HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, July 12, 2022

LEGISLATIVE CHAMBER

Innovation Hub

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HEALTH COMMITTEE

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[Danielle Barkhouse was replaced by John A. MacDonald.]
[Hon. Patricia Arab was replaced by Hon. Brendan Maguire.]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Legislative Counsel

WITNESSES

Nova Scotia Health

Dr. Gail Tomblin Murphy
Vice-President, Research, Innovation and Discovery and Chief Nurse Executive

Dr. Michael Dunbar
Orthopedic Surgeon (QEII Health Sciences Centre) and Innovator in Residence

Doris Grant
Senior Director, Innovation - Research, Innovation and Discovery

Dr. Tara Sampalli
Senior Scientific Director - Research, Innovation and Discovery

HALIFAX, TUESDAY, JULY 12, 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 am the Vice Chair of the committee, and in the absence of MLA Boudreau, I'm the Chair today.

Today we will hear from Nova Scotia Health regarding the Innovation Hub, an exciting topic. I would ask that everyone turn their phones off or put them on silent, please and thank you.

As we begin, I'll invite all the members of the committee to introduce themselves. I will begin to my immediate left with MLA Leblanc.

[The committee members introduced themselves.]

THE CHAIR: Thank you to the members. For the purposes of Hansard, I'd like to officially acknowledge that we have the presence of Legislative Counsel Gordon Hebb, and Legislative Committee Clerk Judy Kavanagh.

Before we get into the questions and answers, we offer the witnesses the opportunity to provide opening statements. First, I'd like everyone to introduce themselves, and then if there are any opening statements, please feel free. I'll begin with Dr. Gail Tomblin Murphy.

[The witnesses introduced themselves.]

THE CHAIR: Thank you to the witnesses. I believe there are opening remarks from Dr. Tomblin Murphy.

DR. GAIL TOMBLIN MURPHY: Good afternoon, Mr. Chair, and to all of you, the Standing Committee on Health. This is a wonderful opportunity for us to join you today. We thank you so much for that - so that we can share with you some of the exciting things that are going on in Nova Scotia Health's Innovation Hub.

As one provincial health organization, we are really in a good place and well positioned to lead innovation in this province - those health-related innovations that we'd like to share with you today. We see ourselves as large enough, and nimble enough, and innovative enough to make a change - a change in the way that we run our system, as well as for the health of Nova Scotians through innovation, and always for the benefit of our patients, families, and citizens of Nova Scotia.

I hope you will hear today that we've got a wonderful community of entrepreneurs, of innovators, who come to us each and every day. They are very keen to create solutions for Nova Scotians. It's really their expertise that we have the privilege of hearing about every day, and their dedication goes beyond what I can even describe. Together, we are working to bring forward some of those - the leading evidence, the leading best practices to test and try to see the impact that they can have in Nova Scotia, and that these solutions we see are important in the province, regionally, as well as nationally and beyond. This will also contribute to the province's economy.

Our goal is to be one front door - a place where people can open the door, come in, and listen, to participate and make contributions in innovation to improve the health and health care for patients. How do we accomplish this? We have values - values that say patients and families are number one, the most important thing in everything that we do. We are here to improve the experience, as well as the quality of care that they receive.

A priority of the Innovation Hub is something I'd like to share a couple of stories on. This has to do with our clinical implementations. How pleased am I today to have Dr. Michael Dunbar, our first Innovator in Residence, to also share afterwards some of his perspective in terms of innovation, and some of what he and his partners on many fronts are leading.

We're meeting with clinical teams and innovators all the time to better understand their interests in being involved. We all support the commercialization of innovations that are developed in Nova Scotia, which is incredibly important. It's helping our clinicians with intellectual property for their new ideas - to bring advice as it relates to innovation, but also to market and to work with them on start-up companies or partnerships.

We're really pleased that we've got an Innovation Launchpad, a place where we test new technologies. We try out many things - new medical devices, new technologies, and new ways to deliver care, to name a few. Thinking about this, this is where the innovators have the opportunity to get their ideas in the door of Nova Scotia Health Authority to be tested with our clinicians, who oftentimes know best what some of the differences are that some of the new ideas will actually make.

One of our examples - not new to any of you - is VirtualCareNS. We know that this is a product in terms of a tool that is focused on those Nova Scotians who are on the Need a Family Practice Registry, who need an opportunity to actually be attached to a provider - a nurse practitioner or a family doctor. They, in this time, are getting same-day access to meet their needs.

Since May 2021, we've had about 18,000 visits that have taken place. About 73 per cent of Nova Scotians to date who are on the registry have been invited to participate. We anticipate that by the end of the Summer, all Nova Scotians will be invited to participate - those who are in need of a family doctor or nurse practitioner. We're hearing from many people - and we can get into more of this - how grateful they are for the experiences.

We believe firmly that research is care, and the evidence that comes from research informs every day our practice as well as our policy. Our clinical trials unit is an example that we see as very important to bringing some of the best drugs, interventions, medical devices, and ways to deliver care to Nova Scotians. We have more than 400 patients who are participating in clinical trials, and about 500 or so research professionals. We take this very seriously.

Not news to any of you, but well known, would be our research team in Respirology, who've been supported over a period of time by the clinical trials unit in Nova Scotia Health Authority for cystic fibrosis treatments since 2010. This has led to the development of a drug, Trikafta, which has been the biggest innovation in cystic fibrosis. This is just one example, but we have a lot more work together in partnerships to do.

We are working to position us in Nova Scotia, through partnerships in Atlantic Canada and beyond, to actually make a dent in research as care through clinical trials. We see, for instance, many health status indicators as Nova Scotians we're concerned about. We see us becoming world leaders, perhaps, as it relates to oncology and autoimmune disorders - things such as MS and arthritis.

As we start to change the narrative, we need to make sure that clinical trials - that there's access for all Nova Scotians. We are testing digital innovations so that access is not just if you live in Halifax and close to an organization, but instead, for people who live in much of our province who are actually rural. This helps to reduce the burden for people who travel to and from appointments.

One other important aspect I would like to share is that everything that we do in the Innovation Launchpad, we test, and we try. We evaluate. We determine what success looks like very early, and we monitor what that success is like on a day-to-day basis. We see this as being foundational to a learning health system.

In the system we are, and are proud to be, a learning health system where everything that we do - the evidence that comes through our rapid reviews, for instance, through much of the work of our Network of Scholars, which is about 80 or so trainees and mentors, 120 total, who on an ongoing basis are actually collecting the evidence to inform quality care. It's where we come together, and we work with patients and families on an ongoing basis from their lived experiences.

Data is important. We know that data and evidence, having it at our fingertips, being open and transparent with data, is what is going to help us together through this journey in our partnerships.

I believe, as apparent to each and every one of us as we share stories, that the COVID-19 pandemic has helped us and taught us how to partner differently, how to look at complex issues and to arrive at solutions together. I think we should be very proud of our frontline staff who every day have come up with some very solid ideas of how to mitigate the virus.

I would like to give you a couple of examples. I know that Dr. Dunbar will, indeed, be sharing more about the Mako, our robot and the Mako SmartRobotics System. This is a perfect example of innovation that is going to bring huge solutions to Nova Scotians. I would like to say that Mike, being probably one of the most modest people I know, is a leading orthopaedic surgeon at the Nova Scotia Health Authority. We're incredibly pleased. On this national stage, as well as the global stage, Dr. Dunbar is daily making an impact on the way that people are receiving care and the advancements in technology.

We're really thrilled that Dr. Dunbar is one of our first of two innovators in residence. His role as an expert is to work with us and Dalhousie University in a partnership to build capacity within our clinician body, within our private industry partners, within our academic partners, and others. He is a perfect example, and we're incredibly proud to have Mike with us today.

A story that many of you might have heard when we did our health innovation showcase, the first patient was Mr. DiQuinzio. Mike himself will probably tell a little bit more about. From his perspective, somebody who worked in cold, icy places on his knees for many years as a pipefitter, he talked first-hand about the difference that his surgery actually made to his quality of life.

Another example that I could bring forward in my last few minutes of this opportunity, is that not that long ago - if I move the story around the clinical trials unit - we

had the opportunity last month at the BIO International Convention in San Diego where we had the largest participation from Atlantic Canada in a way that truly marvelled partnership - but also that in Nova Scotia and in partnerships with other Atlantic provinces, we are open for business and to learn from others, and to learn how to innovate with others.

We were very pleased that during the BIO convention - I think many replied and reported that Atlantic Canada definitely was alive and well - that the clinical trials network called ACTN, or the Atlantic Clinical Trials Network, was announced.

What's really important here - back to the learning health system - we learn from other systems. In this partnership, we've got Vitalité Health Network and Horizon Health Network in New Brunswick. We have our Nova Scotia Health Authority. We also have Eastern Health and Health PEI. Learning from each other is going to be incredibly important as we collaborate.

If you think about that simply, this would be bringing just over a million people in Nova Scotia. If we talk about Atlantic Canada in a partnership, we're now 2.5 million. There are many people who would see that as advantageous in terms of running and participating in clinical trials. Clinical trials are not just for their own benefit, but that research is care, and we see retention and recruitment to come to work with some of the best global experts in many fronts is really important.

There are many initiatives. We hope to tell you more about those, and we believe we're on to something in terms of the Health Innovation Hub in Nova Scotia, partnering, open door, testing and trying. Some things work really well, and we scale them. Some things don't work that well at all and they fail quickly. That's what we're all about. Our role is to seek those opportunities to build those partnerships and government being part of those governments that are incredibly important.

Together, we hope that we can change the agenda and the ecosystem. Thank you very much for this opportunity.

