now offer everyone a couple of minutes to provide opening remarks, beginning with Mr. Beaton.

CRAIG BEATON: Thank you for the opportunity to be here today. On behalf of Mr. Fraser and myself, we are pleased to be here in attendance with representatives from EMCI, as well as the Nova Scotia Paramedics Union, to answer your questions about emergency health services in our province.

Nova Scotia has a world-class emergency health services system. In fact, our ambulances are some of the best. They are manufactured locally in Yarmouth by a company called Tri-Star Industries, which supplies ambulances to a number of countries around the world.

Most recently, government invested $3.5 million to outfit ambulances with power loaders and stretchers. These enhancements will better provide for safer care of patients and reduce workplace injuries for paramedics. Improvements in equipment and infrastructure enhance our system. However, we recognize there are complex and long-standing issues that cannot be fixed with a new ambulance or the best technology.

There are pressures within our health system that have a direct impact on the service we provide. Our reality is that when one part of the system is impacted, the entire system is impacted. Long wait times for ambulances are unacceptable. Ambulance offload delays impact patients and paramedics. Better work-life balance improves morale for paramedics and the quality of care for patients.

Often, the challenges we encounter are unforeseen and sometimes out of our direct control. However, as a health care system, we strive to do better. We cannot continue to fix gaps in a system as they appear. That's not the answer. The status quo is not an option. Instead, we need to look at system-wide solutions.

Nova Scotians deserve better options and easier access to health care. This includes Emergency Health Services. Government recently released its plan, Action for Health, to address many of the system pressures our health care system is experiencing. Emergency Health Services is not immune from these pressures and that plan aims to address them.

The plan includes expanding community-based paramedic programs, expanding medical transport services and patient-transfer units, temporary licensing policies for graduates through the college, improving working conditions for frontline staff, utilizing

programs and services such as 811 and virtual care to help address access to services, focusing on recruitment and retention of paramedics, and continuing to align with industry best practices.

We are working quickly to make changes and put solutions in place, but we also acknowledge that change cannot be achieved overnight. Some changes will take time and the collective efforts of all of us - the regulator, the employer, the employees, and the union.

I look forward to speaking with you more today about some of the initiatives that EHS and our health care system as a whole has implemented with a goal of improving response times that benefit our patients, the public, partners and providers.

In closing, I also want to thank paramedics. We know there are frustrations out there and that people are tired, and they continue to give of themselves every day. I want to thank them for their commitment and dedication. I look forward to speaking more with the committee today. Thank you.

THE CHAIR: Thank you, Mr. Beaton. Mr. Fraser, do you have opening remarks to offer?

JEFF FRASER: I don't, no.

THE CHAIR: Mr. Daniel.

CHARBEL DANIEL: Thank you, Mr. Chair. Hello everyone. I'd like to thank the committee members for inviting EMC to be here today to discuss the challenges and opportunities that exist within the current layout of the health care system. We are a proud employer of over 1,200 paramedics in Nova Scotia. We have been providing expertise and supporting the evolution of the EHS system and the paramedic profession for over two decades.

There's no doubt that the EHS system, along with the entire health care system, is strained. This is not just a Nova Scotia issue - this is the experience of health care providers in jurisdictions across Canada and abroad. The system pressures are impacting our frontline staff who are working harder than ever to care for Nova Scotians today. This is why EMC continues to work very hard every day, with our primary focus being on our staff. If our team isn't well supported, they will not be able to provide high-quality patient care.

We continue to work in collaboration with government, our health care partners, our frontline team, our leadership team, as well as our employee unions, on solutions to modernize the EHS system to ensure the right resources for the right patient at the right time for the right reasons. Based on this, we are ensuring that our team members are

working at optimizing resources and scope of practice by creating improvements in several areas.

Some of these areas include the expansion of our integrated health programming system in both Cape Breton and Halifax. This includes the deployment of single-response paramedic units across the province. It also includes the expansion of our transfer service, both by expanding the current hours and deploying the medical transport service vans with non-clinicians to free up paramedics for emergency response. All these changes and more upcoming for future rollout align with the Fitch report recommendations and with the international best practices for EMS systems.

Similar to our partners, we are also experiencing a shortage of health human resources, as many other jurisdictions across the world are. As such, we continue to focus our efforts on recruiting and retaining paramedics to our province, which boasts a progressive, world-class, advanced emergency medical system. A recent change allowing graduates the opportunity to obtain a temporary license where they will be able to work alongside experienced paramedics has already seen positive impacts.

A concerted recruitment push is one part of our strategy. Retention of employees is also a top priority. With that in mind, we've created an employee advisory council, in addition to other communication pathways to solicit feedback from frontline staff on ways to make further improvements to the EHS system, and to recruit and retain more paramedics. Through this collaboration, and with our health care, government, and union partners, we will continue working to alleviate the pressure on the team and allow EMC's employees to take the time they need to recharge - especially after the last two years of responding to a pandemic.

On June 1st, we are excited to release a number of policies and updates that will not only keep more of the ambulances available in their communities, but also to help our teams get home on time. We are proud of the work that the EMC team carries out each day: those on the front lines and those supporting the front lines, providing excellent patient care as part of the EHS system. Even amongst these challenges there are many positive outcomes. The EHS system continues to receive notes of thanks from patients on a daily basis, reporting on the excellent and professional care they receive.

We know that the current situation is unprecedented and has many feeling exhausted. We're working hard with our partners and team members on solutions that will improve the system and benefit all Nova Scotians. Thank you.

THE CHAIR: Thank you, Mr. Daniel. Ms. Jensen.

JAN JENSEN: Building on Charbel's remarks, I would also like to thank the Chair and the committee for the invitation to be here today to discuss this very important topic.

EMC has been the proud partner of the Department of Health and Wellness and Emergency Health Services for over 20 years to provide all EHS services for the province, including the centralized EHS medical communication centre, ground ambulance and transfer services, EHS LifeFlight, and the Medical First Response program.

The EHS system has long been admired across Canada and North America. It is lauded for its evidence-based clinical guidelines, provincial standardizations of vehicles and equipment, and system integration across all parts of EHS, as well as with the health system. Our EHS providers and clinicians provide high-quality clinical care to Nova Scotians every day.

Nova Scotians are increasingly calling EHS when they are sick and injured. EHS call volumes have increased 34 per cent between 2011 and 2021, and emergency call volumes have increased in the first three months of this year compared to last.

Often the first point of access, the EHS system acts as an early indicator of strains within the larger health care system. Our hospitals are busy and depend on EHS for reliable transfers of patients to and from their facilities, as do patients and their families. Thirty per cent of EHS' call volume is for non-emergency patient transfer. About 140 transfers every day were completed in April 2022, with some days up over 200.

For emergency patients, when paramedics arrive at the emergency department, they often wait to transfer care to ED clinicians. When EHS paramedics are in emergency departments, they're not available to respond to emergencies in the communities. These offload delays are an indication of how busy the hospital system is. Many of these patients are sick and require paramedics to continue monitoring and care. EHS is working with our partners to reduce the impact of increasing call volumes, hospital closures, and ED offload delays on EHS service delivery.

In 2018, the government invested in a comprehensive and independent review by Fitch and Associates. Based on research and best practice, the report's recommendations are resulting in many positive changes, including improved flow of patients, in close collaboration with Nova Scotia Health Authority. We are participating in their Nova Scotia health care and command centre major project, and we're very supportive of that important initiative.

We've increased capacity of the EHS transfer service for patients who require transfer; increased capacity of EHS LifeFlight, with an additional adult team available during daytime hours; increased support to our callers through the medical communication centre team, with our onsite EHS physician and paramedic who call back to patients who are waiting; and we're moving forward with adding a nurse into the medical communication centre, which will provide additional support to low-acuity EHS callers to best be matched with resources that meet their needs.

We continue to work closely with Fitch and Associates to review our operational processes to continue to refine our system to meet the service demands and patient needs now and into the future. We work closely with our partners. Along with our focus on our team, as Charbel has just described, we take the performance of the EHS system very seriously - a system that we've designed and continue to refine together.

[1:15 p.m.]

On behalf of the EHS system, we encourage all Nova Scotians to continue to call 911 in the event of any emergency. The EHS system and our team will respond in the time of need. Thank you.

THE CHAIR: Thank you, Ms. Jensen. Mr. MacMullin.

KEVIN MACMULLIN: Good afternoon, everyone. Thank you for having us here today to once again highlight the serious issues plaguing our ambulance service. My name is Kevin MacMullin. I'm the Business Manager of IUOE Local 727 and I have been a paramedic for 42 years, and I still do the odd shift on the weekends.

I say "once again" because this is now the third time that we have stood in front of a government committee to beg for change - the first being in 2019. That's three years of repeated pleas. Our paramedics are struggling and it's only getting worse. How much longer are we going to leave our pre-hospital care system to crumble?

The time for action is now. We're dealing with a system that has been left to rot and our paramedics are the ones left to pick up the pieces. They deserve respect, dignity, and better wages. We've heard time and time again: We won't consider increasing wages because they are competitive with the Atlantic region. Well, I have news for you. We are not competing with the Atlantic region anymore. We're competing with Ontario. We used to be able to go to Ontario and recruit paramedics to come here. We can't do that anymore because they're being taken up in Ontario, and why would they come here when they can make more money in Ontario?

We're competing with Alberta. We're competing with career changes and early retirements. That is our competition, and they are beating us. Our paramedics are among the most highly skilled and trained in North America, and yet they are the lowest paid. We are facing a nationwide paramedic shortage, and our paramedics are highly sought after by other better-paying jurisdictions.

