HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, December 12, 2023

COMMITTEE ROOM

ER Closures and Doctor Retention

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HEALTH COMMITTEE

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In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Nova Scotia Health Authority
Karen Oldfield
President and CEO

Dr. Nicole Boutilier
Vice-President, Medicine

Doctors Nova Scotia
Dr. Colin Audain
President

Department of Health and Wellness
Jeannine Lagassé
Deputy Minister

Craig Beaton
Associate Deputy Minister

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, DECEMBER 12, 2023

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
John A. MacDonald

VICE CHAIR
Danielle Barkhouse

THE CHAIR: Order. I call this meeting to order. This is the Standing Committee on Health. I'm John A. MacDonald, the MLA for Hants East and the Chair of the committee.

Today we will hear from the Nova Scotia Health Authority, Doctors Nova Scotia, and the Department of Health and Wellness regarding ER Closures and Doctor Retention. Please put all your phones on silent.

I'll now ask the committee members to introduce themselves for the record by stating their name and constituency. I'll change it up: I'll be starting with MLA Leblanc.

[The committee members introduced themselves.]

THE CHAIR: For the purposes of Hansard, I'll also recognize the presence of Chief Legislative Counsel Gordon Hebb and Legislative Committee Clerk Judy Kavanagh.

Welcome, witnesses. I'll get you to introduce yourselves first. I'll go from left to right, and then we'll do opening comments after. I'll start with Dr. Colin Audain.

[The witnesses introduced themselves.]

THE CHAIR: We're going to start with Deputy Minister Lagassé.

JEANNINE LAGASSÉ: Thank you for the invitation to appear here today along with our colleagues from the Nova Scotia Health Authority and Doctors Nova Scotia. I first want to recognize the many health care professionals working in emergency departments across the province. They are highly skilled and work incredibly hard to support and care for patients with unexpected or emergency needs. I want them and you to know that we are committed to supporting health care professionals and patients to receive even better care.

More, faster, Chair. We have heard our Premier and minister say this many times. Delivering more care, faster care, means we must take a whole system approach. This includes emergency care. The change in how we deliver care in one area of our health care system can result in benefits in another. It can also mean unintended consequences. We cannot solve our problems in isolation.

A whole system approach looks at the needs of providers and patients; increasing access to care and how patients interact with the health care system; how we support patients to return to where they call home sooner, freeing up beds and resources in hospitals; how we use existing infrastructure to better support patients and reduce pressure in other areas of our system; and how we recruit and retain the health care professionals we need to deliver quality and timely care now and into the future.

This is not an exhaustive list, nor is it an easy feat in a system that literally touches the lives of every Nova Scotian. Today we will share more about the whole system approach and how it is helping address pressures related to emergency department closures and the need for more health care professionals. Things like improved and expanded virtual care for all Nova Scotians; more services at pharmacies, mobile clinics, primary care clinics, after-hours and urgent treatment centres; and YourHealthNS, an app that puts health care information, resources, and services in the hands of Nova Scotians.

These and other initiatives are meant to help Nova Scotians see the right provider for the right care at the right time. When that happens, it also keeps patients out of emergency departments when they don't need to be there.

Delivering more faster care also means recruiting and retaining skilled health care professionals who are in high demand across the country. In particular, we are here today to discuss physician retention. Through a new and competitive contract with physicians, the community fund grants, a new medical campus in Cape Breton, and the Patient Access to Care Act, we have many initiatives that will keep medical graduates working here and support others to make Nova Scotia their home.

We look forward to taking your questions.

THE CHAIR: Legislative TV mentioned, Deputy Minister Lagassé, and I'm going to guess possibly also Ms. Oldfield, if you could make sure that your microphone is pointing toward you. It's just yours was off a bit.

Would you be next, Ms. Oldfield or - who's next?

Ms. Oldfield.

KAREN OLDFIELD: Just very briefly, Chair, I would like to echo what the deputy minister has said and fully praise our emergency department care teams, but really, all of our frontline health care workers across the province. I had the privilege of doing a tour of many of the facilities in the Western Zone three weeks ago, and had the opportunity to speak to many of our frontline employees face to face and to hear their challenges, and to try to walk for a few minutes in their shoes. They are unrelenting in their work toward excellence and to providing care for Nova Scotians.

I look forward to the opportunity to share and learn today. Thank you for having us.

THE CHAIR: Dr. Colin Audain.

DR. COLIN AUDAIN: Good afternoon. Thank you for giving me the opportunity to speak to you today.

I'm just going to apologize in advance for my voice. I've had a little bit of laryngitis, so if it gives out, forgive me.

As I said before, I'm Dr. Colin Audain. I'm the president of Doctors Nova Scotia. I'm also a staff anaesthesiologist based in Halifax. I'm not an emergency room physician, but I have a significant level of respect for the work they do, and the work of all health care providers working in emergency departments and urgent health care centres throughout the province.

It's important that we begin today's discussion acknowledging that physician stress and burnout are at an all-time high, while physician wellness is at an all-time low. In particular, while the topic of discussion today is emergency department closures, I think it's important to acknowledge that emergency department closures are really a canary in the coal mine. They tell the tale of a health care system that is under significant strain.

I recently met with emergency medicine physicians in the community across the province, such as Digby, Cape Breton, Truro, and HRM. Each community is facing different pressures and challenges. The solutions to their problems need to be tailored to the unique needs of those communities. However, there was a common thread: a shortage of physicians and other providers who are necessary to keep emergency departments open.

In most cases in rural Nova Scotia, family doctors take shifts in emergency departments over and above their office practice and other work in the community. Family physician shortages means there are fewer doctors to cover rural emergency departments 24 hours a day, seven days a week. There is also a national shortage of emergency medicine physicians, so the recruitment landscape is challenging. Physician and nursing shortages are the primary reason emergency departments close.