THE CHAIR: Dr. Dunbar, do you have any opening remarks, or any of the other witnesses? Perfect. For the benefit of those witnesses who have not appeared before a committee before, the way it works is each caucus gets 20 minutes to ask questions. All the questions come through the Chair, so wait for me to recognize you before answering and wait for the red light to come on your microphone before you start speaking. After the first round of questions, we'll look at the time and see how much time we can split up between the caucuses for the second round of questions, normally 7 to 10 minutes or so for the second round. We'll wrap things up around 1:45 p.m. because we have some committee business to look after.

Without any further ado - I believe I have touched everything on my notes - I will turn to the Liberal caucus. MLA Maguire.

[1:15 p.m.]

HON. BRENDAN MAGUIRE: First of all, thank you all for being here, and thank you for your commitment to improving access and health care for all Nova Scotians.

The last time I saw you, Dr. Tomblin Murphy, was three months ago at Public Accounts Committee. I don't know if you remember the conversation that we had then. At the time, you said, ". . . by the end of June, all Nova Scotians on the registry in all zones will have access to VirtualCareNS." That was a commitment made by you, and that was a commitment made by this government.

Right now, 22,834 Nova Scotians are registered for virtual care - that's 22 per cent. A hundred per cent of people without a family doctor have not received an invitation by your own words here today - myself being one of them. I have not received a phone call. I did a quick poll over the last week, speaking to people who don't have a doctor. I have not heard a single person say to me, of the 40 people I spoke to, say that they received a call for virtual care.

So why are you pushing the timelines? Why is this government which made a promise to have everybody have access by the end of June - why is that being pushed back again and again and again?

GAIL TOMBLIN MURPHY: Thank you so much, Brendan, for the question. I would like to give a couple of opening comments, and then I will pass it to my colleagues, both Doris Grant and Tara Sampalli.

The good news story on this - I don't need to tell you that Nova Scotia has successfully increased the people who have come to this province. In particular, we have seen immigration - some very positive signs of people coming to Nova Scotia. You know that better than most.

I would like to say that we have many strategies in place to deal with access. Access for Nova Scotians definitely is incredibly important, so of those to whom the invitations have gone out and those who have been registered - as we have said before, oftentimes people don't need a family doctor nor do they need a nurse practitioner until they actually need one.

We definitely see that the time frame, you're right, has been pushed from June until the end of the Summer. That's for a variety of reasons. I would like my colleagues - I'll start with Doris - to answer, please, and then for Dr. Sampalli to add to.

DORIS GRANT: Just in terms of a point of clarification, we have invited almost 70 per cent of the patients on that Need a Family Practice Registry to the platform. As Dr.

Tomblin Murphy said, not everyone needs a doctor or has accepted the invitation, but we have seen almost 25,000 visits on that platform.

When we were here last time at Public Accounts Committee, we did speak to end of June for our rollout, and there are a couple of reasons why that's been pushed out. One, we are increasing the number of people who have access to the platform, but we haven't been able to really bring in as many providers as we need in order to meet that demand. There are multiple strategies in place and things that we're looking to do to be able to do that, but rest assured that everyone who is using the platform is receiving excellent care.

Another point of clarification, if I may, is that you don't receive a phone call. You receive an email invitation through the VirtualCareNS platform - if you're on that registry. I just want to make sure that nothing gets lost there.

BRENDAN MAGUIRE: I do want to correct some things that were said there. Dr. Tomblin Murphy said that we are welcoming people into this province, which is great, but the list is outpacing people coming into this province. You can't say that a couple hundred people or a thousand people, coming in is having the huge impact that we're seeing right now.

Twenty-two per cent is a fail. In any class, any job - if this was an Auditor General's Report in Public Accounts Committee right now and you achieved 22 per cent of the recommendations, we would be blasted.

I was very specific in Public Accounts Committee, and that's why I wanted to come here today about virtual care. The answer to the health care situation and people not having a family doctor in Public Accounts Committee was that we are going to get people access to virtual care. Twenty-two thousand people have access now, and 100,000 people don't have access right now. Those are the new numbers that just came out today: 100,000 Nova Scotians no longer have access. That has almost doubled in the last year. Doubled.

This is a government that ran on health care. In the last legislative sitting, we heard $6 billion, $7 billion, $8 billion, that this was going to solve the health care system. And that's not even getting to questions I'll have for Dr. Dunbar about how backed up surgeries are. We are now one of the worst places in Canada for access to primary care. We're at 10 per cent of the population has now committed - they've put it on paper that they don't have access to care. You're the experts. You know it's higher than that. You know there are a lot of Nova Scotians who are not taking the time to register for a family doctor.

Dr. Tomblin Murphy, you said that there are other solutions, that there are other things we're doing out there. But we were told in the Public Accounts Committee: by the end of June. You can see why people are frustrated and upset with the system when we're hearing time frames, we're hearing commitments from the government, and we're hearing

commitments from the Premier himself. They like to celebrate numbers. They say we hired 350 nurses. Well, here's a number: 100,000 people. We've never reached that.

What do you say to those people who have absolutely no access, who are going to emergency rooms? One of the comments you made was that patients and families are number one. I truly believe that you believe that, and that it is in your core. But then how do you explain a tweet that went out by the Nova Scotia Health Authority saying: just drop your people off at emergency and don't come in? I mean, that's what they said. We don't have the room. We don't have the capacity. If my elderly parent is sick or someone's teenage son or daughter or child is sick, and they're in a confused situation, there's no room in the hospital for you. That is not patients and family being number one.

What do you say to those people? It can't just be that it's going to get better.

GAIL TOMBLIN MURPHY: Thank you for this opportunity. I'm going to get started, and then I'm going to ask my colleagues to join. Getting started, Brendan, I think you have put a lot of very important issues in your question - some of which I'm in a position to answer as Nova Scotia Health Authority. You will notice that I don't have the Province with me here today.

In all fairness, going back to Public Accounts Committee, you asked many questions as it related to primary care and strategy around primary care. You talked a lot about many other very important questions and initiatives that I am not in a position to answer. What I can answer is that we believe the virtual care strategy in this province, which is a partnered strategy, is incredibly important. VirtualCareNS is one piece of that strategy.

What I would ask my colleagues to share, because I think it's getting at access for Nova Scotians, are a couple of other examples. One is in which we provide access through collaborative practice pharmacy-led, nurse practitioner-led, models; and in addition to that, VirtualEmergencyNS.

I will pass that to my colleagues. Also, in addition to that, I think for us, that we are involved in, to talk about some of the initiatives as it relates to work that we're doing - for instance, with Dalhousie Family Medicine and other types of collaborations in communities.

Over first to my colleague Doris and then to Tara.

THE CHAIR: Ms. Grant.

DORIS GRANT: I'll tell you about two programs that really speak to access. As Dr. Tomblin Murphy alluded to and mentioned, we're in partnership with Sobeys-Lawtons, and they're in two communities. We have launched a Pharmacist

Walk-in Clinic+. Sobeys had previously established a pharmacy walk-in clinic, and we have partnered with them to put a nurse practitioner in with that practice so that we can see more patients.

Right now, in those two sites, we've seen almost 2,500 patients in this province. We also know that many of those patients are unattached. Many of them are coming in from rural communities to get care. We're very proud of that program, and Dr. Sampalli's team is leading the evaluation on that, but right now it is a very positive program for those communities. Again, we're very happy to be partnering with Sobeys on those fronts.

The second one is VirtualEmergencyNS. We have patients who show up in our emergency departments who might not need to be there, but if they don't have anywhere else to go, this is where they go to get care. What we've done is leveraged a virtual platform in the emergency room. We started in the Colchester site and we're leveraging a virtual platform to be able to see patients coming into that ED who don't need the services of the main emergency department.

Patients come in, they're triaged, they're asked if they want to be seen on that virtual platform. They're taken into a designated room and assisted by either a nurse or an advance care paramedic who are hands in the room who can help with the diagnostics, and they're seeing an emergency room doctor virtually.

In terms of flow-through and time through the ED, these are three and four hours. This is a lot better for our patients. Right now, we are looking to roll out that program into other sites across the province. Again, very positive experiences from our patients.

THE CHAIR: Dr. Sampalli. (Interruption) MLA Maguire, I'll allow the witnesses to answer as much as they'd like to answer.

BRENDAN MAGUIRE: My next question would be a couple of things. You said that program has seen 2,500 since it started. The commitment, again with these numbers - the commitment was 200 a week to take the strain off the health care system. I can table that. This started in May, so well below the numbers. You're talking about virtual emergency care when we can't even get virtual care up and running properly, when it's been given a failure rate - 22 per cent of people who have access to that.

I want to read you something that just came in, and this is what really grinds my gears, we'll say. This literally came in at 12:57 p.m.:

> Hi Brendan. I'm going to take - I'm not going to say who it is - to the ER. She hasn't been able to eat or drink since Sunday evening. I tried to call 811 for advice. Nothing. Tried to get an ambulance. Nothing.

The lady who is going to the hospital is in her 80s with a heart condition. This is the fourth time in the last two weeks that they've called an ambulance, that the ambulance hasn't shown up. We know there was an article in the Chronicle Herald. I actually met with that family. Again, didn't show up.

[1:30 p.m.]

There was a young lady who sent me a message on Friday. She broke her wrist and had pictures of her broken wrist - clearly broken. She showed up at the Cobequid Emergency Centre and was told, we're not dealing with those injuries today, you have to go home because they're too busy. This is what Nova Scotians are getting for an extra six or seven billion dollars a year in health care. This is why the virtual care and other forms of primary access is important.

Do you think where you - and I mean the government collectively - are at today on the virtual care system, at 22 per cent, has been a success over the last 10 months?

THE CHAIR: MLA Maguire, I'll ask you to table all the documents supporting all of the facts that you just used. I'll allow Dr. Tomblin Murphy to answer, please.