Nova Scotia is an incredible place to call home. I have called this great province home my entire life, and spent many of those years working as a paramedic. But for many, with the cost of living at an all-time high and wages at a despicable low, leaving is the only option.

Wage increases are possible, and they make a difference. This government saw that with the wage increase for CCAs, and we commend the action they took to improve staffing in our long-term care residences. Now is the time to do the same for our paramedics.

We have seen this government take a few steps toward improving the ambulance service, including the addition of non-paramedic patient transfer unit drivers and a new graduated licensing program, which I hope to share my thoughts on later in this meeting.

I will give credit where credit is due. The investment in power load stretcher systems for the ambulance fleet will improve safety for our patients and our paramedics. I know that this was a specific ask that union representatives had of the then-Opposition Leader. We commend him and his team for listening to our concerns, and the present government for continuing that aspect by making sure that every ambulance will now have a power load and a power stretcher.

You listened and you heard us back then. Please do again. Nova Scotians and our paramedics are begging you. Frankly, we are running out of time.

THE CHAIR: Mr. Nickerson.

MICHAEL NICKERSON: Good afternoon, everyone. I would like to reiterate my sincere thanks for having us here today. My name is Michael Nickerson, and I am a business agent with IUOE 727. I was a paramedic for nearly 19 years. It was bad when I was on the ambulance. It's worse now. It's getting worse every single day. The stories our paramedics share with us are heartbreaking.

Imagine logging on for your shift in Bridgewater just to be immediately told to head to Halifax, then finding out that the community you left - your community, your loved ones - has three pending calls with crews responding from over an hour away, or longer. Unfortunately, this isn't a rare occurrence. Imagine being so distraught and devastated that after a day's work you go home and vomit.

Imagine going to school, working hard and dedicating years of your life to helping your community just to go home at the end of every day feeling like you just can't take it anymore. Imagine being the paramedic crew who has to respond to call after call where a patient has died because you couldn't get there in time - not because of anything you did, but because of a system in tatters.

This is what our paramedics are facing every day. I was with Terry Chapman, our former business manager, when we first appeared before this committee. I was there when Tammy Martin, former NDP health critic, asked what would happen if I had a family member in cardiac arrest and called an ambulance when they were waiting to off-load.

Terry responded, "You wait with a person who will probably be non-living when they arrive." That was in 2019, and here we are again.

That message was frightening then, and three years later, it has only gotten worse. Now we have examples of this happening. We've seen article after article of Nova Scotians who have waited and waited and waited with their loved ones struggling before their eyes.

How is this acceptable? Ask yourselves: If this were you and your loved one, would you still feel like we're doing enough, or you are doing enough?

Back in 2019, following our appearance before this committee, PC MLA Karla MacFarlane brought forward a motion to have a meeting with two members of each caucus - the Premier, the Minister of Health and Wellness, and IUOE representatives. That motion was voted down.

I hope today that the now-empowered Progressive Conservative Party will have the same passion and desire for change that Ms. MacFarlane had back then.

Nova Scotians need change, paramedics need change, we all need change. Thank you.

THE CHAIR: Thank you, Mr. Nickerson, and thank you to all the witnesses for their opening remarks.

We're going to switch over now to the question-and-answer period. Just for the benefit of the witnesses, for those of you who may not have been here before, it's 20 minutes per caucus. Then at the end of that hour we'll revisit and see how much time we have left, and we'll split that up evenly among the caucuses as well.

We'll begin with the NDP caucus. They are going to direct their questions through me to you, and please wait until I recognize you before you answer the question.

Ms. DiCostanzo.

RAFAH DICOSTANZO: I believe we normally start with the Liberals.

THE CHAIR: We start with the Liberals normally? Everything I said was wrong. We'll begin with the Official Opposition, the Liberal Party. The time now is 1:23 p.m. I'll give you until 1:43 p.m. for the Liberal caucus. Who is going first? Ms. DiCostanzo, please begin.

RAFAH DICOSTANZO: Thank you, Mr. Chair. If you don't mind, if you can remind me by 10 minutes because I'd like to be very fair with my colleague and stop. I do

have two questions. I'll start with staffing and burnout and COVID. I'm going to ask either Mr. MacMullin or Mr. Nickerson to answer this.

We know that COVID has impacted the whole health care system, so I'm sure it has impacted emergency care as well. Maybe you can share with us what your experience has been in the last five, six months because of COVID, and especially the last wave.

THE CHAIR: Mr. MacMullin.

KEVIN MACMULLIN: COVID certainly has had an impact on the health care system in Nova Scotia. We see it daily with the nursing situation also, and that affects us when there are off-load delays. But the paramedics, yes, we are suffering due to COVID. It has impacted us because normally over the course of the year, a lot of our paramedics, if they have a sniffle they didn't want to go to work. So in some cases, we have paramedics who have no sick time left, so in effect, they are losing money. It's impacting their families as well. Plus, it's a shortage on our availability to staff ambulances, to be able to be response-ready across this province.

It's really tough when you are reporting to work and you are down five ambulances. That's tough. Our paramedics are suffering with that. It puts an added strain on them, both physically and mentally, because they have to respond more often. It means that they are wearing themselves down and wearing themselves out.

RAFAH DICOSTANZO: Thank you, Mr. MacMullin. Maybe you can also elaborate. We know that there are 29 permanent paramedic vacancies at the moment, but how many vacancies or people are out on sick leave? We know there are 29 you have vacancies for, but the true number of how many paramedics that you are short on a daily basis, if you can give us that.

KEVIN MACMULLIN: On a daily basis, we can be short. It depends on the day. It's up and down every day - it changes. We have some who are off on short-term disability, we have some who are off on Workers' Compensation, we have some who are off on long-term disability, and then we have some who are off on sick leave. It can vary. It can run anywhere from 200 paramedics to 250 who could be off at any given time.

RAFAH DICOSTANZO: That's really what I wanted to understand - the gap between the numbers that the department is giving us and the real numbers that you are short on a daily basis. Maybe you can let us know what the impact is and how you're trying to overcome these problems.

KEVIN MACMULLIN: The impact is that it stretches our resources, as EMC knows. They would like to see better resources also. It does stretch our resources, our ability to respond in a timely way. Calls are affected because of the shortage of staffing and shortage of ambulances that are normally on duty in each community.

Other communities are trying to cover those communities when there's a shortage. It has a big impact, and it affects our paramedics who are out there now on a night shift. They might be driving anywhere from 500 to 700 kilometres answering calls, covering areas off, responding to transfers. It's impacting them all, and that gets tiring on a person. They're missing their lunches. They're missing their time to get home on time. It means that they lose family time that they don't get to spend with their family.

[1:30 p.m.]

If it's a day shift and their kids are going to bed at night, and they're normally off at 7:00 p.m. and they don't get home until 10:00 p.m., the kids are in bed then. That's time lost that you'll never get back.

RAFAH DICOSTANZO: Maybe I can move on to a question that really matters to me as an MLA in HRM. I'm one of those MLAs who are so proud of the immigration and the increase in population that we've been seeing in Nova Scotia in the last seven years. This is a dream that I looked forward to. I've been here since 1984 and think that density, diversity, and what immigration is doing is wonderful.

However, I'm confused and trying to understand how we are missing the boat constantly, whether our government, the new government, on preparing for the future. We have thousands of people moving in, whether it's immigration or migration, it's all positive, but there are services that we can't offer to them.

For example, Cobequid Community Health Centre. It was built 20 years ago and has the ability to have an emergency, and it does operate as emergency, but for the last 20 years, we've operated at 50 per cent of the time. My question is: What happens at night when we close Cobequid? How many trucks are we missing transferring people unnecessarily every day, from Cobequid to only two emergencies that we have in this huge population?

Fifty per cent of the population of Nova Scotia is in HRM, and we have just two emergencies, plus Cobequid. Why hasn't Cobequid been offered as a solution, as a third location 24 hours? Can somebody make me understand what happens at night at Cobequid - how many trucks, how many patients - and if the department maybe can comment after on what their solution is, and if they've seen this issue? This making Cobequid 24 hours is an easy solution for the influx of patients that they're having, that they're adding to the emergency at Dartmouth General Hospital and at Halifax Infirmary.

THE CHAIR: Sorry, you'd like to direct that initially to Mr. MacMullin, and then to the department?

RAFAH DICOSTANZO: Please, and then the department. What is the solution?

KEVIN MACMULLIN: That's more of a question for the department itself. But yes, you are absolutely right, it's fantastic that we're a growing city here in Halifax, that's remarkable. Immigration is to be commended for that, and the opportunities that are here. Part of the solution is that we're going to have to increase the amount of paramedics and units in this municipality. Right now, we're dragging units out of other municipalities and other counties, to come in and keep up with the pace of the fastest growing city in Canada. That's a recruitment drive that we're going to have to do.

THE CHAIR: Thank you, Mr. MacMullin. Mr. Beaton, would you like to offer a response?

CRAIG BEATON: Sure, thanks for the question. Specific to Cobequid 24-hours, that's part of health services planning that we do with the Health Authority, so they would be the ones that would advise us on their resources and the availability of being able to turn that facility into 24 hours. There are a lot of mitigations that are in place currently.

I think I would ask Charbel to talk about what happens in terms of the transfers back and forth because there has been a lot of work done to be able to support dedicated transfers to and from Cobequid to both the Dartmouth General and the Halifax Infirmary. I think Charbel would be best to speak to that, if I could ask him.