This means our province needs to be creative in how we address the challenges in emergency and urgent care, and seek ideas from those who are on the front lines and have a depth of knowledge about the communities they serve. I encourage all partners in health care to continue engaging health care providers on the ground, listen to their ideas, and ask more questions.

In addition, some of the solutions to emergency room closures lie outside of the emergency department. All partners in the health care system need to be working together to find creative and integrated ways to improve access to care, support physician recruitment and retention, promote patient attachment to family doctors, and contribute to creating a healthy and positive work environment for health care providers.

I'm going to sort of stop short of my initial remarks just to preserve my voice. Most of what I was going to say after that had to do with the new contract, and to say that I think we've been making significant strides in achieving some of these goals. I'm happy to take any questions about that.

THE CHAIR: Just to remind everybody, this committee works off 20 minutes/20 minutes/20 minutes. At the end of 20 minutes, I'll call order and then we'll go to the next party. There will roughly be 10 minutes of the round beginning, and just wait until the microphone is on before you start speaking to recognize. Don't feel bad, we do it too.

I will start with the Liberal Party with MLA Regan.

HON. KELLY REGAN: Thank you to everyone for coming in today.

If we look at the annual accountability report, at the unplanned closures between April 1, 2021, and March 31, 2022, I think it says that unplanned closures were for 31,697 hours, or 1,320 days during that period - and that's up. That's double from the year before, which was 627 days. This goes and puts further strain on other open ERs like Cape Breton Regional Hospital or the hospital in Kentville. Do we have the number of unplanned closures over the last year thus far?

THE CHAIR: That would be directed to . . .

KELLY REGAN: I think to Deputy Minister Lagassé.

JEANNINE LAGASSÉ: I don't have that number for this past year. The annual accountability report is filed by the end of December, so it's just being finalized now and will be filed by the end of December.

KELLY REGAN: Otherwise, I would have asked for those numbers, but since they're coming in a couple of weeks, that's great.

If we look over at the Annapolis Valley where they've faced significant pressures over the last couple of years - first, Annapolis Royal, the hospital there was closed, and now Middleton Soldiers Memorial Hospital is rarely open, the ER. Our colleague, the member for Annapolis, has been advocating and asking the minister and the department when or ever is the ER going to be fully staffed and reopened? We've heard that NSHA executives in the Western Zone have committed to getting Soldiers Memorial Hospital ER back to 24/7.

I'm asking, I guess, Ms. Oldfield: When will the ER be fully reopened in Middleton or is it going to be permanently shut down?

KAREN OLDFIELD: There is no intention to permanently shut down the emergency at Soldiers Memorial Hospital. In fact, that is one of the places I visited just three weeks ago, and I can assure you that there is every intention to recruit and to augment the hours. In fact, they were recently increased a little bit from the hours that we had seen over the course of the last few months. The folks on the ground are working hard to recruit and to find ways to make sure that the emergency department is open more. There's no intent to close - every intent to find the ways to augment what we have - absolutely a very important part of our province.

KELLY REGAN: I take it that we don't have a date when this will reopen. Do we have a date for when we will see significant improvements in the hours it will be open?

KAREN OLDFIELD: We do have a date where a new physician is joining and will be spending time between Valley Regional Hospital and Soldiers Memorial Hospital. That will be in January, and I think that will be a big help.

KELLY REGAN: Another ER department that we have seen significant impact on the area is in Baddeck. Some of my colleagues were recently in the area. When they were talking to community and health care workers, many of them told our folks that the ER being closed has had significant impact on the safety and health of the community members, but also those who actually come and visit the Cabot Trail. It's a long drive from Baddeck to actually get to Sydney in an emergency situation.

In April, the department said it wouldn't be reopening the ER any time soon. My question to the Department of Health and Wellness is: Do you have an updated answer as to when the ER in Baddeck will be reopened?

KAREN OLDFIELD: I'll start and ask my colleague to join in as well.

The very complicated emergency department in Baddeck - and again, very important to the entire island - and another place that I visited just about six weeks ago, in fact. I had the opportunity - I spent two hours there with the foundation and with, again, the team on the ground and some other community members. Another place where they're very anxious to - love to get back to an ER. We have urgent treatment there, and hoping and working to a model, again, that is sustainable and that can persevere.

[1:15 p.m.]

One of the challenges - and I'm not saying it's right or wrong; I'm simply saying it is a challenge that is expressed broadly in the community and certainly with our health care providers - one of the challenges with Baddeck is that when it was operating, many people were coming from "over the mountain," as they say - coming from Sydney and other areas. This had the consequence of overwhelming the ER and the physicians there at the time, a couple of whom were very new - new to the area and new to the practice. We need to find a way that we can equalize through the Regional and other areas so that they can have a slice without being overwhelmed. That's part of the challenge. That's something that we have to grapple with and find the answer to. As I say, I'm not saying it's right or wrong. I'm saying it's one of the challenges that we have to grapple with.

KELLY REGAN: I take from that we don't have an updated answer as to when the ER in Baddeck will be reopened. While we're at it, the reopening or the extended hours in January that we just heard about for Middleton - do we know how many more hours those would be?

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: I can't speak to exactly how many hours. It will depend on - one of the beauties of the emergency system all working together that we haven't highlighted yet is that our 10 regional centres, as well as our tertiary centre, never close. We're quite unique in the country about that, in that we have not had a closure in those types of facilities. Often we draw resources from outside in to make sure that we keep that system stable. As we do that, it does depend on, month to month, what the hours would be, but it will be a big help.

The example in Middleton will show you some of the benefits of the contract that Dr. Audain had mentioned. We have developed a way of having a kind of hub-and-spoke model for the physician, where they can be committed fully to a site but have a bonus to be able to support a community site as well. As we hire more people and they come into that new system, we're hoping that's going to beef up the support to those Level 3 emergency rooms.