GAIL TOMBLIN MURPHY: Thank you very much for this question. I do note that depending on how you define a failure rate - I think that what I would like to do is to complete the story today which Dr. Sampalli can tell you about success. What does success actually look like in the eyes of people - patients, families, citizens - who have participated in the VirtualCareNS platform, for one?

Secondly - heartbreaking stories that you raise. Issues that I, in terms of Nova Scotia Health Authority when you talk about 811, for instance, and the role - I would have to defer, to get that information to you because we know that would be a different partner than Nova Scotia Health Authority.

What I can say is that like never before, I see us aligning and working across sectors through our care coordination centre. We are finding ways, first-hand, to integrate system information and evidence so that it's more than ambulances lining up at a door to get in. It's more about how we fully integrate people who are at home, keep them at home, bring them in through an organization, and then get them home - wherever home looks like.

On the positive note, before we talk about what you're defining a failure rate, I would like to say there's hope. There's hope around a fully integrated system using data and evidence to inform those decisions - policy as well as practice. Over to Dr. Sampalli to talk about what you're defining as a failure rate and what we are hearing in our evaluation and our ongoing monitoring.

DR. TARA SAMPALLI: I'd like to say, first of all, access is very important. I fully agree with all of the points you are raising. This has been, for primary health care and primary care, a topic of high importance, and it's important for Nova Scotians.

As Gail and Doris and others have said, we are trying to build access in a number of ways. VirtualCareNS is a very unique model. It's very important to note that it's a Nova Scotia solution. It's been designed that way because, again, we recognize that primary care is at capacity, so we cannot pull providers into VirtualCareNS and take capacity away from primary care. That's a point I'd like to make because that's really important.

When we are designing it, we are thinking of three things. First, how do we provide access, so we don't take the capacity away - how do we add capacity? The second thing is that it is about building it as part of primary health care's suite of solutions for access. This is a way of getting access - it's not all of it.

The third thing is - and this doesn't have in all virtual care implementations - we are very unique in that we don't just give virtual care access and forget about what happens in follow-up care. That's really important. We have built an in-person component to VirtualCareNS, which has been really important to what we are hearing as feedback. That's also critical, because every community is at capacity.

Part of what you're seeing is our importance of VirtualCareNS, which we are hearing from all of our people who have received access - who are receiving the type of access they need. They are responsibly using the service. They are happy with everything they're receiving - every time, it's high experience rating.

What is equally important is the capacity is what it is, and we're trying to build it without talking away capacity. That's one of the reasons you're seeing the delay because it's a Nova Scotia solution. We are not just opening up virtual care - we are building it very carefully, so people don't go to emergency rooms. That's not the way we want to build it. That's why it's a test and try - we learn as we go.

I think the success is in listening to what people are saying and continuing to work toward it. That's where we see the collaboration, we see the partnership, we see access in a number of ways. What we know is people want this type of access.

BRENDAN MAGUIRE: Here's what I would define as success and failure. Fifty per cent increase in the wait list over the last 10 months, failure. Sixty per cent increase in abandoned ER visits under the current government, failure. Twenty-two per cent intake in the virtual care, failure. Again, I do appreciate all the hard work that's going into this. When I hear words like trial and hope and things like that, it doesn't do anything for the people who are trying to access the health care system.

THE CHAIR: Order. The time for the Liberal caucus has expired. I'll remind the member to please table all the statistics and documents that you cited, please, to make sure that they're valid.

MLA Leblanc for the NDP caucus.

SUSAN LEBLANC: Thank you all for being here. I have some general questions about innovation and that kind of thing, and then I'm going to dig into a few specific things.

I'd like to echo my colleague in saying thank you for all the work you're doing in the province. Innovation is something I'm particularly interested in as part of my life before politics, my whole work ethic and work practice was centred around innovation. I just found a great definition - how to explain innovation to a child. I always appreciate simplifying things. It says, innovation relies on the ability to think creatively, to look at something familiar and see new possibilities - which I love, because some of the regular definitions don't include the new possibilities thing.

I think that whenever we're trying to improve systems, it is the only way to focus our attention, so I appreciate the fact that the hub even exists.

That being said, I have a few questions, first of all, about virtual care really specifically. I have heard from a number of constituents who are on the 811 list, and haven't received a phone call or invitation. They have received an email, except it's gone to their junk mail. We've heard from people at virtual care that this is happening to a lot of people - they don't even know. They're on the list, they're waiting for an invitation, and they don't even know that one is coming, so they don't look for it, and they don't check their spam. Who does?

Then they come to us and say, I've been waiting forever, and I've got this particular need now, something has happened, and I really need to see someone. Then we call VirtualCareNS. There's this whole rigamarole that they have to do where they have to call an 800-number and then someone will send them an actual email that's not a spam email. It's a mess.

I'm wondering - speaking of innovation - is there a way to be looking at that system in and of itself to make sure that people are accepting invitations? As you say, 70 per cent have been invited, but 22 per cent have accepted the invitation, so there's a big gap there. I don't believe that it's because they don't need a doctor. Based on what we hear, people need these appointments. That's my first question.

THE CHAIR: Dr. Tomblin Murphy.

GAIL TOMBLIN MURPHY: Thank you so much, Susan, and thank you for the contributions that you've made in terms of innovation.

To your question, what we have learned along the way with virtual care in any strategy is that we need to be thinking about equity. We need to be thinking about literacy. We need to be thinking about a lot of things along the way.

Recognizing that, because we are very close to this and because we monitor on an ongoing basis, what you have talked about we have heard. What we are trying to do, and have tried to do, is increase and find ways to problem-solve for people who are having difficulty. Secondly, more importantly, is to enhance the way that we're communicating. Thank you for that, and my colleagues can speak a little bit more to that.

On the notion that I spoke about, which I think is important, is it's not just for some people in Nova Scotia, for instance, who it goes to their spam, or it goes to their junk mail. What we're really proud of, in our portfolio in the Nova Scotia Health Innovation Hub, we have 42 health care foundations in this province, all of whom are making huge contributions to the citizens and people in communities across this province.

We have three really good examples - getting at access, for instance, whether it's email or whether it's the use of VirtualCareNS. I'd like to highlight the Aberdeen Hospital Foundation. They set up two pilot sites where they actually trained staff in a library to help citizens living in the area to access the information, whether it's email or whether it's the platform, or to provide them a private area where they can be involved in an interaction with a nurse practitioner or family doctor.

Secondly, what we're really thrilled about is their leadership in this pilot - which seems to be working on many fronts - is expanding, and in particular to Bear River in the province.

Back to your question in terms of the spam. I just felt that I needed to overall talk about an issue that's bigger than email for us, and we're learning about that. Over to my colleagues - I think to Doris - who could speak more to the day-to-day problems that we hear about, and how we're problem-solving those in terms of the email contacts.

DORIS GRANT: Thanks for the question. We have heard that before, that things are going into spam. I, like many others, rarely check that inbox, but we are working with our partners to be able to educate our communities to be on the lookout for this. We did start a very aggressive social media campaign to bring awareness to the program, to really target all of those people to say, pay attention to this because we want people to use this platform.

The other thing is that in the Northern Zone and Western Zone, there was a number of people for whom we couldn't find their email addresses, so we sent out thousands of

letters to be able to make sure that they knew that program was available to them. For those who are having issues registering - whether it's downloading the app or just trying to figure it out - we have a team of people who are providing help and assistance. As Dr. Tomblin Murphy talked about, that library program is really helping people in that community. Sometimes it's a friendly face that they're greeted with, and really walking through the program with.

The other thing that we're working on are equity booths. We know that not everyone has access to the internet, so we're trying to make those resources available across the province so that people have a safe place to go to be able to leverage that program. Again, it's multi-level. We know it, we hear it, and we're trying to solution it.

SUSAN LEBLANC: Without taking credit, I'm pretty sure that the equity booth thing came from Dartmouth North. I'm glad to hear it's under way - from all the amazing community members working on access in Dartmouth North.

Here's the thing. All of that is great. To me, it's not rocket science. It feels like, just send a letter to everybody in the province and be done with the email invitations. It seems like people are going to get. That's what Employment Support and Income Assistance does. They just send letters because who knows when people are going to have access to computers.

Here's the other part of this. We're talking about minute details of a program that's really important right now. Let us not forget that this is supposed to be a stop gap measure, so people have access to care until they are attached to a human being in front of them - a doctor or a nurse practitioner, I'm not fussy which. A primary care provider - I'm not a big stickler for that, for sure. What is the hub doing to address that? Again, let's not forget why we're even talking about virtual care. That's one part.

The second question is: If someone accepts their invitation to virtual care, what happens to them on the list? Do they stay on the 811 list? Just wanted to double check that.

GAIL TOMBLIN MURPHY: Thank you again for a very powerful question. We're all about giving examples in which we are involved around access.

First of all, I'd like to acknowledge that what we hear from people on an ongoing basis are star ratings that are about 4.6 out of 5 getting connected to a provider - as you say, not fussy which - within a short period of time - 35 minutes, for instance. We're also hearing from people, can we just stay in this, as opposed to going back and being attached?

We also have the privilege and opportunity in the Nova Scotia Health Innovation Hub to be working on a variety of projects right now that are actually enhancing access through collaborative practice kinds of environments. I'm going to pinpoint and ask first Dr. Tara Sampalli to speak a little bit about what we've been doing in primary care as it

relates to some of our work with Dalhousie, and in particular, about some work in Dartmouth North.

[1:45 p.m.]

Secondly, if there are other things, Doris, that you would like to add to that, please feel free.

So it's more than taking as a temporary and then going back to something, which people are paving - that back to something maybe needs to look different in terms of our future state.