CHARBEL DANIEL: Thank you for the question. During the evening when Cobequid is closed, the transfers are booked in to come into the NHI as the main point. Previously - I would say probably eight or 10 months prior to - it was several units that would be assigned to this to help move these transfers in.

Since then, we've actually established and put on a dedicated unit that coordinates and collaborates with the NSH in making sure that it has the transfers lined up and knows exactly where they need to go in order to help facilitate those movements to their appropriate location.

Above and beyond that, we've also done some significant work within our transfer service by expanding that two-fold on the patient transfer side. We've introduced non-clinicians, called transport operators, that have allowed us to increase that capacity by 100 per cent. We continue to do that increase on the multi-patient transfer units, which was just completed last week. We hope to see further expansion on that side as well.

THE CHAIR: Thank you, Mr. Daniel. MLA DiCostanzo, we are at nine minutes, 53 seconds remaining.

RAFAH DICOSTANZO: I'll try. Maybe I'll continue the same question in the second round and give it to my colleague for now. Thank you.

THE CHAIR: MLA Clark.

BRAEDON CLARK: Thank you, Mr. Chair. I just wanted to start with something that Mr. Daniel was just mentioning around patient transfer, which I think is a really important part of the conversation.

Last October, there was a news release that went out announcing $3.1 million in new funding for patient transfer units, 28 new drivers, double the total number of patient transfer hours. The department was actually mentioning this on social media today, and it's a wonderful concept. However, it's not clear to me if that has actually happened yet. The commitment was that the province-wide coverage would be in place by the end of the year, meaning 2021. Perhaps Mr. Beaton could give the committee an update - if that is actually in place yet or, if not, when it might be.

CRAIG BEATON: There are two different types of transfers. I can get Jeff maybe to elaborate a little bit on each one. There's the medical transport service, which is the MTS units. That's the one that we had indicated we would have available to the entire province by the end of 2021. All those routes have been added onto the system.

The MTS units deal with low-acuity patients - typically those who don't need care enroute, so a lot of appointments. You are looking at dialysis patients, et cetera, moving patients in and out of the system.

The patient transfer units - specifically it's mostly done for inter-facility, in between hospitals, moving people from one hospital to the other. To give you some indication on that, I do know that a couple of years ago - I don't know the exact date, I think the latest stats we have would have been last year - roughly 55,000 transfers are done out of the 180,000 calls that we answer every year. That used to be that 70 to 80 per cent of those transfers were performed by an ambulance, so one of the mitigations was to try to develop new models of delivery, which is MTS and PTU. I'm happy to report that just last April, only 34 per cent of those transfers are now being done by ambulance, and the majority of those now are being done by MTS and by PTU.

To give you an example of some quick math on that, if we're doing only 30 per cent, we're taking 20,000 ambulances off the road from being dedicated to doing patient transfer to actually being able to respond to what we want them to be doing, which is emergency response - which then gets to providing more timely response in communities. It's a significant change in the system - I know Kevin talked about it in his opening comments - and one that we think is a real benefit.

I'll let EMC speak to how the workforce is seeing that, but from our end, it's a real positive.

BRAEDON CLARK: Thank you for that, Mr. Beaton. Just to be clear, the end-of-the-year timeline to get to province-wide for the MTS was achieved? Am I understanding that right?

CRAIG BEATON: Yes.

BRAEDON CLARK: Another project that I'm interested in was a pilot project announced in July last year for the QEII, building on a previous pilot project that was in place at Dartmouth General, dating back to about 2017-18, I believe. It's a $3 million investment at the QEII, having two teams working around the clock to ease the pressure on what I understand - and granted, I'm not the expert - is the bottleneck point, which is the transfer piece from the ambulance to the in-patient at the hospital.

The results at Dartmouth General, according to what I've seen, have been very good in terms of a 65-per-cent or so reduction in offload times, which is fantastic. That project at QEII announced in July, was supposed to start in September 2021. I'm just wondering if that project is up and running. If it is, what have the results been thus far?

CRAIG BEATON: Yes, that project was announced. I think what you're referring to is the offload teams, also called transition teams. Throughout the Summer and the Fall, with waves of COVID, staffing was obviously an issue in terms of trying to stand those up. The Health Authority has been able to stand up the teams, to have those transition teams operational at the QEII. They've been fully operational since December.

We're definitely seeing some impact, but offloads, as you know, are a symptom of a broader system issue in terms of access. The offload teams are supportive at the QEII. I don't have the direct results in terms of details to share with you today, in terms of what the percentage is, but anecdotally, we hear through the NSH that those have been beneficial.

BRAEDON CLARK: Perhaps I would just ask Mr. MacMullin his view, if he has one, on those pilot projects that existed at Dartmouth and at the QEII, and if he thinks that's a good step forward in the system.

KEVIN MACMULLIN: Yes, it's a step forward to have these pilot projects work and that, but still, where we're missing the boat here. The problem we're having is in retaining our paramedics. It's an issue. We lost 13 paramedics just in the month of April who left us. That's a significant impact on our operations. We have to stop that.

Everything we try is a step in the right direction by both EMC and the government. However, we have to stop losing paramedics. We have to retain what we have. Those 13 paramedics were all experienced paramedics that we're losing - people with a lot of experience. We can replace them with people, new paramedics, but those new paramedics won't have the experience that the ones leaving us have.

THE CHAIR: MLA Clark. Three minutes and a few seconds left.

BRAEDON CLARK: Thank you, Mr. Chair. I guess I would just follow up with Mr. MacMullin around the 13 paramedics who have left. Obviously, nobody wants to see

that. I asked Mr. Nickerson - we talked about this before the meeting started - if there was one thing, what would be the first step to make sure that that number of 13 is six, and two, and then zero, and then we start moving in a positive direction? In terms of a first step, what would you suggest?

KEVIN MACMULLIN: Thank you, Mr. Clark. The first step would be to bring our wage renumeration up to par where it is across Canada. We have to be competitive. We have to look at retaining who we have. The members who left, those 13, I'd like to be able to call them up today and say, guess what, the money is there - we now are at a level that we're comparative with Ontario and other places.

I'm sure the people who are travelling out west for two weeks at a time would like nothing better than to have their two weeks here and make it four weeks. They'd rather come back and be here where their children are, where they can see them grow up. They don't want to be away for two weeks at a time, and it's the same with others.

We have to look at retaining, bringing back what we lost, and attracting more people here. We've got a beautiful province here in Nova Scotia. We have the highest-skilled paramedics around. We have the challenges for the paramedic who wants to come down here, learn the ropes, and find out what it's like to be a paramedic in Nova Scotia. They'll be challenged. They'll be assisted with all these challenges. We have a lot of programs available here for paramedics.

BRAEDON CLARK: I just want to go back to something that Mr. Beaton mentioned earlier around the pilot project at the QEII Health Sciences Centre. Two questions, I guess, in the time I have remaining. He may not have enough time to answer, but we can get back to it. When do you think there might be results available from that pilot project - statistical, formal results? Are there discussions under way to consider expanding that beyond HRM to other parts of the province?

CRAIG BEATON: It's complex, because the in-and-out flow of the hospital changes every day. So it's really hard to determine whether or not we're going to have concrete results and whether or not they're attributable directly to the offload teams themselves specifically. We do know from talking to front lines that they are certainly making a difference. We've been hearing that from some of our physician leadership at the QEII as well.

One of the other big pieces that we're looking at in terms of some changes around access and flow is - you might have heard it referred to as a command centre, formerly called a care coordination centre. Work is under way on that project right now. That's about to bring some real-time data analysis, specifically starting in the Central Zone. This is modeled after both Humber River Hospital as well as Atlantic Jewish. We had teams up there last week, actually, looking at some of the benefits and impacts of care coordination.

THE CHAIR: Order, please. The alarm means 20 minutes are up. I don't mean to be rude, but those are the rules of the game here. When 20 minutes are up, 20 minutes are up. We will now switch gears to the NDP caucus. I was advised by the clerk that it's not set in stone that the Liberals have to go first - it's just been tradition. However, we will now switch to the NDP caucus. MLA Leblanc.

[1:45 p.m.]

SUSAN LEBLANC: I don't have any questions left. Just kidding. Thank you all for being here.

It's heartbreaking to hear the stories that you bring to us. This is the third time I've been at committee with you, Mr. Nickerson. I've also talked to colleagues, other paramedics, and it's just terrible. The stories are terrible. You really hit it home, Mr. MacMullin, when you talk about how people can't go home and put their kids to bed, or they have to be away for two weeks, and they miss two weeks at a time, and they miss watching them grow up. These folks work so hard to keep us safe in Nova Scotia and they deserve better.

The last time you were here, Mr. MacMullin - sorry, not here, but at the Public Accounts Committee - it was in February. At that time, you said that if you had a magic wand, you would add 250 paramedics to the force right away. You've mentioned today that in April there were 13 paramedics who were lost. I'm wondering if you keep track of that as a long-term thing, or have you been keeping track for a long time about how often folks are leaving? Can you tell us if you know if they're going to other jurisdictions or other professions - or none of the above, something else?

KEVIN MACMULLIN: We're trying to keep track of it, more so since January. We see that we are losing approximately 30 paramedics so far this year and that over the course. It's difficult to track, but we do know that some of them are leaving for other jurisdictions. Some have gone to P.E.I., some have gone to New Brunswick, and some are out west.

Some people are going to what's called NSHA - Nova Scotia Health Authority - working in hospitals. That's a big attraction now. The hospital system is in deplorable shape also. They can't get enough nurses through their nursing program so paramedics are now being hired to come into the NSHA, do triage and be department paramedics to assist because they are highly skilled, highly trained and they are a valuable asset and we're losing them.