With Baddeck, Dr. Don Brien and Brett MacDougall, the executive team in the Eastern Zone, are working really closely with that community about what the community wants and needs and how they can work with the doctors who are there now to provide a stable service. They're an urgent treatment centre now, so they are open regularly for urgent treatment, and they are piloting a few things with EHS in the area to kind of expand that service for the locals.

The goal is still to try to have a Level 4 emergency room there over time, and with the right support, I think they'll get there.

KELLY REGAN: I take from that we don't have a date for that particular one, and we don't really know how many more additional hours we're going to get in Middleton. Thank you for confirming that.

I'm going to switch over to doctor recruitment. I had a reach-out yesterday from a young person who lives here in Halifax Metro. They shared with me the letter they had just received from their family doctor, whom they've been with for the past few months. This person has been on the wait-list three times now in the last three years. Every time they get a doctor, the doctor leaves. The latest one says, I'm writing to inform you that after one year I am closing my family practice of medicine, and that will be in February of next year.

We keep hearing about doctors being recruited. How long are doctors staying? Are they actually staying permanently? Do we have any idea how many are leaving after one year, and why are they leaving after one year?

I'll just table that with the clerk so she has a copy of that.

NICOLE BOUTILIER: We know over the last two years that we've had a net gain of 150 physicians into Nova Scotia. I don't know the details of that, so it's hard for me to speak to that example, but in general, sometimes doctors do switch their focus of practice, in particular in family medicine, as there are a lot of opportunities for emergency work, hospitals, medicine, specialist care. I don't know the specifics of that.

We did last year put in a physician hotline, where if people are struggling with a family practice, they can call us or any practice, and we send out a team that's composed of people from the Office of Healthcare Professionals Recruitment, as well as Nova Scotia Health Authority Medical Affairs, and the Department of Health and Wellness, to actually go to the practices and meet with them. I believe MLA Barkhouse was at one of those that we did, where we invited community members in to see what we can do to help with the practice. We'd be happy to take that example and have a look and see what we know.

We do know that a lot of our physicians stay when they come. We had a 90 per cent retention rate, and the 10 per cent who have left, we do exit interviews on people who are not retirees. The majority of reasons that they're leaving are for family reasons. They have

family in other parts of the country. The other reason they sometimes leave is to get more training and to do specialized work that they may or may not bring back to Nova Scotia.

KELLY REGAN: Perhaps you could speak to what a person like that, who has a health condition that they're trying to have investigated, how they're going to get their tests, where that information should be deposited now that they no longer, once again, have a family doctor.

NICOLE BOUTILIER: We worked really hard to increase primary health care access for people who are on the list or are not getting regular care. This year alone, we've had a total of almost 2 million extra visits. We're up 18 per cent from last year. We have community pharmacies; we have the Pharmacist Walk-in Clinic+ program; we have VirtualCareNS - we have access for people who are on and off the list for that; mobile clinics; primary health care clinics; there are UTCs - urgent treatment centres. We've created a lot of primary care access in the community for people who need it such as in your example.

KELLY REGAN: You have a problem, so you go and you have tests done. Where do the tests go? That's the concern that I'm hearing from people. I can go, if I have a sore throat or something like that, but there's no place - if it's somebody with a complicated health issue, there's no place to send those tests to. If there is a place, people are not aware of it. That's why I'm asking.

NICOLE BOUTILIER: There are two places. Unattached people through VirtualCareNS have the ability to have regular follow-up with the person whom they see in that system for tests. The second piece for unattached patients is primary care clinics. We have 14 and expanding to 19 across the province where people who are on the list can make appointments and be referred to a PCC, and they would be seen in person. If you go on VirtualCareNS and you end up needing to see somebody in person, you'd be referred to the PCC where they would see you in person.

You probably have heard we have developed an app that allows people to look at the choices for what's going on with them. We're hoping that will help patients navigate to the right place by answering some simple questions as they go on it.

KELLY REGAN: People are being told that that's not the case when they go in, that they can't see the same person, that there's no place to send the test results to. I'm not sure that everybody in the health care system understands how that particular aspect of it works. I would just urge that if that is the case, everybody needs to know it, because they don't know that at all. That's what we're hearing from people - that they can't. They're being told. I wanted to share that with you.

Recently I had an exchange back and forth with the health minister. She was very helpful in letting me know how many doctors had been recruited in my particular area. This

was before I became health critic, so I was just asking about my neck of the woods. We went back and forth, but one of the things I think that we're not grappling with is the number of physicians who have changed how they're practising. Someone may still be listed as a doctor who is continuing to practise, but in fact, has reduced what they're doing or changed what they're doing. When I pressed further, I found out that in my neck of the woods, we were seeing reductions in service even as we have more and more people moving into the Bedford-Sackville area. (Interruption)

Pardon me? I didn't catch that. I didn't hear what you said.

THE CHAIR: Order. MLA Regan.

KELLY REGAN: I'm wondering if it's possible to get the data on physician retirements and service reductions or changes for the entire province. I recognize that you may not have that information at your fingertips right now, but I would like to know how many physicians are actually leaving - and that's retiring, closing their practice, or changing what they're doing, because I think that is having a big impact. Certainly, when we look at the most recent doctor recruitment numbers where we see the numbers continuing to rise - it was over 3 per cent in Halifax Metro once again this past month. I would like to see those numbers if possible.

THE CHAIR: Associate Deputy Minister Beaton.

CRAIG BEATON: Sure. I think in terms of the overall data, what we can say is - and Dr. Boutilier had referenced this earlier - there have been 150 new physicians this near in terms of net gain. (Interruption) No, yes. Sorry, you're correct, it is. It was from September - it was 2021 to 2023. Out of that, what we do know is that there were 312 new starts and there were 163 departures. Those departures could be for a number of reasons. We would have to look at the data to see if we could break it down a bit further than that.