TARA SAMPALLI: Thank you so much for that question. The underlying consideration is, how do we get people access to a primary care provider and practice? To what Gail has said, we have been working on a number of initiatives, trying to understand what the barrier is in the process of things that's really preventing people from getting access to primary care providers in a rapid way.

We have started work with Dalhousie Family Medicine clinics. There are two clinics, one at Mumford and one in Spryfield. Part of our exploration was just looking at the process of things, to your point: What's going on here? Why can't we get access? Why can't Dal Family Medicine clinics offer access to more people who are waiting on the registry?

We looked at that process, that clinical workflow, and very quickly we identified that it always comes down to: Are the right people doing the right things? What are the bottlenecks in the process?

That's all it took. It took a week working with everybody to understand what is sitting on a physician's list of things to do and what's sitting on a family practice nurse's list of things to do. We started to change things, but also thinking innovatively. We also looked at how do people get off the registry and into your practice - the process of it. There are so many steps involved.

We actually have implemented an innovation. It's called a rapid onboarding team. It's going to front-facing to the province, this team. All they'll be doing is taking people off the registry and getting them into the practice, and what is even better is they're going to attach them to the right providers. We don't do that very well. Sometimes a provider can have the same type of patients, very complex needs, and that can be very daunting. So we are doing that.

Dalhousie Family Medicine Clinic is a proof of concept, but at the tail of it, we have Dartmouth North. We have a clinic there. We have two more in Northern and Eastern Zones. But the main idea behind it is to really get people very quickly off the registry and

attached, and we are building capacity within the practice. Really, in the short time that we did, the Dalhousie Family Medicine Clinic is going to take on 3,500 more new patients. As we ramp this up across the province, we're going to be seeing more of these clinics take on patients from the registry.

That's really the more permanent solution that we need to look for, and VirtualCareNS is going to be part of the journey. As people are being onboarded, they'll still have access. This is where we are headed with the attachment part of it, which I think is critical.

SUSAN LEBLANC: You can just answer this with a nod, but are you speaking of the Albro Lake clinic, with onboarding the nurse practitioners at Albro Lake, or is this a new project? Okay, then we need to discuss. I'll ask you more later about that.

I'm wondering about the pharmacy program. We've already spoken about it a little bit - that you brought in Lawtons and Sobeys in Truro and New Glasgow. Obviously, it seems to be going well. I was wondering - a couple of things about this. Number one, was there a cost to the contract with Lawtons?

GAIL TOMBLIN MURPHY: No, there was not a cost associated, Susan. In fact, we see it as an example of a good opportunity again to test and try through a project like this, a relationship with private industry partners, which we do all of the time. I think Dr. Dunbar will tell you a little bit more when he gets the opportunity to talk about Stryker, for instance, and the Mako robot.

So no. What we brought to the table, which is . . . (Interruption) That's it - done.

SUSAN LEBLANC: Again, sounds like it's going really well. Is it going to be expanded? When is it going to be expanded? Was it considered to partner with independent pharmacists? Will that be considered if there's an expansion? There are a lot of independent pharmacies, especially in rural Nova Scotia, that I'm sure would love to have a crack at this program. Just wanted to hear a little bit about that.

GAIL TOMBLIN MURPHY: Again, Nova Scotia Health Innovation works in full partnership, so we work with the Pharmacy Association of Nova Scotia, for instance, which represents many of the pharmacists who you speak about today. We see a variety of partners helping to bring a variety of innovative solutions. Presently, we are speaking with PANS about other opportunities to test and try models of care delivery that again will provide access to Nova Scotians. The answer to that is yes, oftentimes we are working with a variety of partners to crack some of the very complex questions to come up with the most innovative solutions.

Doris could tell you more, but we've got a number in the launch pad right now of things that we're testing and trying.

SUSAN LEBLANC: I have so many questions, but I do recognize that Dr. Dunbar has not been asked anything. I'm not going to ask you what you think I'm going to ask. I want to ask you about the physician assistant pilot that was happening in orthopaedics. My understanding is that it is a three-year pilot. When is it scheduled to end? Will it be expanded? If so, how many will be hired, and what has been learned from the pilot? I only have five minutes.

THE CHAIR: Dr. Dunbar.

MICHAEL DUNBAR: Thank you for the question. I'm not intimately involved in the negotiation or the contracting, but I'm remotely aware, and of course, I'm quasi-involved as an orthopaedic surgeon because they're within our realm and sphere of practice.

I can tell you a lot about our learnings. Our learnings have been extremely positive, both from an allied health care worker perspective in terms of surveying those around the physician assistants, in terms of if they feel it was a value provided to them and others, and that would be unanimously positive, as well as the patients who also felt there was a lift associated with that.

There's been no friction or opposition or strangeness with respect to sometimes what happens with turf wars and things like that between different allied health care. The bottom line is listening to the questions you've been hearing. There's a lot of room in the pool for everybody. We need all the help we can get.

You're probably very aware that the standard of care in the United States would be that every orthopaedic surgeon would have a physician assistant, and the physician assistants are employed in that model because they're cost effective. If nothing else, the value of the dollar rules in some jurisdictions, mainly the United States, and it's very clear in that sense that you amplify the productivity of the surgeon by having a physician assistant.

We see it as extremely positive. We're very supportive of what we see as the short-term pivot. We have a group of patients who are with an oncology orthopaedic team and who have complicated needs with respect to chemotherapeutics, monitoring their renal and liver function, a very complex set of metrics that need to be followed. They're ideally suited there. We're hoping that one will be deployed with those. The other two are hoping to be deployed to Dartmouth, where we've hired several new arthroplasty surgeons to amplify their care to allow them to be really quite efficient and almost factory-like with respect to their approach to getting joint replacements done.

It's been extremely positive. As an orthopaedic community, we're very supportive of it. We're grateful that it was brought to us, and we would like to see it continue.

SUSAN LEBLANC: Maybe this is not in your wheelhouse, but do you see other outside of orthopaedics usefulness, and maybe the oncology part that you referenced? I'm not sure if that's in orthopaedics as well, but do you see other places in our system where physician assistants could be useful, helpful and cost effective?

MICHAEL DUNBAR: Absolutely. I believe one of the pilots was in the emergency room, so that's a logical fit. Not only would this be the paradigm in the United States for orthopaedics, it would be for multiple other disciplines, both medical and surgical. I think it's an untapped resource.

Interestingly, when we put this out the last time, we had individuals all across the United States who said, I was a medic in the Canadian military. I went to the States to be a PA. I want to come back, please let me in.

So we're really keen to see this expand. We think it's an untapped resource.

SUSAN LEBLANC: I know that there are several people who fit that bill who live in Nova Scotia right now and would want to practise. I'd love to see that happen.

Quick question. I met with someone from Nova Scotia Health yesterday who thinks about physical activity and active transit. I'm wondering if active transit is anything that's ever crossed your desk as an idea to do innovative research about. In terms of upstream funding or upstream health care, is there anyone thinking about that in terms of how good it is for us?

THE CHAIR: Dr. Dunbar, with 20 seconds.

MICHAEL DUNBAR: We're going to run out of time. Maybe the next person can bring it up and we can finish - but absolutely. The best time to plant a tree was 20 years ago. The second-best time is today.

The short answer is that we need to get into schools right now and start educating kids about healthy living to reduce the burden of arthroplasty that's coming up into the future. That's another way to address the wait-list - the longer-term seed planting.

THE CHAIR: Perfect timing, doctor. We will turn to the PC caucus, the government caucus. MLA Palmer, I believe, is up first.

CHRIS PALMER: Thank you again to all of you who are here today for reminding us that as we address the primary care issue, virtual care is one piece of that, and it's a multi-initiative approach. Thank you for putting more context into the conversation today. It's very important for people to know the context, for sure.

I also think Nova Scotians need to know some of the other great work that the Innovation Hub is doing. I guess I can address this question to any one of you up there. I'm wondering if you could give us a few examples of other projects that the Innovation Hub has been part of and how they're reflective of the hub's goals for patient outcomes going forward, and if you're able to, as a follow-up, give us any sneak peeks into some of the things coming up in the future. I could direct that to Dr. Tomblin Murphy.

GAIL TOMBLIN MURPHY: Thank you so much for that question. What a brilliant question because this helps me to bring Dr. Dunbar back in.

We're really thrilled, as I said in my opening comments, through our Innovation Hub and Innovation Launchpad, that one of the things we're really proud of to test and try is our robotics. Dr. Dunbar can tell you more about his experiences there.

As well, aren't we thrilled that we have actually named a robotics centre of excellence in this province? This is huge go-forward.

As Dr. Dunbar answers this, as well, to recognize Dr. Dunbar as an innovator in residence has been incredibly important for us as well as our partners. Over to the man.

MICHAEL DUNBAR: I appreciate it. Where to begin? Let me first state that the questions from Mr. Maguire are not lost on me, because I am primarily in the trenches. I deliver arthroplasty care. I am first and foremost a surgeon and a clinician, so I'm acutely aware of the suffering that's out there amongst our patients. I've been at this for a long time - 23 years now. I was involved with the national benchmarks 15 years ago that were sponsored by the Canadian Institutes of Health Research. I helped set the benchmark on the wait time, so I'm painfully aware of where we're at with respect to access to care.

I would also suggest that this has been a systemic problem that's been promulgated through multiple layers of government over time. It's not a problem that occurred overnight. The same headlines that you would read in Nova Scotia are, of course, occurring across the country, particularly in Northern Ontario right now with respect to access to primary care and emergency rooms in particular. This is a national problem that's not going to get solved overnight.

When I get up in the morning and I want to go forward and think, "How am I going to really embrace this and make a positive aspect of it?" what does come to mind is innovation. It speaks a little bit to the other question from Ms. Leblanc about what we are doing about innovative ways to get healthier children and reduce burden of disease.