We don't want to lose them there. We don't want to lose them anywhere. We want them back here in Cape Breton. I mean in Nova Scotia, sorry. I'm being a Cape Bretoner - John knows that.

THE CHAIR: Thank you, Mr. MacMullin. MLA Leblanc.

SUSAN LEBLANC: We've heard loud and clear that part of the problem is wages for paramedics. We hear it's a national problem. We also hear that our paramedics are sort of at the same rate as around the Atlantic Provinces, but as you point out, we are not competing with the Atlantic Provinces - we're also competing with Ontario and Alberta.

Have you heard anything from the government about a plan for competitive wages for the paramedics here?

KEVIN MACMULLIN: Nothing yet. We haven't heard anything substantial that they are looking at it. We're hoping. We keep having meetings with the government all the time and I keep bringing up wages. We have a workforce planning group. We have a meeting on June 1st and that will be discussed again. I'll be bringing it up. It's the conditions that paramedics are working under that are deplorable. They are leaving because not only for the high wages but the conditions of work in other jurisdictions sometimes are a lot better. They are leaving for that. They need a break.

We need to get them back. Wages are going to solve it in that. CCAs got an increase of 23 per cent, so the enrollment went from 300 in their schools to 910. That's significant. Imagine what it would do in Nova Scotia. I'm certain we would see enrollments in our schools increase if the amount of remuneration was competitive. When they come out, they are going to start at a salary that's going to be affordable with the price of everything today and inflation - where it's at the highest in 31 years - and a big student debt because they have to spend a lot of money to become a paramedic.

SUSAN LEBLANC: Thank you for that. You mentioned that you have been meeting with the department but in another meeting that we had, you mentioned that you had been trying to get a meeting with the minister and the Premier. I'm wondering, have you met with them yet?

KEVIN MACMULLIN: No, unfortunately I haven't had the opportunity to meet with the minister or the Premier. I would love to have a meeting with either, or both. We want to bring solutions to the table. We don't want to be part of the problem - we want to be the solution to the problem.

SUSAN LEBLANC: That seems right up their alley since they are the solutionists, Mr. Nickerson. They should want to talk to you right away, if that's true.

We've heard anecdotally that some paramedics will call in sick near the end of their shifts so they can get home in time and not have to go over - referencing what you were saying about missing bedtime and that kind of thing, and to get some rest, of course. We also know that paramedics quickly run out of their sick time because of COVID, and that

they can't always get access to the short-term leave that they need. Can you speak about the challenges facing paramedics, in terms of getting time off?

KEVIN MACMULLIN: The challenges are immense to try to get time off. If you look at January, February, March, April, it's hard to even get time off then - we're that short-staffed. It's very difficult to fill the gaps. People calling off at the end of their shift are usually facing perhaps an hour's drive home to their base, or even two hours. They are fatigued, they are tired, so they have to call off. They have to report off sick in order to get back home and try to get some rest. They're going home, but it's early in the morning and they have to be back out on night shift that night. It's difficult.

SUSAN LEBLANC: Something that not everyone realizes is that the system is in an even worse state now than, say, during the first few waves of COVID. Does the union have the number of Code Criticals issued this year, like since January? Can it be provided to the committee?

MICHAEL NICKERSON: Thank you. I think I do have updated stats - just bear with me here. Since the PCs took office on August 31, 2021, there have been 1,183 Code Criticals in the province. Again, that's since August 31st.

SUSAN LEBLANC: Thank you for that. Can you just define once again what you define as Code Critical?

MICHAEL NICKERSON: Sure. We characterize Code Critical as two or fewer ambulances available to respond to emergencies in a given county.

SUSAN LEBLANC: I wanted to ask about the dispatch situation, the dispatchers. I'm pretty sure what I heard Mr. Daniel say earlier was that you made the shift so there are dispatchers now who aren't necessarily paramedics working in the ambulance dispatch. What I think I heard you say is that it is going to be freeing up paramedics to go from dispatch. Non-paramedics can do dispatch now, so that means that the paramedics who are there can do other things.

I'm wondering if anyone can speak to how many paramedics have left dispatch and gone back on the trucks. Do you have that number?

THE CHAIR: Who is best suited to answer that? Ms. Jensen.

JAN JENSEN: Thank you, Ms. Leblanc, for the question. Just to clarify, when that change was made, that was a small change to the hiring requirement for a communication officer within the EHS medical communications centre.

Previously it was a requirement to be a licensed paramedic to be hired into that role. That now is an asset, so it's not a requirement. If a paramedic applied to that position, they certainly preferentially would be selected, if they were the appropriate candidate.

We haven't had paramedics or former paramedics who were communications officers as a result of this leave to take employment in the ground ambulance system.

SUSAN LEBLANC: Just to clarify your answer, you said there have been none who have taken leave to go back onto the trucks, is that right? Is that what you just said?

JAN JENSEN: That's correct, yes.

SUSAN LEBLANC: I'm wondering if someone from IUOE could explain, from your point of view, why it's important to have a trained paramedic on the line in an emergency while one waits for an ambulance?

KEVIN MACMULLIN: I was a former trained dispatcher in Cape Breton. I believe it's important because while there is a script to follow, as a paramedic, you have an understanding of what is going on in the field, so you may want to be able to respond more appropriately with other resources. It just jumps you ahead a little bit to be a paramedic when you are doing dispatch in that. As I say, I think that gives just a little better edge to things.

SUSAN LEBLANC: The last time we met at Public Accounts Committee, there was some conversation based on a request from paramedics to have a provision of statistics around half-staffed or empty ambulances, hours of forced overtime, and the numbers of paramedics who are not able to access vacation time. At the time, Mr. Beaton and Ms. Jensen both committed to going back and seeing what information could be made available. I'm wondering if either of you have any updates.

CRAIG BEATON: Sorry, I missed the question. Could you repeat that?

SUSAN LEBLANC: When we were at the Public Accounts Committee on the same topic, we talked about wanting to access stats around half-staffed or empty ambulances, hours of forced overtime, and the numbers of paramedics who are not able to access vacation time being provided. At the time, you and Ms. Jensen said that you would go back and look for some information and statistics. I'm just wondering if there are any updates on that.

JAN JENSEN: I don't have statistics on those particular things right in front of me here today. I know that there has been increased transparency around vacation. Perhaps Charbel, you may prefer to speak to that.

CHARBEL DANIEL: Vacation and time off has been a high priority for us. We've been working very hard with the union to try to ensure that the paramedics have the time off that they need. This year - as an example, with the seniority vacation bidding process that's happened as part of the collective agreement - has seen the highest uptake in our organization's history for people submitting vacation, and also the highest approval rating for approving that time off.

Just as an example, there are roughly about 11,000 shifts to cover off for vacation per year based on the workforce that we have. Through the seniority vacation process, prior to the year even starting, before April 1st, about 6,000 of those shifts have been approved. Just to give it as an example, for year over year, last Summer, during the months of July and August, where there were about 1,000 vacation shifts that had been approved, this Summer we've already pre-approved 1,500 vacations. We've made it a very high priority for us to ensure that the team gets the time off in order to recharge and recoup. We've been very happy to collaborate with the union on that to make it happen.

SUSAN LEBLANC: It still would be good to get all those other stats though. If you can keep working on that and get back to us, that would be great.

When the previous Liberal Government released the Fitch report finally, two years after its publication, we could see more details about what people who work in emergency care have been telling us. For example, it said that on average, ambulances spend one and a half hours offloading patients for Category 1 calls, three hours, 15 minutes measured on the 90th percentile, and that the system needlessly wastes the equivalent of 13.5 ambulance 12-hour shifts per day waiting at hospital EDs to offload patients.

Of course, that was in the Fitch report, which basically was a while ago, so these numbers could be very different now, but the standard wait time goal is 20 minutes at the 90th percentile. Wondering, to the department, have offload times gone down since the report was published?

CRAIG BEATON: In terms of the specific data around whether or not offload times have gone down since the Fitch report, I don't know, but maybe Jeff might be able to speak to that. I can tell you that in terms of meeting the standard of offload times across the province, it's typically right now around 34 per cent of the time we meet the standard.

THE CHAIR: Mr. Fraser.

JEFF FRASER: I can confirm that the offload times have degraded a little bit over the last year. You can probably attribute a lot of that to the impact of COVID on the operations.

SUSAN LEBLANC: Can you speak to that a little bit? I think I just want to follow up on that. Offload times, we're only reaching the standard 34 per cent of the time, which

seems pretty bad, and you're saying that you think it's because of COVID-19. Can you unpack that a little bit for me?

[2:00 p.m.]

JEFF FRASER: We have seen a bit of a degradation over the last year. We believe that a number of factors are contributing to this. There's no doubt that there's an increase in call demand - that's one of the things. COVID has added to everybody's operation a significant amount of latency, so there's dressing and undressing, and things they need to get ready. Again, although we've seen some relief, perhaps, in the last few months, but over the course of the last year, it's been fairly complicated as we take patients into the emergency department.

The other piece is that we're taking patients a lot longer distances because we've had to deal with these closures as well at the emergency departments. So of course, we get to the hospitals and they're a little bit busier. These are all factors.

Our focus, though, has been looking at what we can do to keep some of these people out of our hospitals. What we do know - although somebody had alluded to it earlier - is 50 per cent of what we do really does happen here in the Central Zone. We use a scale called CTAS when we look at our patients. It's a way we work with the hospitals to categorize patients. About 70 per cent of the patients that we see within the EHS system are CTAS threes, fours, and fives. The fours and fives are relatively stable.