The other piece that I would touch on is that the new contract that we've had, there's significant interest. I would say that the earliest indications - because we've just implemented this effective October 1st, so new information - is it's showing signs that physicians are making decisions to continue to practise in community rather than closing out practices and providing ongoing support to patients. We do believe that the new contract is a signal of continued progress in retention.

KELLY REGAN: If I could get the number of physicians who have reduced their practices - I think we would need to see the data. There's a reduction. It's a big difference to have somebody reducing their practice hours by 10 per cent versus somebody who's doing it 50 per cent. I think it would be really good information for us to actually understand what those reductions are because they are happening, and we are hearing that from Nova Scotians. If I could get that provided to the committee, that would be a huge help there.

In terms of - actually, I'll pass that over to my colleague.

THE CHAIR: MLA DiCostanzo, you have two minutes.

RAFAH DICOSTANZO: My question is actually to Doctors Nova Scotia. Your predecessor said that the situation at the ERs is not surprising, and things have just gotten worse. We know that in the number of primary care doctors. People were going to emergency for primary care services. What are you hearing from ER doctors, and what support do they need from the government? How do closures impact already burnt out and overburdened health care workers? What is the situation? What are you hearing?

COLIN AUDAIN: I think it is having an impact. What I've heard from emergency physicians is they're really struggling to try to keep the emergency departments open. I believe that having more family physicians will improve the situation, not only because they're going to spend time working in the emergency departments, but because providing access to patients will keep many of those patients away from the emergency departments.

[1:30 p.m.]

I'm hopeful that the new contract - specifically the longitudinal family medicine model - will provide incentive for people to spend more time providing that type of care, as opposed to going to other areas and aspects of medicine, which will help alleviate the problem.

THE CHAIR: You have 10 seconds.

RAFAH DICOSTANZO: I will come back to you in the second round.

THE CHAIR: MLA Leblanc.

SUSAN LEBLANC: I'll start with ER closures and delays. It's difficult to grasp the depth of the problem or assess the success of different initiatives without up-to-date information and data from the emergency departments. Unfortunately, the most recently released data on physician vacancies, physician hiring, and ER closures is well over a year old. I'm wondering if someone can provide up-to-date numbers for these different categories for the past month. How many physician vacancies are there currently in emergency departments, and how many emergency physicians have been hired, i.e., net increase for the last month?

THE CHAIR: MLA Leblanc, you said anyone, so I'm just going to look to see if they're going to have it . . .

SUSAN LEBLANC: I don't know who's best to answer.

THE CHAIR: . . . or whether they're going to have to get it to us.

JEANNINE LAGASSÉ: We do not have that information with us today for the last month. (Interruption) I think we can - I don't know. Nicole, I don't want to commit to that one.

THE CHAIR: The clerk will send a letter out asking for some stuff that wasn't there. I know the clerk is doing a great job with that. You have a comment, Ms. Oldfield? Your hand is up.

KAREN OLDFIELD: Yes, just to acknowledge that we can break it out, and we'll just take a number of days to produce that. Yes, we have it, and yes, we can get that. Not a problem.

SUSAN LEBLANC: The other number I was wondering about was how many physicians have been hired through the Come Home to Nova Scotia campaign in the last month.

KAREN OLDFIELD: We would not have the last month, but again, we can make the numbers available. We just need to slice and dice a little bit. We just don't have them here.

SUSAN LEBLANC: I appreciate your getting the numbers to us. It's unfortunate that we don't have them today, because then we can't look at them as a committee, but perhaps we can have a follow-up meeting if necessary.

There were more deaths in emergency departments in the first nine months of this year, 2023, than all of last year or any of the five years before that. I know that the challenges in the system, like the growing number of Nova Scotians without a family doctor or emergency closures or wait times, are all interconnected. I just want to ask about how those issues lead to worsened patient outcomes.

Earlier this Fall, the Premier dismissed the increase in ER fatalities as being the nature of emergency rooms, because he was like, People go to the emergency room when they're really sick, so more people die there. I guess I'd like to ask Dr. Audain this, as you were speaking about the stress on emergency room physicians and health care workers in general: Do you agree with the Premier's statements, that it's the very nature of emergency rooms, or do you believe that there's more to do be done to reverse the trend of more fatalities and to improve health outcomes?

COLIN AUDAIN: I think it's hard to show that there's a cause and effect. Obviously it's concerning if there's a trend toward more fatalities in the emergency department, but without knowing the details of those fatalities, it's really challenging to

make a comment with regard to that. It is true that when people are in a dire situation, they go to the emergency department. Could you repeat the first part of your question?

SUSAN LEBLANC: Just that we know that wait times and deaths are related to lack of primary care, that kind of thing. In general, are we seeing a trend - we know we are seeing a trend - but are we seeing a connected trend? Also, if there's no way to make those connections for sure without knowing the details of the fatalities, then is there any work done internally on when someone dies in the emergency room? I know there's an investigation done, but can we - obviously without knowing personal information - can we say, This many people died from chronic disease-related issues, or whatever?

COLIN AUDAIN: I think typically whenever there's what we call morbidity or mortality - you know, someone dies in the hospital or there's an event that is challenging - most departments have quality assurance to look at each individual situation to try and determine whether there was something that could be changed in the future to decrease the likelihood of that event happening. That's not - we don't always find that there's something that can be improved upon, but that's the purpose of that type of investigation. I assume that's what each emergency department has - I know that's what my department has, and we look into all those types of situations.

With regard to your questions about wait-times in the emergency department, I guess what I would say is that emergency departments would triage the most acute patients and they would not be the ones waiting. They would be the ones who would be seen right off the bat. That's not to say that not having resources is a problem. If they're struggling to get through patients, that's going to be a challenge and it's going to cause moral distress for the people who are working in the emergency departments. Having more resources will, overall, improve the environment, and the care will be better for everybody, but I don't think you can make the connection between the increase in fatalities with the human resource issue that we have.