When you start to look at a lens from 30,000-foot across a jurisdiction like Nova Scotia, you start to really understand the fantastic opportunities we have as a jurisdiction to change the paradigm and look for disruptive ways. Frankly, amongst those in the trenches, we've been waiting for the bottom and waiting to say, something's got to hit the bottom so

we can break the system and start over again. I think, unfortunately, through all those reasons I alluded to, we've gone there.

[2:00 p.m.]

What very positively I've seen through the Innovation Hub and through the leadership of Dr. Tomblin Murphy and her team - as well as other members through the hospital organization and the government - is an appetite to do innovation. I've seen the whole groundwork change with respect to embracing new models of care, and enthusiasm to bring forward ideas that before would not fly. I think a primary example of that is robotics.

I'm really proud to say that we have actually managed to land the second robot in Canada - an orthopaedic robot here in Nova Scotia. Humbly, perhaps not humbly, there are reasons why it's here and not in other leading jurisdictions across the country. That's one of multiple [Inaudible]. My colleagues in gynecology and urology, soon to be general surgery, neurosurgery have also gone down this path and have been well supported, and received by the innovation group in the hospital to bring these tools forward.

What I find very interesting about the robotic platform and potentially the centre of excellence is something that intersects all the questions that have been asked today. It's really about the data, and it's about understanding the continuum of care and the ecosystem of data that exists within a province like ours.

I would perhaps wrap up by saying that we have a unique opportunity because there's no other jurisdiction in Canada like Nova Scotia with respect to the breadth of pathology that we have, the older population, the critical mass of about a million people, but also the fact that we have a well-defined clinical pathway with the majority of large procedures happening under one jurisdiction.

For example, 100 per cent of cardiac surgery is done here, 100 per cent of neurosurgery is done here, and we have excellent ties with our ancillary community hospitals.

I think what becomes very interesting to me is the robots allow us to start to collect data, to look at patient-specific variables. Through other data sets that we have, using our partners across the province, we can become a living health laboratory like others have talked about in the past. We can take what would have been lemons and turn them into lemonade - because that data is powerful, as you all are painfully aware, and it's powerful in innovation in terms of developing predictive analytics, new models of understanding.

For example, one of the things we've been doing through innovation is we're understanding now that everybody we operate on in orthopaedics for hip and knee replacement, about 15 per cent of them show up in the emergency department within 90

days. The number one reason they come back is for pain control, and that occurs at around Day Six. We now have enough data through the Pharmacare data sets and others to say, could we predict who's going to come back after surgery and take limited resources like physician assistants, et cetera, and better apply them? Or say, these are the individuals who clearly need to get into the virtual network, as opposed to a more homogenous approach.

That's really quite a long-winded way of getting out what I've been sitting on here with all these questions and getting my input in. There is a pathway. There's an ecosystem that I think we need to embrace.

Finally, I would toss it back, because I think there's a political need here as well, because we need to socialize these concepts through the citizenry. We need to look at new ways of understanding ethics about how we use this data and operationalize in the future. We can't be in an Orwellian field where we say, you can't look at my data. The paradigm shift to make this all work is we have to get others saying, I want you to look at my data in an appropriate, anonymized way, because I want to use it to bring resources back to the camp, bring it back to Nova Scotia. I think we can do that.

CHRIS PALMER: Thank you for those answers. It's obviously very clear that the Innovation Hub is doing such great work to move towards better outcomes for people. Dr. Tomblin Murphy, you mentioned earlier in your opening statement what it's been able to do for people in rural areas. I represent a rural constituency. Could you elaborate a bit more again on things that are being done through the Innovation Hub and how they'll improve outcomes for rural people? Is there any other innovation or technical types of things in the rural areas?

GAIL TOMBLIN MURPHY: I will get started, and then I will ask my colleague, Doris Grant, to add to that, and Tara Sampalli.

That is critical, and thank you so much for that question. Oftentimes, across this country, and in particular in this province, we need to be thinking about rural strategies - how we deliver health services in rural strategies. We are at a time that, as you know, some of the transformation in the health care system has meant that we put the decision-making in the hands of our zones. We have four zones, and I think it would be safe to say that all four of them have rural areas, but three of them in particular are more rural than our Central Zone.

We've got some good examples, but I would first like to say that we need to create an infrastructure so that innovation is sustainable. It's not just a good idea; we have to prepare the actual site to take that innovation on, to sustain it, and grow it. That means change management.

Recently, what we've done is we have hired our clinical champions - one of them in each of our zones - who are basically the innovator champions. They work closely with our

operations people in addition to what we're doing in the Health Innovation Hub to make sure the greatest ideas happening in the zones, in rural areas, are actually being implemented.

If I think of some of the examples - for instance, we talked a bit about VirtualEmergencyNS. That came as the result of a physician, Dr. Jan Sommers. First of all, we need to make sure that people access care - that they do it differently. She started during COVID-19 - setting up her own Zoom, for instance, trying to figure out all the things she was doing as an attending emergency room doctor; in addition to that, trying to bring the innovative solutions.

We also know that there are parts, for instance, of Eastern Zone and parts of our province - I don't need to tell you or others here - that are very rural. So how is it in Neils Harbour and other places that we can use innovative models of care? How is it that we can actually link 811 and integration of services in a way that we otherwise haven't? How is it that we could put nurse practitioners in place?

It's not just nurse practitioners. As you're probably aware, we have been focusing on maximizing the scope of practice of all of our providers. That has been something where they've been working under scope for a number of years. If we think about that example of access for a nurse practitioner - because of the change in the Act, we now know that nurse practitioners can admit as well as discharge.

Those would be a couple of examples. I lob it over to both Doris and Tara to give examples in rural Nova Scotia.

MICHAEL DUNBAR: There are a couple of things that came to mind, and I think they're germane - the things that interest me. Virtual care is obviously an important component, but it's anemic - for lack of a better word - to just represent a Zoom meeting to our patients. We'd like to do more than that. We're all well aware of the multiple devices and the myriad of things that we have that can collect biometrics and look at what's happening to our patients.

Dr. Karen Cross comes immediately to mind. She was the surgeon entrepreneur in the University of Toronto, and we've scooped her. She's a plastic surgeon. She's gladly moved to Nova Scotia, and she's here. Importantly, she's brought MIMOSA Diagnostics with her to the Innovation Hub, which is a wound care app that allows us to look at patients' complex wounds.

What's interesting about that to me is that it intersects medicine with diabetic footcare. It intersects all forms of surgery. Unfortunately, it's really hard to assess over Zoom what your wound is like, what the temperature is, and whether I need to put you in an ambulance and bring you to Halifax or get you in an emergency department where we don't want you to be for all the reasons we've talked about. There is a lot of technology

that's been enabled to allow us to do that - extend the reach of a qualified clinician remotely.

The other person that comes to mind who was featured in the Innovation Showcase was Emily Johnston, a PhD pharmacist working with us who's developing an opioid app for post-operative care. As I alluded to, the number one reason people are coming back to the emergency room post-surgery - again, where we don't want them - is because of pain control issues. If we're able to have a virtual presence and proctor and mentor those patients remotely, we think we could keep a significant number of those out of the emergency department.

Interestingly, and the positive other spin you get from this, is that also collects a rich data stream, which is a self-fulfilling iterative. That same data then allows us to develop decision support apps and predict who the patient is that's likely to have the pain post-operatively, and how I can manage their prescription pre-operatively. What would I put them on to avoid opioid dependence, or even to remove opioids all together?

As we all know, opioids are a very challenging issue around North America, in particular. These apps and decision support tools we could develop have high value to other jurisdictions who would pay for those because those patients who get readmitted in the United States come out of the bundled care, so the hospitals and/or surgeons pay for those patients.

There's a true monetary platform where we could take that same iterative information and iterative process and monetize it through the Innovation Hub. I think what's changed is the understanding that that's possible, and also the appetite to say that that's not only possible, but that it's appreciated and a potentially desirable thing to do.

DORIS GRANT: One of the other things that I just wanted to mention - and it was Dr. Tomblin Murphy who brought it up initially - is clinical trials. We know that many of our specialists live and are in the Halifax area, but we also know we have patients all over this province who would benefit from participating in a clinical trial. Those who are in Glace Bay shouldn't have to drive the five hours to get to Halifax to be able to do that. So one of the efforts that we're taking on as part of our clinical trials unit is to really focus on decentralizing those trials so that people can get that care in their communities.

We're just early days, but that is a focus for us so that people, once again, can get care in their communities regardless of where they are. So again, there's a lot of work underway related to clinical trials because sometimes the best course of treatment for that patient with that disease is an experimental therapy that is on trial through Health Canada. So there's a lot of opportunity there to bring new medicines to Nova Scotians.

TARA SAMPALLI: It is such an important thing. We think about, first of all, understanding what the needs are. There's a lot of focus on rural communities and trying to

understand through what we do as rapid reviews. Every day, there's a different question that comes up as to how can we do this differently? What kind of access? We are always producing information and bringing innovation from other countries and communities so that we can actually adopt that. That's one thing.

We also invest in our health care professionals. Dr. Tomblin Murphy is a leading expert in this phase and thinking about strategizing on how we do things better. Part of it is also giving the types of supports that professionals need in these communities where they don't have the luxury of being in big practice teams. For instance, in our pharmacy plus clinic, we have a nurse practitioner who is supporting the other nurse practitioner to transition into practice and giving those types of supports in those rural communities which is really critical.

Like I said, the Dalhousie Family Medicine Clinics - the next phase is really bringing it to those rural communities where access is important. We continue to think about innovative models, but we also think about evidence and the types of models that need to come into these rural communities, but we engage those communities in understanding the needs. Those were the things I wanted to add.