Much like we talked earlier about our intention to continue to separate out our system into a split production model and have transfers done differently than leveraging across the emergency and urgent ambulance fleet and staff, we are also looking at innovative ways. Some of it was mentioned through the opening remarks around leveraging off our physician in the communication centre and our nurse program that we're putting in place. This allows us to deal with those patients in a much different manner than just taking them to the emergency department.

Although we are seeing some increases in offload, as a system we're looking at what we can do differently to have a patient-centred safe impact. What we do know - and this was highlighted in Fitch's review in 2019 when they were here - there are other things that can happen. Transportation to the hospital is ancillary, not mandatory.

We're looking innovatively not only internally at what we can do but looking at some of the best practices around the world, and how other systems have tackled these challenges. We take far too many people to the emergency department who probably could benefit from a new care plan or a different care pathway. That's really what our focus is on - to take that pressure off.

A lot of the people who end up in those hallways are people who are sick, but marginally sick. So what can we do for them to keep them out of the emergency department and give them the care that they really need? We see a lot of people in our system. We know that with the tools that are in place and the things that we continue to develop, we have an ability to make a patient-centred safe impact. That's really where our focus is going to be. It's less about taking more people to the hospital.

More ambulances, more doctors, more nurses don't always mean better care. It's about using the resources we have in the most efficient way. That's really where we're spending our time right now: what can we do as a system to take pressure off the overall health system but provide patients with a much better experience? In turn, we're confident that the providers will have a much better experience.

THE CHAIR: MLA Leblanc with 15 seconds.

SUSAN LEBLANC: Invest in community collaborative care centres. That will take some pressure off the paramedics. People will be healthier. More later.

THE CHAIR: We'll now switch to the government side of the House. We'll begin with MLA White.

JOHN WHITE: Before I begin, I want to recognize that we're about to enter EMS Week. On behalf of the government, I want to express sincere gratitude and appreciation for the job you folks do, day in and day out. I believe the theme is Faces of Paramedicine.

Kevin, you and I have known each other for 35 years. Your long-time partner, Rick Young, grew up on the same street as me. We grew up playing road hockey together. I trained in martial arts with Troy Bennett and a long-time friend we lost, Tony Neville, who was a paramedic. Your firefighters - Keith Wilcox, Keith Politte, who are still serving with you, and I fought fires alongside of - I can tell you that on behalf of the Glace Bay Volunteer Fire Department, and as a medical first responder, when I see you guys show up, you are the face of angels. I mean that sincerely. That's how we think of you. I believe all MFRs look at you that way.

Mr. Beaton, we were excited to learn about the $3.5-million investment to modernize ambulance equipment. I believe it was a great solution to a long-time issue. As a medical first responder, I've responded to many lift assists. Can you tell us a little bit about how these are going to make it safer for paramedics, and for patients as well?

CRAIG BEATON: One of the key injuries that we are aware of, through the data that we have and working with our partners at EMCI, are musculoskeletal injuries. These power loaders and stretchers will make it much easier for paramedics to be able to load patients in and out of the ambulance.

The $3.1 million investment will outfit all of our fleet with these power loaders and stretchers. Currently, we have it installed on 60 per cent of the fleet. It is targeted that I think before the end of the year, all of our fleet will now house these.

I don't know, Charbel, if you would like to give a little bit more of a description on how the workforce will benefit from these, I think that would be good.

CHARBEL DANIEL: Just building on Mr. Beaton's comments, as you mentioned, a significant number of the leaves that we have are musculoskeletal, and lifting and moving patients. These power loads, power stretchers, really take all of that pressure off the paramedics to have to do all that lifting and moving. We're looking forward to the completion of this project.

Another piece that's also in the process right now, and we'll see the rollout of it next month, is our first-in kits. This also focuses on a very similar strategy, which is a redistribution of the first-in kits that paramedics bring in on scene. They have a lighter distribution to help reduce the number of musculoskeletal injuries as well when carrying in the equipment to deal with these 911 calls. We're very excited about these initiatives and it's important to move them forward.

JOHN WHITE: Excellent. Did you say the end of 2022 for installation?

CRAIG BEATON: Yes.

JOHN WHITE: What are some of the common barriers for delivering emergency services in rural Nova Scotia?

CRAIG BEATON: Specifically with rural Nova Scotia, I think the common barriers are very similar. Staffing is obviously a key issue in relation to EHS, but also in the broader health system. One of the things we do experience a bit more in the rural parts of the system is due to staffing issues within the health system. We see closures of emergency departments, and I think Mr. Fraser alluded to that earlier, that you do start to see longer transit times. That would be one of the key ones. Jeff, did you want to add to that?

JEFF FRASER: Yes, as Mr. Beaton alluded to, there's no doubt that there are a number of things that really complicate accessing people in rural areas: our staffing complement of the EHS system, the ability to off-load within the target, the transport destination is key. So even though we do have a number of emergency departments closed, we also have protocols within the EHS system that we take the patient to the most appropriate facility.

Sometimes some of the smaller community hospitals may not ideally be where we need to take that person if they need definitive care, and we have to drive them a lot longer.

It's the right thing to do for that patient, but it does complicate things in rural Nova Scotia, that's for sure.

The other challenge is our system has been built in mind that we match resources where there is demand, and there is demand in our larger areas. That's where most of our call demand is. That's a balancing act for us that becomes harder and harder to balance as time goes on. That's why we're spending so much time looking at what we can do as a system to keep people healthy and out of the hospital.

EMS systems have been designed to be reactive. We're really looking at what the opportunity is here in Nova Scotia for the EMS system as we look towards the future, building it with what we can do to help people remain in their homes longer. We demonstrate that around some of our community paramedic initiatives.

JOHN WHITE: Ms. Jansen, how are recent staffing changes that allow for hiring your staff without paramedic improve the response times?

JAN JENSEN: Mr. White, would you mind clarifying?

JOHN WHITE: I understand there were some recent changes - that you could hire staff without paramedic training, such as the patient transfers and stuff like that. I'm just wondering how that will help in response times.

JAN JENSEN: Okay, great - now I understand your question, Mr. White. Thank you very much. I'll start and then I will hand it over to my partner here, Charbel, to build on it a little bit.

We have put a lot of focus around increasing the capacity of the transfer system, which you've heard referred to here today several times. We have also discussed here today that we have an objective to decrease the number of interfacility transfers or non-emergency transfers that are completed by our emergency ambulance paramedics, and to shift as many of those as possible onto our patient transfer units and our medical transport service units, as they're a more appropriate resource for that requirement.

We're aiming to continue to drop that, but we're down from approximately mid-60s or so completed by emergency ambulances into the low 30s, and we'll continue to move that forward. I'll pass it over to you, Charbel, if you have more you'd like to add.

CHARBEL DANIEL: No, I have nothing further to add. I think that sums it up quite well.

JOHN WHITE: I'm just wondering, are other jurisdictions using non-paramedic staff in a similar way?

JAN JENSEN: I'll start again, and I'll hand it over to Charbel. Yes, many other EMS systems use clinicians other than providers in transfer units that are dedicated for that purpose. That is very common in EMS services everywhere really - certainly across Canada.

I will make one more comment just to build on your previous question. By decreasing the number of transfers completed by emergency paramedics and ambulances, the goal is to increase their capacity to be available in the communities to respond to 911 calls. I think that's what your first question was. That is the objective we're driving toward with increasing the capacity in the transfer service.

JOHN WHITE: Can you tell us anything on what steps you're taking to make sure that delivery is done safely? Are there any special steps in that regard?

CHARBEL DANIEL: Sorry, could I just ask for clarification?

JOHN WHITE: If we have non-paramedics transferring patients, I'm just wondering, are there any special steps put in place to make sure it's done safely?

CHARBEL DANIEL: Prior to this change, our patient transfer units are non-response ready. They don't have red lights on them, they don't have sirens on them. They're not designed to respond to emergencies. In fact, internally they're not outfitted to deal with a true emergency. So upon transportation, if they did encounter a patient who started to deteriorate, the protocol was to pull over and to call 911 to have an ambulance arrive and support it. That hasn't changed.

As well, even though the configuration has been changed to having a non-clinician on the vehicle, that non-clinician is operating as the driver of the vehicle. The care that's provided in the back of that patient transfer unit is still done by a paramedic for all the transfers that take place.

JOHN WHITE: Excellent. Ms. Jensen, a different question. Can you tell us about the model of care behind urgent treatment centres?

JAN JENSEN: I wouldn't be the right person to speak to, where the urgent care centres aren't an EHS initiative.

THE CHAIR: MLA White, we'll direct it toward Mr. Beaton?

JOHN WHITE: Please, Mr. Beaton, if you can answer.

CRAIG BEATON: The urgent treatment centres have been instituted in two locations - in Parrsboro and in North Sydney. Those are used as an opportunity where we're not able to have a full-staffed emergency department but still able to provide

emergency treatment. Not all EHS calls would actually end up there; they would be more of a day treatment for emergency care in those locations.

[2:15 p.m.]

JOHN WHITE: To elaborate on that question - and this is my final comment - I understand that one in three ambulance calls do not result in patient transfer. I'm assuming that the urgent care clinics would be where those patients probably end up. I'm wondering if that ends up resulting in more ambulance availability. I think that's the line of question I'm asking.