SUSAN LEBLANC: I saw that there was some discussion over here, if either of you would like to make a quick comment on that.

NICOLE BOUTILIER: Thank you for the opportunity to answer. We do know one thing is that the Canadian Triage and Acuity Scale levels are increasing. The acuity of patients presenting at the emergency department is going up. If you look over the same two-year period, we went from about 20 per cent to about 30 per cent of people being in the category of One or Two of the urgency. We hear this all the time, whether it's folks going to the OR or folks coming to the emergency department. The acuity that the doctors are experiencing is much higher than they've ever experienced. It has a lot to do with COVID-19 and breaks in people doing things later than they would have in the past.

We continue - and the frailty, the general frailty and age of our population has made the presentations that much more acute in the emergency department. Some of the focuses

that we've had are on actually identifying - we actually call it frailty at the front door - and trying to really assess people as they come through the door for all those things that we know makes their care so much more complex.

SUSAN LEBLANC: That's really helpful. I wonder if there is any data that could be looked at in terms of connecting the people presenting with high acuity, is it connected to the fact that they don't have regular family care or primary care? Is it connected to the income situation where we know that people are cutting their prescriptions in half so that they can spread them out over a longer time? Do we have any concrete data on all of that? I would suggest that - for sure in the city - that stuff's happening all the time.

NICOLE BOUTILIER: That's something we do across - Dr. Audain was explaining morbidity, mortality, quality reviews, that type of thing. We do look at cases like that, and we could - if we do see trends across cases, we watch for that too. If there's something that's system-wide impacting what we're doing, that would be under the quality review process where we would get that type of detail.

SUSAN LEBLANC: I just wanted to ask a question about urgent treatment centres because it's been talked about so far in the committee meeting. Earlier this year, a Cape Breton emergency physician told reporters that urgent treatment centres are absolutely not comparable to an ED, and some of those places that have been turned into urgent treatment centres should be turned back into emergency departments immediately.

My question is: Can you speak to the difference in care available between urgent treatment centres and collaborative emergency centres or emergency departments? For instance - and I'd like to know more than this - can an ambulance go to an urgent treatment centre? I guess I will ask that to Ms. Oldfield.

KAREN OLDFIELD: I'm going to defer to Dr. Boutilier.

NICOLE BOUTILIER: An emergency room is definitely not an urgent treatment centre. They're very different in that an emergency room is for the highest level of illness, like the triage ones and twos and threes. It's providing a different level of care. They're open 24/7 - various things. They would be on the EHS status system, where they would go there regularly.

Urgent treatment centres, on the other hand, are for more urgent-type care that people can't necessarily wait for an appointment for. They have regular appointments available every 24 hours, so let's say next-day access to it. They would see things like if you needed stitches, perhaps an X-ray. Depending on the place in the province where you are, there's some variation. They're all based on a standard set of things that they do, but there is some variation from site to site, depending on what's available at that site. They definitely have a different scope of practice, but it is something that's very widely used by people. They can get those appointments.

You mentioned the ambulances coming to UTCs. We have been trialling working with EHS, looking at what we could potentially take to a UTC during the day, and we're piloting a few things around that.

SUSAN LEBLANC: Thank you for explaining the differences. I will nitpick a little bit and say that the fact is, emergency departments aren't open 24/7. That's why we're talking about these things. There are many that are closed for days at a time or just open for limited hours. I think this is what the doctor is getting at - in certain communities where emergency departments have closed and what's replaced them, for lack of a better word, is a UTC, it doesn't make much sense.

Also, I have a question about the UTC, really quickly. Is it not true that if you go to a UTC, you must already be attached to a family practice somewhere in your community? No. Okay.

NICOLE BOUTILIER: I just wanted to make the point that the emergency system is never closed, 24/7. We have regional centres, and we ensure that when we're doing - with EHS, we work very closely to make sure that people get to the right centre for the level of care they need.

THE CHAIR: MLA Burrill.

GARY BURRILL: Just sticking with this, this was, I'm sure you're aware, Dr. Margaret Fraser who made this point in industrial Cape Breton. As I understand it, she's saying that the range of services that an emergency department provided is the range of services that is, in fact, needed in some of the communities that she and the physicians she speaks for are serving, and that that range of services needs to be reinstated. I think that's her point, given the on-the-ground clinical experience.

Does she not have a point? Is she missing the mark here? Is there something she has overlooked?

NICOLE BOUTILIER: The executive leadership team and the primary health care team and the emergency team at the Northside General Hospital in Glace Bay would all have worked together to come up with a solution for that community that they felt that they could meet the needs of. Many of them have come back to this type of care after not doing it - North Sydney had been closed for a number of years prior to this.

We can provide the service that everyone needs - I want to make that point - regardless of what they have. They can get that service. The urgent treatment centres are a different level of care. We do have a lot of emergency rooms in Nova Scotia for the population, and we are working every angle we can to keep what the community tells us they need. A lot of these are born from community meetings and engagement with the communities. We work with the communities to provide service. They like it. They come

to depend on it. It's regular. It's scheduled. They can get it. They know when it's open. That has been a big improvement for a lot of these communities.

[1:45 p.m.]

SUSAN LEBLANC: In January of 2023, as part of the actions to improve emergency care, the department committed to hiring physician assistants to provide care in emergency departments. I'm just wondering if maybe Deputy Minister Lagassé could confirm how many physician assistants are currently working in emergency departments and at which locations, and what plans are there to expand the physician assistants in emergency departments program?

JEANNINE LAGASSÉ: I'll ask Dr. Boutilier to jump in if I don't have this exactly right, but currently there are physician assistants in four sites: Dartmouth General Hospital, Cape Breton Regional Hospital, Cumberland Regional Health Care Centre, and South Shore Regional Hospital.