CHRIS PALMER: Just one last comment. If after our meeting, I could maybe get the name of the contact for the innovation champion in the Western Zone, that would be great. I'll pass it on to my colleague now.

THE CHAIR: MLA Sheehy-Richard.

MELISSA SHEEHY-RICHARD: This is a very exciting topic. I should have mentioned earlier, I am sitting in on the Health Committee today, but it does feel a little bit like the Public Accounts Committee sometimes.

I'm really excited to hear about the Atlantic Clinical Trials and how that, like you say, in Glace Bay can really help somebody who maybe doesn't have the ability to participate here. It's one of the main reasons I ran. Although I'm rural, I do fall under Central Zone, which is kind of a little challenging in itself, but I think I'll skip over that because we did touch enough.

I do have a question that I was wanting to touch base on, and that's about the health challenge winners. That really piqued my interest on the work that was done with the cancer care and the mental health and wellness. I was wondering if you could elaborate a little bit more on those two winners of the health challenge.

GAIL TOMBLIN MURPHY: Thank you so much for that question. We have definitely learned along the way on the health challenges, but I would have Doris because she's probably so excited inside to tell a story about one of the winners of the health challenge. Also, there are many other winners who might not have been the recipients of

the first health challenge, for instance, and those are the winners who we deal with each and every day. Doris, why don't you tell the story that I know is coming?

[2:15 p.m.]

THE CHAIR: Ms. Grant, with two minutes and 10 seconds.

DORIS GRANT: We initially started the health challenge very early in the pandemic. I want to say we had the first one - it was the Summer of 2020. We were all immersed in that, but we wanted to really learn about the companies that are in our region, and we wanted to be able to figure out who those companies are in our area that were working on diseases, and areas that were of interest to our patients, and, also, the health system. So we targeted the health challenges to clinical themes.

As you said, the first one was cancer care, and the second was mental health and addictions. The first challenge - the winner of that health challenge was a company called Adaptiiv Medical Technologies. This is a company that uses 3D printing combined with a novel algorithm to really develop and print very specific devices that are used in radiation oncology. They are selling these devices and this technology all around the world.

This was a technology developed by a Nova Scotia Health Authority physician, Dr. James Robar, in the medical physics department. Again, we had partnered with Dalhousie at the time in order to commercialize the technology and I was formerly at Dalhousie helping to work on that. I have seen this company grow and make such a difference in the lives of our patients, from an accuracy perspective in terms of treatment but then also from a patient experience.

It really is, for me, an absolute delight to see this company grow and do so well on the global stage. Right now, this company is down at a conference highlighting some of their more recent partnerships with some of the leading companies in 3D printing - HP - and then also, they've partnered with . . .

THE CHAIR: Order, thank you. We'll now move on to the second round of questioning. It looks like we should have about enough time for eight minutes per caucus. We will begin with MLA DiCostanzo.

RAFAH DICOSTANZO: You pronounced it beautifully, thank you.

My main questions are going to be about the pharmacy walk-in clinic. I was very excited to hear about that. Anything that expands the scope to other allied health workers excites me a great deal. However, I'm trying to understand how this came about. Why is Sobeys interested in having a nurse practitioner when we are desperate for nurse practitioners at our walk-in clinics?

What is the government seeing here? What is Sobeys offering you that the walk-in clinics are not offering you? As you mentioned, there was no RFP, no money being given to Sobeys - we're just paying a salary for the nurse practitioner. Did I understand it correctly? Maybe you can give us an outline of how this came about. Why did we go with the pharmacy when we have need for nurse practitioners in our walk-in clinics?

GAIL TOMBLIN MURPHY: Thank you. I will get started, and then I'll pass it to Doris Grant.

Number one, we do have a number of nurse practitioners in this province as well as across the country who have been underutilized for a number of years. It's not necessarily that we don't have the numbers. It's more that we have not appropriately utilized nurse practitioners.

For instance, in other jurisdictions like Ontario, we would have nurse practitioners who are independent in terms of their practices. It's a much different model than what we have in Nova Scotia.

That being said, as the chief nurse executive in this province, we are meeting with all of our nurse practitioners. There are a certain number of them who have been underemployed in the past. That is, working as registered nurses in areas that they are not working as nurse practitioners. That went on for a number of years. Part of the innovation has also been around strategies in place to enhance the providers working to their full scope of practice, and working in teams.

I'm going to be frank. The life and the route of a nurse practitioner has not been easy, going back to some of these threats that happened in the system. It's all around payment, oftentimes - remuneration. With sometimes physician assistants and other roles, if people are feeling they're impinging on what they are doing in terms of providing care, it is a very political issue, as you know, as well as a professional issue.

That being said, in terms of nurse practitioners, we are invested in finding ways that those nurse practitioners who are available to us can be working in the areas that they're very interested in delivering care. Working in emergency rooms differently, for instance, or working in - you're correct - some of our walk-in clinics and other areas. We have a lot of room to bring forward some innovation.

Again, we meet with many partners - Sobeys only being one of them - to bring solutions. How is it that we perhaps could work together to enhance access for Nova Scotians working collaboratively? Bringing a pharmacist and a nurse practitioner working together to provide some of the care that Nova Scotians need, but over to Doris to fill in those earlier blanks, if you'd like to add anything, or Tara.

DORIS GRANT: Several months ago, we had a meeting with Sobeys and the executive team from Sobeys, and there was a lot of goodwill between the parties and good faith negotiations, and there really was a commitment to how we do better for our communities. You know that Sobeys is embedded in their communities, especially a very strong presence in New Glasgow, and it was like, how do we work together to do this, to be able to deliver better care, to be able to take some of the pressure off that emergency room? How do we do that? Through really collaborative discussion, we all collectively came to a nurse practitioner in this already established walk-in clinic could make a difference - let's try it.

Are we going to be doing this 10 years from now? I don't know, but what we did commit to do was to try this model that we haven't seen before in this province, just to see if it would make a difference.

RAFAH DICOSTANZO: I'm still not there because to me - these are walk-in clinics that were already established for pharmacists to use because a regular Lawtons will have a very small room for the consultation room. This is totally different. We have a walk-in clinic that Sobeys is paying for, for the building, for everything, and we as government are not paying them any money for housing the nurse practitioner. So, what does Sobeys get out of this?

There's no financial (Interruption) - no, but it's not. It's separate, right? It's not in the pharmacy, because only in the pharmacy, they have the small consult room, they call it. Is this a walk-in clinic that Sobeys built for this purpose, or did they use it - what did they use it for before? What kind of walk-in clinic is this compared to a doctor's walk-in clinic?

TARA SAMPALLI: That's a great question. Before I even speak to that I want to say that we are trying to understand how people work and work in different ways. This is about innovation. When we think about pharmacists, there's so much we need to understand and so much we need to bring to support the way we work and community care.

Within the Sobeys way of working, pharmacists have a clinic-type of setup where - and we are working with PANS as Gail mentioned - pharmacists are not only seeing and filling out prescriptions, but they actually do take people into a consultation type of room and provide that care.

In this particular collaboration, it was an opportunity to bring better access to the community. That was the foundation of it all, to say how can we partner with, for instance, the primary care practices that are in the community? What will it look like for us to maybe engage with a different type of a provider - because there are certain gaps in the scope of practice.

So that's where we started with this model as a test and trial - to bring a nurse practitioner to see if they can work with the pharmacist, and where those bridging places

are. The nurse practitioner is also about bridging the space between primary care and this community clinic.

RAFAH DICOSTANZO: I don't think you're understanding my question. Did they build a special space for your nurse practitioner, and they're not charging you any money to house her? Is this what is happening? So Sobeys, out of the goodness of their heart, built a clinic for the government and are not charging money for it? Is that what you're telling me? The rooms are very small, and they're needed for the pharmacists to use, so where is this nurse working, and how can the pharmacist use that room at the same time? That's what I'm trying to understand. Was that a separate location?

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

SUSAN LEBLANC: If you can answer in 20 seconds, go ahead.

THE CHAIR: Dr. Sampalli.

TARA SAMPALLI: It's not a separate location. It is in the pharmacy, and the only thing we are doing - it's a consult room.

THE CHAIR: Order. Thank you, MLA Leblanc, for allowing that to happen. MLA Leblanc.

SUSAN LEBLANC: Just want to hearken back a few years to the NDP government, when there was a very innovative practice in health care called the collaborative emergency centre that was started in many communities. It allowed emergency care in small communities and improved access to primary care. I understand very well, because of work I'm doing in my community, about the different models of collaborative care at Nova Scotia Health Authority. My favourite at this point is the turn-key health home model.

To me, it seems like we know what the solution is for access to primary care. It was piloted with the collaborative emergency centre. We have a number of very well run and useful turn-key models. I think of the one in Preston that I got a chance to tour a couple of years ago. It feels like that is the way to go. Years ago, under the Liberal government, there was a budget where I think there was $10 million or $20 million that was specifically for collaborative care. The following year, there was no money in the budget for collaborative care.

I'm wondering if you're looking at collaborative care as an innovation for access to primary care, or access to health care in general, and if you can talk about what the barriers are. Why aren't we just doing it? Why aren't we just putting money into collaborative care? We hear that new doctors, graduating doctors, younger doctors, want to work in that model

because they don't want to take on all the responsibilities of the administration, the hiring and firing, and all that stuff. Why isn't it happening more?

GAIL TOMBLIN MURPHY: Again, very astute of you to outline the historical perspective and the importance of collaborative care. We have been involved - and Dr. Sampalli and others has been involved with me - in an evaluation of basically these different models. Whether they're turn-key types of models, whether they're clinical services models - a variety of different things.

In terms of what we learned from the collaborative care model and access to health care and what those barriers are, I believe that Tara would be in a good position to speak to those evaluation findings - building on what we learned. Also, why we in the Innovation Hub, remembering what our role is and what it's not - how we're testing and trying other types of access models as well, in addition to the turn-key kind of solutions.