CRAIG BEATON: I'm happy to kick it over to my colleagues here at EMCI, but you're correct. About one in three ambulance calls do not actually result in a transfer to a facility. They're actually treated and released by the paramedics on site, which I think is a big testament to the professionalism and scope of paramedics who are able to actually show up on site, treat the patient, and provide them with a positive outcome, and then not have to transfer and leave. I don't know, Charbel, if you or anybody has anything to expand on that, but you were correct in that.

CHARBEL DANIEL: One of the strategies is to create alternative patient dispositions, or alternative pathways for patients to be seen, so that an ambulance 911 call or an ED visit isn't always necessary. These urgent care centres truly help fill that void and gap.

Even outside the calls that we are responding to and that we do a treat and release through our clinicians, it also provides them a pathway to not even engage in the 911 system and go to an urgent care centre where they can be seen and treated.

JOHN WHITE: I want to pass it over to MLA Palmer.

THE CHAIR: MLA Palmer.

CHRIS PALMER: Good afternoon. Thank you for being here again. I know it's probably a little frustrating to be here again, speaking to the same issues after a few times, but as a new committee member, I'm listening - the messages are coming in loud and clear.

Many of us have met with many paramedics and people in our offices, so the challenges are real. I represent an area that has had some of the highest Code Criticals that are out there - in the western region - so I'm really interested in the solutions, for sure.

I'd like to direct my first question, if I could, to Mr. Beaton. We know the staffing challenges have been discussed here - recruitment, retention is very important. They have been long-standing challenges in our health care system for a long time.

If I could ask Mr. Beaton: What would you say the primary drivers of the staffing challenges among paramedics are, and what is the department doing to address those at this moment? We've touched on a few of them, but if you could drill down on that for me, I'd appreciate it.

CRAIG BEATON: Thanks very much. I would say that staffing challenges within the health system in general - not only here in Nova Scotia, but also jurisdictionally and across the globe. We know there are significant issues there.

Specifically with paramedics, one of the things that we are doing is working collaboratively with our partners at the Office of Health Care Professional and Recruitment. That's the new office that has been set up to look specifically at the intention of trying to recruit and retain health care professionals. They are active in that work.

It has been alluded to here earlier that they also sit on the paramedic workforce committee, which members on this side of the floor actually all sit on, including the union, as well as the college, EMCI, the Office and the department. That is really looking at some of those more immediate solutions like temporary licensing of graduates, but also looking at longer-term solutions around health workforce planning and what the models of care may look like in the future - so forecasting out how we can utilize paramedics for broader system delivery.

We know there is a finite resource of those currently right now, so looking at things like training, and ways to incentivise paramedics or for those who are thinking of getting into the workforce. Those are all key pieces that this committee is looking at.

We've seen some early wins, as I've mentioned, around that temporary licence. Those are some of the key things that we're currently doing with that committee.

CHRIS PALMER: Thank you, Mr. Beaton. Thank you for touching on the temporary licence and some of those initiatives that the government has taken so far.

I guess a question I would have is: Is there a process in place to ensure that paramedics who do have a temporary licence can safely work with patients before they write their national exam to gain full licence qualifications?

CRAIG BEATON: There is a process in place where they work with a fully licensed paramedic. They are not currently working unsupervised at this point. That would be the procedure and process in place right now.

CHRIS PALMER: I would just like to say that it's great that we are getting the information today, but what I'm really interested in hearing, and excited to hear, is that there is communication between all the groups that are represented here today - that that

communication is going on there. That's my final comment. I think I'd like to pass it on to my colleague, MLA Barkhouse.

THE CHAIR: MLA Barkhouse.

DANIELLE BARKHOUSE: Mr. Beaton, are there any strategies to encourage Nova Scotians starting their careers to consider becoming paramedics?

CRAIG BEATON: Mr. Fraser actually chairs our workforce planning committee with the union, so I think I'd ask Jeff to speak to that.

THE CHAIR: Mr. Fraser.

JEFF FRASER: Thanks for the question. As Craig alluded to, this workforce piece - we're looking at everything. We're looking at recruitment. We're looking at retention. We're looking at how to attract people into this profession that's under a lot of duress right now.

MLA Palmer pointed out that we're working together. Having the college, having the schools, having the employer, having the union there together - and having the office to quarterback - is allowing us to look at everything. Today, I don't have anything to update you on, but I will tell you - as I think Mr. MacMullin alluded - we have a meeting coming up on June 1st, and a pretty full agenda. That's one of the things we plan to discuss. The work continues. It's pretty intense. We're at it every week, trying to push things forward.

DANIELLE BARKHOUSE: Ms. Jensen, when one part of the system is broken, it impacts the entire system. I know that this was touched on a few times here today. What work is being done to support access and flow in the system, more broadly, that will help improve offload time?

JAN JENSEN: Thank you very much for that important question. I can speak a little bit to what we're doing in terms of the EHS system - the EHS operations. We certainly are collaborating very closely with our partners and our colleagues at Nova Scotia Health in all aspects of patient flow, particularly when the need for EHS transfer is there and for solutions around ED-offload delay.

We've already spoken about increasing capacity within the transfer service. We have hired a patient-flow manager who works between our medical communication centre, our operations and LifeFlight teams, and with Nova Scotia Health for coordination and prioritization of EHS patients who require transfer.

We are working very closely with Nova Scotia Health on their initiative around the care and coordination centre. We're sitting on their project teams and looking forward to that project being launched. Even operationally now, our patient-flow manager and our

leadership teams within operations and the medical communication centre are working quite closely with Nova Scotia Health around increasing that coordination and flow. As patients continue to flow throughout the health care system, that will assist in ED-offload delay and moving EHS patients through.

Those are some of the efforts that we're putting in to collaborate and work toward those solutions.

DANIELLE BARKHOUSE: Ms. Jensen or Mr. Daniel, government has signed a new contract with EMCI last year. What is different with this new contract, and how will it help address issues in the system?

JAN JENSEN: One of the big changes within the DHW/EMC contract is a major focus around clinical performance, and to expand the look-around performance and monitoring within EMC.

THE CHAIR: Order. Apologies - time is up.

Gauging the time that we have left, and considering that we have a couple of committee business items to address, we will offer eight minutes per caucus for round two. We will begin with the Liberal caucus, starting with MLA DiCostanzo.

RAFAH DICOSTANZO: Thank you, Mr. Chair. I've chaired many, and it's always been the Official Opposition that started first. I apologize to Judy if I was wrong, but that was my understanding as a Chair.

Again, thank you. Maybe I can go back to what I started about HRM. I looked up how many emergency departments we have in Nova Scotia. It came up 37. In Halifax or in HRM total - 50 per cent of the population lives in HRM - has 2.5. I consider Cobequid as 0.5, because they're not open 24 hours. It just boggles my mind. How do we come up with this division of 50 per cent of the population having less than three - 10 per cent of what's available as services in emergency?

I'd like to ask Mr. Beaton, was he there when - I'm sure not - the Cobequid Community Health Centre was built, and the decision was made to not offer 24-hour service? I know 20 years ago the population was much less, so maybe that was the reason, but things have changed so much, and we are always reacting rather than being proactive.

Now we're building this amazing centre in Bayers Lake. I remember the day that it was announced. I went to the opening, and somebody told me at the time that it's going to look like Cobequid. Of course, I assumed it's going to have an emergency. It was a year and a half later that I realized no, there's no emergency at the new centre. Here is half of the population having just three places where there's emergency. Halifax West or this area has

the highest number of apartments and density, and we're not offering them emergency services.

Who is making those decisions? How can we think of five years down the road instead of - that decision must have been made in 2015, 2016. It was announced in 2017. That was almost 10 years ago. It's amazing. I think the world of this decision of upgrading the Halifax Infirmary, the Dartmouth General Hospital, and building a new hospital. We needed it desperately. Our government invested $2 billion. I couldn't be prouder of that investment, but I think that we're falling short of the services that are required because of the population increase.

How can we solve this? How can we add an emergency department to this amazing hospital that's going to have x-rays, dialysis, and so many services, but not being used for emergency services? Can you explain the logic and what you think we can do to improve that?

CRAIG BEATON: I wasn't around when Cobequid was built, I will say. You're correct in that there are two main emergency departments in HRM, but the size and scale of those I think are built with the intention of trying to serve the entire population. It's not necessarily the number as much as it is the resources and the availability of service delivery that are able to be provided at those. That's really under the purview of the Nova Scotia Health Authority.

One of the things that's exciting that we are currently under way with right now in relation to how services are planned within the province is clinical services planning across the Health Authority. That's looking at how all services are provided to Nova Scotians - whether it's in Central, Western or Eastern Zone - and really looking at what the standards are for service delivery that patients should be adequately expecting, and then using that as a trajectory to forecast where we currently have gaps, where we're currently achieving the standard, and using that as a planning tool going forward.

That's one piece of the work that's currently under way in terms of planning for forecasting. You specifically asked about how we are forecasting for the future. That is certainly one of the methods that we're doing that - developing clinical services plans. That's an ongoing process that we're working on with the Health Authority right now.

The other part that you talked about was around the Community Outpatient Centre in Bayers Lake. You're correct. I don't know the exact dates of when that was announced. We're really excited about the potential of having that service there, as well as the provision of ambulatory care to patients - not only in Halifax but from outside Halifax who have to travel into the city. Hopefully that answers your question.

RAFAH DICOSTANZO: Ambulatory care is one thing, and emergency service is another. I was told we were going to have a primary care walk-in clinic. I've been

screaming and shouting, why can't that walk-in clinic offer 24-hour service so at least simple emergencies can be looked after and alleviate those people going to the Halifax Infirmary and Dartmouth General Hospital? A lot of people - if they have a child with a fever, they would go to the IWK - or would go to the Halifax Infirmary for simple things.