SUSAN LEBLANC: My B part was: What plans are there to expand so there are more sites with physician assistants in emergency departments?

JEANNINE LAGASSÉ: We're always working with our partners at Nova Scotia Health Authority to be able to expand the program. I think earlier in the year we did announce that at Dalhousie University there's a physician assistant program starting in January with, I think, 24 students. We're starting to train them here ourselves, always looking if they may want to come from other places, but absolutely actively looking to expand the program.

SUSAN LEBLANC: I just want to ask a quick question about family practice anaesthesiologists, if that's the right word. I understand that in some places there was a pilot - maybe in Yarmouth, was it? - there was a pilot for a family practice anaesthesiologist. It makes sense, seems like it's - I don't know. I want to know what you think and if the idea is going to expand. Are we going to start training family practice anaesthesiologists here? I understand that there are some family practice doctors who would like to improve their skills so that they can stay in their communities and practise in Nova Scotia. Could someone just speak to where we are with that?

NICOLE BOUTILIER: We have recently run a family practice anaesthesia pilot. We had a lot of learnings around that pilot, and it's currently being evaluated for spread and scale across the province.

GARY BURRILL: I'd like to go back to this question, Dr. Boutilier, about the urgent treatment centres. You said that they are popular. I don't think there's any question about that, and I think you're right too, that in light of some of the mega-closures that they are an alternative to, they're particularly welcome. I don't think this is Dr. Fraser's point.

Dr. Fraser's point is that in some of the areas where the physician community is serving, industrial Cape Breton, the clinical need is for what is provided at an ED more than what is provided at an urgent treatment centre.

The question I'm interested in your analysis of is: Is she not right?

THE CHAIR: That's to Dr. Boutilier, correct, MLA Burrill?

GARY BURRILL: Yes, please.

NICOLE BOUTILIER: We could have a debate about how many emergency rooms is the right number for Nova Scotia. We could have a debate about what providers are doing what in what area. What I want to reiterate is regional hospitals that are never closed, that are open 24/7, provide all the services Nova Scotians need. We are connected through an emergency health system where everybody is working together to take the folks to the right place at the right time.

It is a change. There's no doubt it is a change, but we're talking about emergency rooms that were closed in the current status, because you could not get people to work in them. They were going to where they're going now anyway, but now we have backed it up so that people don't have to go for everything. They can get service in their own community for a variety of things now that they couldn't before. To me, that's an improvement from where we were.

THE CHAIR: MLA Burrill with 25 seconds.

GARY BURRILL: Would you not acknowledge that Dr. Fraser knows something about this and that she may have some point?

NICOLE BOUTILIER: Dr. Fraser is an emergency room physician who worked for a long time in Cape Breton. She is a member of that emergency room community. They all have had an opportunity to provide services and contribute to . . .

THE CHAIR: Order. That's the end of the 20 minutes.

Next will be MLA Barkhouse.

DANIELLE BARKHOUSE: This question is to Deputy Minister Lagassé and CEO Karen Oldfield. As leaders in the health system, I am sure you are concerned about emergency department closures, and are committed to finding ways to reduce closures and adjust services. Can you tell us what can be done to help reduce closures, and are there indications that investments under way across the health system can or have been or will lead to fewer closures?

JEANNINE LAGASSÉ: I think I'd start by speaking about the emergency department improvement plan that we released in January of last year. We spoke a bit about it when we had the question about physician assistants.

A number of things were announced in that plan that we've been able to move on, including adding physician assistants in four sites and nurse practitioners to eight different sites. Different practitioners have been added to care teams. We've added patient advocates in eleven sites and care providers in five sites. We've also added virtual emergency care at various locations - eight sites - so that people with less urgent needs can be seen through virtual care as an option in that emergency room. The flow lead and offload assessment teams have been added in eight sites. We've established the care coordination centre at the QEII as a first location, but it is being expanded across the province - so a number of initiatives taken in the emergency rooms in particular.

Perhaps my colleague would like to speak about things we've done in relation to primary care to help people to avoid having to attend at the emergency room.

KAREN OLDFIELD: Diverting from the emergency department in the first instance, where appropriate, is one of the things that we're focused on as well. We talked a little bit already today about creating a number of additional primary care access points. Actually, if you were to add it all up between the community pharmacies, the Pharmacist Walk-in Clinic+, the virtual, the mobile clinics, and the whole gamut, it is pushing 60,000 additional appointments a month. That's a lot of appointments.

The corollary is that, where appropriate, people are able to access and hopefully, depending on their particular situation, not end up in the emergency department. This is really preliminary. I'm going to be very interested in the full-year numbers.

Dr. Boutilier spoke earlier about the higher acuity, so a higher percentage of CTAS 1 and 2 coming into the emergency departments. The reverse of that is that we're actually seeing slightly fewer 4s and 5s, which - what we're trying to prove out is that, because there are increased access points, they're able to seek care there.

Preliminary information would suggest that our strategy of diverting from the emergency room is starting to work - very preliminary - I'm not drawing any scientific conclusions at this point.

The other thing I'd like to speak to, which helps that - Dr. Boutilier alluded to YourHealthNS. YourHealthNS launched on November 1st. We've had just over 135,000 downloads since that time. The evaluation so far is very interesting. What it's showing us is that there's a high conversion rate of people who are able to navigate - that is one of the objectives of the app, helping to navigate - showing all the different pathways to care. The virtual aspect is very novel. Any unattached person can seek virtual care through that app. I think in a month, we've had close to 13,000 virtual care visits from unattached people.

There's also an aspect for attached people to use the app free twice a year. I think the number there is maybe just under 800.

That's going to help. It is helping and going to help, and the fact that we've had that many downloads in a relatively short period of time I think is one of the things that is going to be a pathway to the future. It's very important, and will help and is helping to divert away from the EDs. The diversion strategy is very important to our fragile ERs across the province.