TARA SAMPALLI: Again, such a great question. One of the things we are trying to do is understand - there are over 95 collaborative care teams across the province, and there are all different types of models like was mentioned. Some of them turn-key practices.

Part of the thing is really to understand that it all comes down to how people are working to scopes of practice. We have a number of family practice nurses, we have nurse practitioners, we have social workers, we have pharmacists. The opportunity for us through that evaluation was to understand how we can support or understand how these teams are functioning. It's one thing to just provide a budget for that. It's a whole other thing to have them come together as a team.

This is not unique to us. Scotland is also working on how to help not only to work well together as a team, but how the public understands the different roles we play. That's where we came to: we need to invest some time in really helping these teams improve the quality of how they work together. That's where we are investing in the Dal Family Medicine clinic - it's about helping these teams really work to full scopes of practice.

Within that, your question is really key: the younger, newer providers want to practice in a different way. The one that's coming to Dartmouth North is going to be even more exciting, because it will allow different providers to practice in the way that they'd like to by bringing them into well-established practices so they feel supported. They can actually come in and practice and support, but they have a well-established set of providers mentoring them and giving those supports.

We are trying to look at how we can support our providers, but also the community-level needs. While we think there should be more collaborative models, collaboration itself can be collaborating with community programs and services. It's not bound by a physical space. That's really critical, and that's where we're investing -

different communities, different needs, different types of collaborations, including the Pharmacist Walk-in Clinic+ type. That's where the next layer of innovation is, thinking about those models of care, but learning from the evaluation we have done. We are still in that collaborative space, for sure.

[2:30 p.m.]

SUSAN LEBLANC: I just want to go back to my question about activity before my time was up before. What I'm specifically asking about is active transportation. I happen to be my party's Health and Wellness critic, Environment critic, Communities, Culture and Heritage critic, and I was Public Works critic. Literally all of my critic areas come together in the topic of active transportation.

That is something that makes perfect sense to me as a place for planning and priorities, and top-level government thinkers to be putting effort and emphasis on. There are millions of studies, but the one study that I often refer to is one from England where I think a thousand people were monitored who rode their bikes to work. I don't even know what the amount of time was or the distance, but with those thousand people, there was 50 per cent less cases of heart disease and cancer.

That is kind of mind blowing. All they did was ride their bike to work half an hour a day, or 40 minutes a day. It feels like a massive place to be focusing in terms of upstream health care. But we cannot do it if people are terrified of riding their bikes and then winding up on Dr. Dunbar's table because they've been smooshed by a car. It's really dangerous right now.

Where does your work intersect with the people at the Department of Public Works, and the people at the Department of Environment and Climate Change, and the people who are at top-level planning for this province?

THE CHAIR: Thank you, MLA Leblanc. I'll ask you to table that report, please. Dr. Tomblin Murphy.

GAIL TOMBLIN MURPHY: I think I'm going to punt this one to over to Dr. Dunbar because I know he's excited to talk about this.

THE CHAIR: Dr. Dunbar - 20 seconds.

MICHAEL DUNBAR: I did my PhD in Scandinavia, so I'm aware of the phenomena. You're absolutely right. We have to set the winning conditions amongst all of us. The work is under way, and the seed is planted, and the lessons are within the Scandinavian countries. We're going to run out of time, but I support it.

THE CHAIR: Thank you, doctor. Over to the government caucus. MLA Johnny White.

JOHN WHITE: Thank you, Chair. J.W. is in the house.

Listen, folks - I want to start off by congratulating and thanking you for coming in to speak with us because when I hear you talking about the possibilities - you're already looking into the future. You talk about innovation. I mean, you guys are on the forefront of moving us out of the position we're in, and I really do appreciate all that you're doing. I realize that there are challenges. I know what you're talking about, and you're dealing with it.

This province has been in need of doctors for at least a decade. It's been going on for a while. Since April 1, 2021, we've taken on over 160 doctors. Maybe now, Nova Scotians are realizing that there's a reason to register on the Need a Family Practice Registry. Thank you very much for your work, I really appreciate everyone here for it today.

Can you tell us about how you work with clinical departments to transform health care based on internal needs? For example, if the surgical in-patient unit has a particular issue or challenge or need, how can the Innovation Hub be tapped into at the patient level to link innovation and solutions?

MICHAEL DUNBAR: I have pragmatic examples that we're doing within surgery, and then I think it speaks to that global situation we talked about with data. Like MLA Leblanc, I wear a lot of hats, too. I'm also the Research Director for the Department of Surgery, and what I've challenged our membership with is understanding the data sets that are available within the province. We have rich data sets. For example, we can collate the national Discharge Abstract Database, the ambulatory care record, the physician billing record, the VON record, the Pharmacare record. We can actually have, I believe, one of the richest data sets in the country about the patient experience as they go through the process.

Understanding a lot of this is reactionary and it's not upstream where we'd like to get, but it is about what happens to the patients within the hospital. Actively, we have directed resources to understanding amongst all surgical divisions in Nova Scotia who ends up in the emergency department.

We've picked this because it's an important determinant of - it's the things that are on your desks, on the hospital administrator's desk. It's in the media every day about what's happening in the emergency department. We would like to take responsibility as the Department of Surgery to understand what's our contribution to that burden and what can we do to reduce the patients showing up in the emergency department.

That's about the data stream. It goes back to what I said earlier about the ability to then take those data sets and understand what patients are having what procedures with what co-morbidities on what medications ended up being readmitted, ended up traveling to an emergency department. We also have information, for example, of how far did they travel for their index procedure, and did that have an impact on their bouncing back to the emergency department?

We then have the ability through the Innovation Hub and the Innovator in Residence chair to make linkages to Dalhousie and other universities to take advantage of the brilliant masters and PhD students who are sitting there looking for projects and rich data sets to do machine learning and artificial intelligence on. That's frankly what gets me most excited, is the potential to marry those data sets with the assets we have out there and set the winning conditions for everyone. Our job, as health care providers and researchers, should be to provide the most interesting data sets so that the students want to access them, so that we can come back to those who are paying the bills and say, here's what we think we should do.

Through the innovation piece, we think we can monetize that and come up with the decision support apps that I've talked about - about what was the determinant that made this patient be admitted, and what should we do about assigning limited resources?

I'm going to take this opportunity to say as I said before, we're all Nova Scotians. It doesn't matter what caucus you're in, what side of this aisle you're on. We're all in this together, and we have to set the winning conditions amongst all of us.

What I need, and I'll speak for myself as a research director and potentially Innovator in Residence - there are paywalls that the government puts in place for us to access those data sets. Those are simple strokes of the pen to make those go away, for us to enable better leverage on those data sets. That's a political decision that you should discuss when we're not here, and go back and forth to figure out why that is.

There are privacy laws that are in place that need different interpretation. They need to be more forward thinking about how we're going to use that data in the future in an appropriate, anonymized, safe way, but to take advantage of that as opposed to saying, this is Orwellian, and nobody can look at anybody's data. There's socialization of these concepts that needs to come, not only from the health care system, but also from the government system to say to the citizenry, this is important, and the answer lies within - we can do it.

I use what's happened in surgery as what can happen to any clinical department. What interests me about this is that this same template can be translated in Cape Breton, in Hants, anywhere. It can be translated to psychiatry, pediatrics, any discipline we want to look at, and we should look at, because of the completeness and the breadth of that data set adds only more power to the machine learning and the artificial intelligence.

JOHN WHITE: I have a couple minutes left. It's exciting just listening to you and the possibilities. It really is. I wish we had more time. I know I have one question left. Maybe I'll just give you a minute to explain the difference for anyone who's watching with VirtualCareNS and VirtualEmergencyNS, and maybe the role the Innovation Hub plays in both programs.

DORIS GRANT: VirtualCareNS, again, a program designed for the unattached patients in this province. We started the deployment of that solution in the Western and the Northern Zones, and then are now rolling out the solution in both the Central and the Eastern Zones. As Dr. Sampalli said before, this is a Nova Scotia solution. This was working with all of our providers to be able to design it and to implement it. It's housed with Nova Scotia physicians and nurse practitioners, all within this province.

VirtualEmergencyNS is another virtual care platform that sits within the emergency department in the Colchester hospital. It's early days for that. We're seeing very positive results from both our patients and our providers. We're in discussions with folks in the Western Zone and the Eastern Zone to figure out where we should go next. There's a lot of demand for that, to be able to, again, see those patients once they're in our emergency department.

Again, one is at home - in their home or their library - and the other is once they're in the emergency department.

THE CHAIR: Thank you, Ms. Grant. Eight seconds, MLA White.

JOHN WHITE: I don't think I have much time. Again, I want to thank you very much. I am excited for the future. I really am.

THE CHAIR: Order. Thank you to the witnesses for all the responses today. I will afford a minute or two if anyone has closing remarks that they'd like to wrap up. Dr. Tomblin Murphy.

GAIL TOMBLIN MURPHY: Thank you so much for this opportunity. Once again, what a positive opportunity in Health Committee to hear about the innovative solutions. All of you - regardless, as Dr. Dunbar said, of party or politics - are here for the right reasons. Thank you for this discussion today.

As we've shared, there's a lot of work that's been going on. We have a lot more work to do together. In a short period of time, we have been able to move forward because of the support of many of our partners' really big ideas, like our command centre, which is what we call a care coordination centre. We didn't have the opportunity to talk much about that today, but that brings alive the importance of real-time data to inform decisions. We are being noticed for our pace, for our partners, and for the opportunity to do things differently at this end of the country.