[2:30 p.m.]

If we can offer at least 24-hour walk-in clinic service that offers some kind of emergency services, that would make sense. Is any of this being said at the table? I think in Halifax, it's not so much just staffing - staffing is an issue all over Nova Scotia - but beds. We don't have the beds to move people from - to get beds to stay overnight for emergency. That's why they're in corridors.

We have those beds at Cobequid. We can build a few beds at the new centre where they can still have their x-ray, their blood test, whatever, and make use of an incredible facility that we're having. It's a vision for five years down the road where we're expecting double the immigration, which is wonderful. Where are these people going to go for emergency services?

I had for the first time in five years an email from a constituent on Flamingo Drive who didn't get emergency services. The ambulance never showed up. I have never heard of that. This is 10 minutes to the Halifax Infirmary. There is a fire station up the road from Flamingo Drive. He didn't get the services. To me, this is the sign of what's going to come in the next few years, and we're not preparing. What is the plan? I didn't see anything in the Progressive Conservative plan about increasing the services at Cobequid.

Alleviate seven or eight trucks every night. Why are we doing that? Sorry, I'm just a little emotional about it and would like to hear that this is being discussed - the future plans are being discussed. If you could let me know.

THE CHAIR: Mr. Beaton with 38 seconds.

CRAIG BEATON: I think I would go back to what I referenced earlier. The future needs and the projections, in terms of what services are needed for Nova Scotians, really will come out of the health services planning that's currently under way right now with the Health Authority. It's in its early stages, but that is going to be the key driver. We haven't had an opportunity to do this type of planning previously. There's been planning that's been ongoing, but not necessarily in this concerted way. We're really excited about what this clinical services plan will deliver, and we'll certainly use that to help forecast what the models of care will look like in the future.

THE CHAIR: Perfect timing. Moving on to the NDP caucus. MLA Leblanc.

SUSAN LEBLANC: I just wanted to ask a couple of questions about the EMCI contract that was included in our research package. Many of the targets are redacted. For example, the one associated with performance standard that, quote, "EMC will ensure SSP ambulances responding to calls have two paramedics." I'm going to ask the union: How often is that target not being met?

KEVIN MACMULLIN: You're asking about the response times, Susan?

SUSAN LEBLANC: No, the part of the contract that stipulates that there's a target - we don't know the target because it's redacted - that the ambulances will have two paramedics responding. Is that met all the time, or do we know how often that is not met?

KEVIN MACMULLIN: At the present time, there are two paramedics in the EHS emergency SSP units. However, sometimes if there's an ambulance not available, there is a paramedic in a transport unit with a transport operator, and they would be assigned to the call.

SUSAN LEBLANC: To what Mr. Daniel was saying earlier, that would be an ambulance that is a transfer unit that wouldn't necessarily have all the bells and whistles for a proper emergency call, but that would still be used to get the paramedic to the call? Is that the idea?

KEVIN MACMULLIN: That is correct. That has happened in the past where we've had instances where there were ambulances responding, however, for immediate care a paramedic and a transport operator were sent to the call.

SUSAN LEBLANC: That would be a less than ideal situation, I assume.

KEVIN MACMULLIN: Yes, that is less than ideal. We realize we'd like to have two paramedics on those calls because some of them are challenging calls. Depending on the number of patients involved, severity of patients' illness or injury, it would be great to have two paramedics on that call.

SUSAN LEBLANC: The Fitch Report states, "In evaluating current funding to expected performance, the EMS system could perform for a Total Response Time of 10:59 mm:ss at a minimum of 80 percent of the time." I'm wondering if that target is reflected in the new contract, Mr. Daniel?

THE CHAIR: Mr. Daniel.

CHARBEL DANIEL: I'd have to defer that question to Mr. Beaton.

THE CHAIR: Mr. Beaton.

CRAIG BEATON: Jeff has the numbers on that.

THE CHAIR: Mr. Fraser.

JEFF FRASER: Thanks for the question. Ideally, that was suggested by Fitch with no offload delay within the system. To give you a sense of where we're at today, when we look at the most recent numbers from April across the province, it's about 16.5 minutes for our rural areas, and about 8.2 minutes in our urban areas. It's not where we want it to be - hence why we're spending the time looking at what we can as a system to try to optimize those things.

May I provide a clarification just around the piece around the non-paramedic responding to calls? I think it's important because, again, I had the benefit of listening to the conversation.

As we talk about separating out the fleet to a split production model of the providers, there is no doubt that the patient transfer units (PTUs) don't have the same clinical equipment that's onboard. Our expectation as the system designer and regulator, with our partner in the operation, is that when we have mass casualty or large events that do occur, we have the ability to direct all resources to be able to serve that type of event.

Even though every vehicle may not have a paramedic on it, when we have a mass casualty event, there's a process that unfolds where patients are triaged appropriately. Some people are treated at scene, some people are released, some are transported to hospital, and some are very low acuity.

It is not the regular operating experience for us to assign non-paramedic units to calls within the community, but there will be times when we do hit a critical event that we will do that for the benefit of the public.

SUSAN LEBLANC: I just want to go back to my other question because I had a couple of B-parts to it.

You gave a 16-minute and an 8-minute offload time, but is that the reality or is that the target? I'm just wondering, is the target actually contracted for EMCI and the province?

JEFF FRASER: Thanks for the question. We have response time expectations that we have. I think what's important to understand is that there are things that are within our partners' ability to control, and things that are out of their ability to control.

As a regulator, we have to factor that in when we look at evaluating the response time compliance. For example, if a bridge is out, we have an expectation that they, knowing that in advance, would put a plan in place as best they could to be able to serve a community that may be isolated.

When it comes to things like offload, which is out of the operator's scope of practice or span of control, we have to be reasonable with that piece. Our service is built upon a 30-minute offload. I think we talked about that earlier. We're not near that yet, and there are reasons why that's in place. There is an accountability, but the accountability is to things that are in their control versus the things that are out of their control.

THE CHAIR: MLA Leblanc - 1 minute, 15 seconds.

SUSAN LEBLANC: Really quickly - the contract says that there's going to be a response time transition date of April 1, 2024 when the response times will change. Why was that put in place and what will that look like?

JEFF FRASER: The system is operating. Again, we look at our partner and the things that they can influence. It's more of a health system's approach to things.

The intention was to leave time so we could actually develop very meaningful and attainable targets within the community. The noise of the last two years of COVID really distorts the data a bit because, as was explained earlier, there's a latency. Maybe not as much now as it would have been six months ago, but six months ago, every call had a latency on it. Every paramedic had to arrive, screen, and dress. All those things are all factors that are included in that.

We continue to look at what's reasonable. We continue to look at what happens in other areas that have similar models to what we do and are trying to make sure that we adopt the most sensible approach to response times. Response time performance is key, and it's important, but it's not the only important tenet within the agreement. More important is the ability to put the right provider at the right patient at the right time.

THE CHAIR: Order. Thank you, Mr. Fraser. The time for the NDP has expired. We're moving back to the government caucus - MLA Barkhouse.

DANIELLE BARKHOUSE: We talked a little bit about this as well, but I'd like to clean it up a little bit. We know that paramedics are mostly concentrated in the HRM area. Is there a strategy to ensure that paramedics recruited are not concentrated in Halifax, and are distributed according to population size and regional demands?

I will send this over to Ms. Jensen or Mr. Daniel.

CHARBEL DANIEL: Thank you for the question. Part of our onboarding strategy and hiring strategy is looking at where the vacancies exist and offering those specific areas to potential employment paramedics.

We do focus in those areas specifically and try to push our teams and workforce to help fill those voids wherever we can. We have our postings up that are generally up right

now, looking for paramedics. When we have their application come in, we direct that workforce in the direction of where those gaps essentially exist, to fill.

DANIELLE BARKHOUSE: In the spirit of fairness, I'm going to pass the time over to MLA Dave Ritcey.

DAVE RITCEY: Thank you so much, Mr. Chair. This question is directed to Mr. Beaton. Earlier this year, you appeared at the Public Accounts Committee on a very similar topic. I know February to May is not that long, but can you expand on any new changes, improvements, or actions that have been made between now and the time you represented the Department of Health and Wellness in the Public Accounts Committee?

CRAIG BEATON: When we first appeared in February, there were a number of initiatives that were already under way. We're starting to see those come to fruition, and starting to see real benefits from them.

Three months seems like a long time, but when you're talking about system-wide changes, it's not a huge amount of time. We have had a number of meetings with our partners - many of whom are sitting here today - to look at what some of the solutions are that we can be looking at innovatively, to be able to address some of these serious problems that are facing the EHS system.

That being said, we're also looking more system-wide and looking at things that we can help and support on the broader access and flow issues. I know the command centre has been referenced here many times. That's a significant initiative that is currently under way, which we believe is probably going to see in the realm of around a 10 per cent increase in efficiency in hospital operation. That will therefore translate into lower offloads, better patient care, and the availability of the EHS system to be able to be alleviated and then be able to do more response for emergency systems.

I look at PTU and MTS, and I don't want to understate, if we look at some of the stats around that. If we're diverting 50 per cent of our call volume that previously was ambulances taking patients - that's two paramedics and an ambulance that are potentially doing a low-acuity transfer from one end of the province to the other - and now we're leaving them their home community, that's going to translate into better response times, and we'll see more coverage within those communities.