DANIELLE BARKHOUSE: Can you update the committee on the new YourHealthNS mobile app, and how you intend for it to directly address some of our broader health care needs?

KAREN OLDFIELD: I just started down that path. I'll just throw in a couple more things. If anybody has not downloaded it, you can access it on your phone or a web version. I would encourage you to play around with it. One of the things that is important and which we'll be able to use to really help Nova Scotians is there's a significant education component. For those who have a chronic disease - I'll just choose diabetes - there's a lot of material that one could refer to if they have a recent diagnosis or want to learn more about that particular thing or have a family member or friend. The education parts are very important.

As well, this is Version 1. Version 2 is scheduled, I think, to come out early in the new year. One of the things that people like is the ability to start to have more agency over their own personal health. It's in the palm of their hand; it's on their computer. You can't do everything we intended to do yet, but you can make a blood collection appointment, you can make appointments for vaccines, you can make x-ray appointments. Eventually, you will have more things in the palm of your hand, like the results from those tests.

As I say, it is going to be a very important piece of our health care - not just in Nova Scotia but across the board - so that people are able to direct, guide, navigate and educate themselves, not just the health part, but the wellness part, which I think ultimately is something that we need to be talking about a lot more in Nova Scotia.

DANIELLE BARKHOUSE: I agree 100 per cent. I love it. It was just the other day that I downloaded it with a constituent. The fact that they now feel like they have some control as well is fantastic. You guys are so great - I had six questions, you answered them all, those two little things. (Laughs) What I will do is pass it on to Nolan and work on some more.

THE CHAIR: MLA Young.

NOLAN YOUNG: I just wanted to say that Shelburne was one of the first places to be able to have the pharmacy pilot. It's a piece of the puzzle - it's taken some strain off. There are always more things to do, but we're moving along well.

My question would be to ADM Beaton and Dr. Audain. I understand that the new four-year physician and clinical academic funding agreement with Doctors Nova Scotia contains a few measures focused on emergency departments, such as hourly rates and the framework for a service agreement for emergency physicians. I'm just wondering if you could talk about these measures and any other measures in the agreement that would be aimed at improving the ED situation.

[2:00 p.m.]

CRAIG BEATON: I'm happy to start and then I can pass it over to Dr. Audain for some additional comments. I think the biggest piece was that emergency department physicians will see a 10 per cent increase in their wages or contract over the total life of the contract. In addition to that, there's also what we call the rural specialist practice support program, which provides an additional $16,000 for those who are working in rural emergency departments. This is particularly important because many of them also have family practices as well in their community. Rural EDs are often staffed by family physicians, so that's why that particular component is really important.

There's an increase rate hourly for physicians in EDs. There's also increase for the broader department funding, as well for the rates, to make it more competitive, particularly in tertiary hospitals, but also there was a $10 increase in regional hospitals, as well as an increase in community-based hospitals to make them more competitive.

In addition to the community hospitals, there's also been an increase in the hourly rate, as well as a potential blend for - sorry. We created an hourly rate specific for community-based hospitals to make them more competitive. There are also enhancements to what we call our locum program to allow physicians who are not necessarily from those communities to travel. Emergency physicians now have the availability through the locum program, including those who live in the Central Zone. In addition to that, we have as part of the contract - the 2023 physician contract - we've also instituted a review of what's called the Murray Hybrid formula, which is the formula for funding for emergency departments. It's expected to be completed in June of 2024.

COLIN AUDAIN: I think Craig touched on most of the things that are in the contract, but I would like to highlight the Murray Hybrid formula piece a little bit more. Basically, in its current form it looks at the volume and acuity of patients who are in an emergency department over a period of time. It uses that to provide funding to the leadership in the emergency departments so they can staff their departments, have the funding to do that.

A new piece that's been added to that now - that was never part of the original formula - is to look at patients who have left the emergency department. The emergency physicians I've talked to feel that's an important piece to consider because if you had more staff in the department, it's likely - or hopefully - be able to see more of those patients, they may not have left. I think that's a really important piece to consider - a formula, which is a bit more nuanced and flexible.

NOLAN YOUNG: Dr. Audain, you stated in an article that, "During my term, I hope to see primary care stabilized in the province. Although it's not the only problem in health care, in my opinion, it is the most pressing today." We're starting to better understand the need for a system-wide approach, the impacts of one part of the system on others. Could you please talk about the connection between stabilizing primary care and stabilizing emergency departments?

COLIN AUDAIN: I think that I talked about that a little bit before, but as I said in my opening remarks, in a lot of rural Nova Scotia it's family physicians who are staffing emergency departments. If you don't have family physicians in the province, you're going to have continued emergency department closures.

The other piece to that is that emergency departments are the overflow for people who don't have regular primary care, so there are a lot of ways to try to mitigate that. If you have more family physicians, then you can stabilize primary care in the province, then you're going to have more attached patients, and you're going to have fewer patients who are going to the emergency department just because they don't have a family physician who could support them.

The work that's been done on the new contract to try to incentivize primary care I'm hopeful will start improving the situation. Anecdotally, the feedback I've had from most family doctors I encounter is that they are optimistic about this new model. It's a complicated model. It has a lot of detail in it, but then again it needs to be because the system is complicated. We're still sorting through the best way to deliver that, but I think it's going to be a positive in the long run.

THE CHAIR: MLA Young, could you table that thing you commented on?

NOLAN YOUNG: Yes, thank you.

NOLAN YOUNG: My question goes out to ADM Beaton and Dr. Boutilier. The community fund for the Office of Healthcare Professionals Recruitment, HPR, is a great way to support communities in their efforts to recruit health care professionals. Could you please talk about some of the projects that the fund has supported? I guess additionally, could you please talk in more general terms about how the NSHA and the OPR work with communities and hospitals to address their health professional needs?