Thank you to all of you who've been part of that. We believe strongly that we're well positioned to be leaders on the global stage. Now it's our opportunity to do this. We're noticed each and every day about what is going on at this end of the country - how is it we can learn from you. We're laying the foundation and we're really pleased. We'll continue to work hard through building capacity and looking at and answering the types of questions that you've asked today.

We believe strongly in our Innovation Launchpad. We believe strongly in our Innovation Catalyst Fund. We believe strongly in people like Dr. Dunbar and Dr. Cross, who are our first two innovators in residence. We'd like to thank them for the contributions that they're making.

It's not easy. We need to build a culture of change. This change is not something that many people are used to. Change management is not easy, but together through many mechanisms and partners, we are trying every day to do all of this with a continuous quality-improvement lens and the evidence on an ongoing basis to inform it. Thank you for this opportunity today.

THE CHAIR: Our pleasure. Thank you very much to the witnesses. You are now free to leave. We have a few minutes of committee business to look after.

I'm going to propose a two-minute recess while we allow the witnesses to gather their belongings and head out. We'll reconvene at 2:46 p.m.

[2:43 p.m. The committee recessed.]

[2:46 p.m. The committee reconvened.]

THE CHAIR: Order. We'll reconvene from our brief recess. Moving on to a couple items of committee business. MLA DiCostanzo.

RAFAH DICOSTANZO: I have a motion I'd like to put forward. I have provided the hard copies to the clerk, and she will distribute them. It's very short, not a big one, and it relates to my questions as well. If I may?

THE CHAIR: You may swiftly. I'd like to get make sure we get through the committee business.

RAFAH DICOSTANZO: I waited . . .

THE CHAIR: We have an agenda of committee business.

RAFAH DICOSTANZO: I waited to do it at the right time.

THE CHAIR: Order. MLA DiCostanzo.

RAFAH DICOSTANZO: I move that this committee formally request the Nova Scotia Health Authority to provide a copy of the contract agreement with Sobeys or Lawtons for the delivery of the Pharmacist Walk-in Clinic+ program offered in Truro and New Glasgow.

THE CHAIR: MLA Leblanc.

SUSAN LEBLANC: I think this is a good idea. I think that the government members pride themselves - or at least when they were in Opposition, they prided themselves on their commitment to transparency and the request of transparency of the former government. This is really simple, and I think that it would be very helpful and useful information to know how that contract was arrived at, but also how possible it would be to expand those types of services in different communities.

THE CHAIR: Any further discussion on the motion? MLA Maguire.

BRENDAN MAGUIRE: I'd call for a recorded vote.

THE CHAIR: There's been a call for a recorded vote. Could the clerk just read the motion one more time, please and thank you.

JUDY KAVANAGH (Legislative Committee Clerk): I'm going to ask Ms. DiCostanzo to read her motion.

RAFAH DICOSTANZO: I move that this committee formally request the Nova Scotia Health Authority to provide a copy of the contract agreement with Sobeys or Lawtons for the delivery of the Pharmacist Walk-in Clinic+ program offered in Truro and New Glasgow.

[The Clerk calls the roll.]

[2:49 p.m.]

YEAS	**NAYS**
Susan Leblanc	Melissa Sheehy-Richard
Rafah DiCostanzo	Chris Palmer
Hon. Brendan Maguire	John White
	John A. MacDonald
	Kent Smith

THE CLERK: For, 3. Against, 5.

THE CHAIR: Moving on . . . (Interruption) On the advice of the clerk, I'll officially formalize that the motion is defeated.

Moving on, the first item of business is correspondence that was back and forth between our committee and the Associate Deputy Minister of Health and Wellness, Craig Beaton. Is there any discussion on the correspondence? MLA DiCostanzo.

RAFAH DICOSTANZO: That is for the CEO not showing up at the meeting, correct? Is that the one we're discussing? Alright. It's the next one that I wanted to speak to. I apologize.

THE CHAIR: This is correspondence resulting from the May 17th meeting. There was a question for clarification and providing some data. That was responded to with what I read to be all the information that the committee requested. If there's no discussion on the correspondence, we'll say thank you very much to Associate Deputy Minister Beaton for providing it to the committee.

Moving on to the witnesses for the September 13 meeting. There has been a request for substitute witnesses. MLA DiCostanzo.

RAFAH DICOSTANZO: For this one, we actually would like to find a date where the CEO is available. The CEO was entrusted by the Premier to fix health care, and part of that responsibility is for her to speak directly to Nova Scotians and provide answers that they deserve. Dr. Carr was here all the time, so what is the difference, and why can't she? If there are other dates that she's available, we would like the committee to try for those dates.

THE CHAIR: I'll ask for the clerk to provide some comments. It's been a challenge for that meeting.

JUDY KAVANAGH: It has been a challenge. It's up to the committee, of course. My position is that it's difficult to get six people in one place at one time. This is a meeting with an unusually large number of witnesses. The other four have said they are available. The remaining two have said they can come if the committee is willing to accept a substitution, so I'm simply putting it to the committee. What's your decision on this?

THE CHAIR: MLA DiCostanzo.

RAFAH DICOSTANZO: I just want to be clear. We will take whatever date. We'll move that topic to the date that she is available to answer questions.

THE CHAIR: MLA MacDonald.

JOHN A. MACDONALD: Is it a possibility that you could have the October one be in September, and then you've got the month of October trying - I'm just asking. You're nitpicking on days. I'm just throwing it out there.

JUDY KAVANAGH: It's always possible to try. I know that the October meeting cannot be moved to September. That's the one on gender affirmation care, and I was actually hoping to have that one today. Again, that's a meeting with a lot of witnesses, and October was the earliest date I could get all of them together in the same place at the same time.

I did discuss with Ms. Oldfield's people and Ms. Lagassé's people whether or not another meeting date in September would be possible for them, and it's not. If the meeting doesn't take place on September 13th - it is for some of them, but then again, four other witnesses, I talked to them, there is no other date in September that the other witnesses can all be there. If the meeting doesn't take place on September 13th, it can be later in the year.

THE CHAIR: MLA Maguire.

BRENDAN MAGUIRE: I just want to put on the record here that this is my first time in Health Committee. I've been on the Public Accounts Committee for eight years. I've never seen a witness avoid a committee like this. We've asked for Ms. Oldfield to appear at the Public Accounts Committee previously, several times, and there's always a reason why she cannot appear.

The Liberal Party has asked for her to appear. She is the one where the buck stops. She is the one who eight or nine people were fired and let go by this current government - people who had health care experience. People who were doctors and specialists who were let go by this government in place of one person who has absolutely zero health care experience.

Someone said to me the other day, it's like she's the Oak Island treasure of the Nova Scotia Health Authority. Some people believe she exists . . .

THE CHAIR: Order. Please keep it on topic, MLA Maguire. You're comparing the CEO of the Health Authority to a television program. (Interruption) Order. If you'd like to carry on commenting with relevant comments, then please feel free. MLA Maguire.

BRENDAN MAGUIRE: What's very relevant about this topic, Mr. Chair, is that she's refusing to appear time after time. In fact, in other committees, she's sent letters in advance saying she's not going to appear, and this government will vote over and over to make sure she does not appear.

Everything in health care is getting worse and worse and worse, and this person is responsible for a $6 million to $7 billion budget, but refuses to appear in any committee to

show any type of responsibility. My question to this committee and to this government is: What is she hiding and why are you hiding her?

THE CHAIR: Order. I'd like to remind the member that this is a topic and witnesses that were approved by this committee . . . (Interruption) Order. The topic and the witnesses were approved by this committee, which includes five members of the government, two members of the Liberal caucus, and two members of the . . . (Interruption) MLA Maguire, please don't interrupt.

MLA Leblanc, we have four minutes.

SUSAN LEBLANC: I just want to say that I do think it is concerning, Mr. Chair. I sit on two Legislative Standing Committees where both the Deputy Minister of Health and Wellness, Ms. Lagasse, and Karen Oldfield, the CEO of the Health Authority, have requested to not appear in front of the committees. This is the third or fourth time, and it's deeply concerning.

I think that this committee, in an effort to actually have our witnesses, should look at a different date - even if it's November - and figure out a time when those two people can appear. As my colleagues have said, they are in charge - the deputy minister and the CEO of the Health Authority. Unless we bring in the minister, which I don't think is going to happen, they are the ones who make the decisions.

THE CHAIR: Thank you, MLA Leblanc. MLA Palmer.

CHRIS PALMER: Just to clarify, what's being asked is to get the witnesses being asked by my colleagues to change the date if possible. Is that the request being made?

THE CHAIR: The clarification is there are four of six witnesses that can make it on September 13th, and two cannot. We're trying to decide what to do with that date - whether or not to accept the substitutes, or to ask the clerk to find an alternate date when all witnesses can appear. MLA Palmer.

CHRIS PALMER: I just want to go on record that I'm supportive of asking the clerk to find another date for those witnesses.

THE CHAIR: Thank you, MLA Palmer. MLA DiCostanzo.

RAFAH DICOSTANZO: If you still have time, maybe you need five minutes to extend the meeting with five minutes? Motion on the floor.

THE CHAIR: If I may, we have two minutes. It sounds like the government caucus is agreeable to asking the clerk to find dates. If I'm reading the room correctly, it appears as though the direction to the clerk should be to find a date with all six witnesses.

I see that it is agreed. The consensus is that the clerk shall seek an alternate date where all six witnesses are available. MLA DiCostanzo.

RAFAH DICOSTANZO: As soon as possible. Let's not make it next year. This is very urgent information that we would like to ask.

THE CHAIR: Thank you. Knowing Ms. Kavanagh, I know that she works as swiftly as possible as she can in all situations.

Seeing no other hands - and seeing as how everyone seems so happy - I'd like to call this meeting to adjourn.

[The committee adjourned at 2:59 p.m.]