Dropping that within eight months of instituting the PTUs and increasing that service, doubling the time and the availability of hours, we're starting to see some real impacts there, which is beneficial for the system. But we also think it is beneficial for the morale of paramedics who really don't want to be caught up in offloads, and don't want to have to do long transfers. Now they are actually able to be in their home community, serving those patients and addressing some of those calls, and some of the stories that

we've heard of here. Nobody wants to hear about anybody's loved one who has to wait an exorbitant amount of time. We've stated from the beginning that that's not acceptable.

[2:45 p.m.]

We're working diligently and I would say there are a number of initiatives. Jeff is relatively new here. He's been on the job for seven weeks. Jeff has extensive experience in the system with over 31 years as a paramedic. Having him help drive some of the strategy, and working with our partners like Kevin, Michael, Charbel and Jan, we're starting to see some real positive gain in the system, but we also know we have to fix the other side, including the access and flow.

Command centre is one solution for that, but we also have a number of initiatives with our partners at the Health Authority to look at how we're doing discharge planning, working with the teams there, the meetings that we've talked about previously around having daily calls with EHS and the Health Authority about how we triage and move patients in a more concerted fashion.

There are a number of pieces that were under way, but now there is a very strong concerted push. We all want to try to find those solutions that will help address the workforce. We do want paramedics to stay in Nova Scotia. They're an excellent resource for the health care system.

DAVE RITCEY: Thank you, Mr. Chair, and thank you, Mr. Beaton, for the answer. I'll direct my next question to Mr. Daniel.

When you appeared at the Public Accounts Committee in February this year, you spoke briefly about the employee advisory council and its intent to bring together various stakeholders. Can you please provide additional details on the advisory group and expand a bit more?

CHARBEL DANIEL: Since that meeting, the employee advisory council has formed. In fact, they've had several meetings. Dr. Ron Stewart is a member on the council and helps lead and guide the discussions there.

There's been a lot of great information and feedback that we've received from that council that's truly forming some of our next steps into what we're doing. When we talk about different patient dispositions, different initiatives that are going into place to ensure that our teams do get home on time, when we look at our recruitment processes in the campaign that's launching and how that has been managed and what it looks like, it's all from that employee advisory council. They've really been a strong voice representing our frontline clinicians and showing what they're looking for, how we can really listen to them and make the changes that they're looking for. We're really proud of that committee.

THE CHAIR: MLA Ritcey.

DAVE RITCEY: How much time do I have left?

THE CHAIR: Fifty-eight seconds. MLA Ritcey.

DAVE RITCEY: Wow. That's great. I'll take that bit of time and just thank each and every one of you who arrived here today to provide us with necessary feedback that we needed to hear. On behalf of our group over here, I just want to thank you for your time.

THE CHAIR: Thank you, MLA Ritcey. That concludes the time for questions and answers. We do have a brief window of time for anyone who wishes to offer some closing remarks - not mandatory, but if you're interested in wrapping things up and putting a bow on it, as they say, by all means. Mr. Beaton.

CRAIG BEATON: I guess I would just highlight that the EHS system is a really busy system. There are over 180,000 calls per year, and we have very dedicated and extremely professional staff - paramedics who are working in that system. While we know there are challenges, we also believe that we're moving in the right direction and have advanced some real priorities. We're definitely focused on trying to see improvements in the system.

I'd just like to thank the committee for their interest and their questions today.

THE CHAIR: Would anyone else like to offer concluding remarks? Mr. Daniel.

CHARBEL DANIEL: I just want to thank the committee as well for having us here today to really highlight some of the great work that is being done, and also address some of the strains that are on the system that we're aware of and working toward.

We've talked quite a bit about recruitment and the different strains on the system. I want to assure everybody that our focus is equally on retention and ensuring that our workforce, whom I know have been highlighted as health care heroes during the pandemic, have truly been heroes long before and will be heroes long after.

I appreciate the time today and I am looking forward to the future of the health care system.

THE CHAIR: Ms. Jensen.

JAN JENSEN: Thank you for the opportunity. Again, I just want to repeat that we appreciate being invited here today. We appreciate that this is an important topic for this particular committee, and certainly for the people of Nova Scotia. It's certainly important to all of us who work and have worked for a long time in the EHS system.

The system is under strain for various reasons, as we've spoken about earlier today, but we are working hard to continue to refine the system and work in a very collaborative way moving forward. It is a well-designed EMS system. We want to continue to build on those very solid foundations that are there.

I do want to thank the few people who mentioned that next week is Paramedic Services Week. I had the good fortune last week of standing among 20 of my colleagues to receive the Governor General's EMS Exemplary Service medal. I also want to take this moment publicly - from all of us probably - to acknowledge everyone who works in the EHS system and to wish them a happy Paramedic Services Week that's coming up.

THE CHAIR: Mr. MacMullin.

KEVIN MACMULLIN: Thank you very much for inviting us here today. It's an important day, in particular for all of the MLAs. We've heard a lot today about how we're strategizing and planning, how we're going to change and how we're going to adapt this system to be responsive for the citizens of Nova Scotia and the paramedics involved. However, that takes time, and we're out of time. We are certainly out of time.

This is going back to February when I appeared before the Public Accounts Committee. We are losing paramedics every time, and we just cannot afford it. Faces of Paramedicine is next week - all the paramedics in Canada. There's one face missing from that: it's the broken face. That's the face I get the calls from daily from paramedics, begging to get them help out on the front lines, begging me, how are we going to solve this problem?

There's only one thing that's going to solve this right away, and that's called money. We have to spend the money. How are you going to keep people if you don't pay them appropriately? You're not. How are you going to attract people if you don't pay them appropriately? You are not. You people all have the ability in your hands as MLAs right now to make a difference in this province. I ask you: please listen to our pleas and do something about this now.

THE CHAIR: Mr. MacMullin, could you table that document that you referenced please, so that it can be recorded properly? We'll get one of the Pages to look after it afterwards.

Mr. Nickerson, in the interest of time, if you don't mind offering your remarks swiftly, I would appreciate it.

MICHAEL NICKERSON: No real closing comments, but to answer a question that MLA Leblanc had earlier, since the Public Accounts Committee meeting, what's been reported to us by our members was 97 shift overruns totalling 161 hours since the Public Accounts Committee meeting.

THE CHAIR: We appreciate the information. Ms. Leblanc, I'm sure you're happy with that.

SUSAN LEBLANC: Not really.

THE CHAIR: Well, pleased that you got a response. I'd like to invite the witnesses to - you don't have to go home, but you can't stay here. (Laughter) Thank you very much on behalf of the committee for appearing before us today. We have a couple minutes of committee business to conduct before 3:00 p.m., so we'll give you 60 seconds to make your way out.

Moving on to committee business, we have correspondence listed in an April 25 email from Sharon MacIsaac regarding the new pre-school autism services. Do we have any comments or feedback on that? Hearing none, we will make sure that it gets recorded properly.

Is there any other committee business to address? MLA White.

JOHN WHITE: Given that our next meeting is based on a request from Heart & Stroke, and that it was to discuss the improved conditions of cardiac arrest for Nova Scotians, I'd like to ask if the committee is willing to give some extra time for them to present rather than questioning. I can make a motion on it, if you wish, but I think we'd probably agree on this - I would hope.

THE CHAIR: Thank you, MLA White. I will put it up for discussion that the request has been made that instead of the typical 10 minutes that folks are offered for their opening remarks, that we potentially extend that to this group, just for that meeting, to allow them ample time to present what they'd like to share with us.

MLA Leblanc.

SUSAN LEBLANC: Can we just get a clarification before we agree or disagree on who the witnesses actually are?

THE CHAIR: Yes. We'll pause now to consult with the clerk.

JUDY KAVANAGH: It's a good question. I don't know their names yet. The letter came from a group of organizations, including Heart and Stroke, IWK Health, Braveheart Support Society, and Maritime Heart Centre - so the request came from them. I am dealing with one person at Heart and Stroke who is making the arrangements at their end.

THE CHAIR: Thank you, Ms. Kavanagh.

MLA Leblanc.

SUSAN LEBLANC: I guess our concern is that we don't need extra time to hear from government representatives, but if it's simply the organization that is going to be doing the presentation, then we are okay with that.

THE CHAIR: In consultation with the clerk prior to the meeting, it was advised that it doesn't need to be formalized. It doesn't need to be a motion if it's a friendly agreement - that we'll offer 20 minutes instead of 10 to this organization. I'm seeing a lot of nods, so I'll ask Ms. Kavanagh to advise the witnesses that they have 20 minutes to present, instead of the typical 10 minutes. Thank you very much.

Is there any other committee business to address? Seeing none. For the record, I will note that our next meeting will take place on Tuesday, May 31, 2022, from 2:00 p.m. to 4:00 p.m., with the organization presenting as we discussed, the Heart and Stroke, IWK Health and Braveheart Support Society, Maritime Heart Centre, regarding improving cardiac arrest outcomes in Nova Scotia.

MLA Palmer.

CHRIS PALMER: Sorry, could you please confirm the time of that meeting on the 31st.

THE CHAIR: Yes, Tuesday, May 31, 2022, 2:00 p.m. to 4:00 p.m.

MLA Dicostanzo.

RAFAH DICOSTANZO: Why is it 2:00 p.m., and not 1:00 p.m. to 3:00 p.m.? Did they ask for that?

THE CHAIR: We pause now to consult with the clerk.

JUDY KAVANAGH: It was the time that I suggested for that date because there's a Human Resources Committee meeting across the street until noon, and so staff need time to pack up and come across the street and set up here.

THE CHAIR: That's agreeable for everyone involved?

Seeing none, I'm going to call this meeting adjourned.

[The committee adjourned at 2:58 p.m.]