THE CHAIR: Who do you want to start with, MLA Young?

NOLAN YOUNG: Whoever's ready - ADM Beaton?

CRAIG BEATON: Sure, I can start. The community fund actually is a really excellent way of getting communities involved in the recruitment process. We do know that when communities are involved, there is a significant increase in the recruitment effort and the success of the recruitment effort, but also on the retention side. It's a very personal decision for people to make, to move to a new community, and the community fund actually has been able to really support a number of communities in enhancing their ability to come together as a community to push that forward.

Last year, there were 28 organizations that were funded. This year, we're still in the midst of the process. It was just finalized, so we'll have some teams going through, but the Office of Healthcare Professionals Recruitment is working really closely with communities on a number of innovative and new ideas. There are a few that I could highlight. One in particular is actually one that was out of Pictou County, Dr. Boutilier's home turf. It's a really great initiative that was done with the community there where they're actually using 3D technology to bring videos to prospective candidates. In this case, it's physicians. If you can picture for a moment, a physician is actually given virtual reality. They can actually put that on and see what it looks like to walk into the Aberdeen Hospital or what the life of a physician is during that day. It's a really powerful tool to give them an idea of what it is that they're walking into. That's one great example.

Truro has done some unique work with some digital marketing campaigns, again focused on physicians. They're currently now working through the process of retaining that physician. The fund is not solely focused on physicians, however. It's a fund to actually support all health care professionals.

I know you had a secondary portion of that around OPR that I can refer to Dr. Boutilier.

NICOLE BOUTILIER: About how - sorry, could you repeat that part of the question?

NOLAN YOUNG: I could read this again, yes. I was hoping that you'd be able to - the community fund for the Office of Healthcare Professionals Recruitment is a great way to support communities in their efforts to recruit health care professionals. I'm just wondering if you could talk about some of the projects the fund has supported. Additionally, if there are any other general terms such as discussed here, stuff that is working with communities and hospitals to address their professional needs.

NICOLE BOUTILIER: The thing with communities is these grassroots recruitment committees that have come together in all kinds of - I think we're up to over 40 across the

province - are essential for us because as we recruit a physician or other health care professional, they are actually taking the candidate and embracing them by the community, and showing them all the things and the people that they can get.

For instance, I do come from Pictou County, but I can't take any credit for their project. They have brought people together in a new way through that committee. I was at a medical staff event there last week, and they have a whole range of folks. We have people who are already retired, we have people who are just new to the town, and what a difference it makes for those people to be actually involved in the community. They've had things like - they've done learnings for international folks coming in like what kind of food they should have in their grocery stores, what kind of religion access should they have? That is what embeds people in communities, and that's what keeps people here and helps us retain them, when the community puts their arms around our new recruits.

THE CHAIR: MLA Young with 90 seconds.

NOLAN YOUNG: I'll be quick. ADM Beaton, the Patient Access to Care Act provided the tools to streamline health professional mobility and make it easier to recruit both domestically and internationally. Could you please talk about the impact these changes have had or could have on recruiting much-needed nurses and physicians?

CRAIG BEATON: The Patient Access to Care Act is actually about reducing barriers for bringing in health care workers from all areas, not just nurses and physicians. A recent example I would give you is some of the streamlining that was announced last week by the Nova Scotia College of Pharmacists where they've opened up streamlined pathways to a number of jurisdictions. I probably won't get them all correct, but I know the UK, the US, Australia, New Zealand, a number of areas. It really does speed up the process for us, actually, being able to bring in health care professionals. You're probably familiar with the nursing example with the Nova Scotia College of Nursing who also did this, where they opened up licensure pathways, and they've had over 19,000 applications, which will have a significant effect in terms of bringing in internationally educated nurses in terms of the overall workforce as we move forward.

The College of Physicians and Surgeons of Nova Scotia has also done a number of works, so what I can say about this is that the regulators have really stepped up and have embraced the Patient Access to Care Act, and it's really given the ability to open the door to allow international health care professionals to come in a much timelier way. In some cases where processes took up upwards of two years, it is now down to a matter of weeks.

THE CHAIR: Order. We're in the second round. It will be 10 minutes each. It looks like we did well, so we'll start with MLA DiCostanzo.

RAFAH DICOSTANZO: I'm back to Dr. Audain, if he doesn't mind. Dr. Audain, I really want your opinion on the incentive for doctors to stay in Halifax or outside in the

rural area. They just talked about that, how much - first maybe you can tell us: What is the incentive that you're giving to family doctors and to specialists, and how has that, in your opinion, affected the shortage in Halifax? In Halifax, the number of unattached has gone up five times in two years. Tell me that is not related to the incentive.

You can have as many community members trying to attract, but when they know there are 100,000, 200,000 if they go an hour outside of Halifax, they're not coming to Halifax. How, in your agreement with the government, was that not part of the agreement, and why is Halifax suffering so much more in the shortage? Dr. Boutilier said we have 150 net gain. Do you have numbers of how many of those actually were in Halifax, especially in the Halifax West area? I have an article here actually that says how the Houston government threw gas on the fire of the Halifax doctor shortage. The numbers are here, and I will table that.

I also have another article here that says more than 20,000 residents of the Bedford-Sackville network were without a doctor. This is an increase of 378 per cent since 2021, since this new government came. What is your opinion on removing the incentive from doctors to stay in Halifax and how that has affected having family doctors and specialists? If you can give us some numbers, please.

COLIN AUDAIN: I don't have any numbers for you, but I can say that for this new contract, there was a lot of thought put into where the needs were and how to incentivize physicians to work in various places. To start with the family medicine primary care example specifically, that's not specific to rural Nova Scotia. The incentives that are part of the Longitudinal Family Medicine Payment Model apply to all family physicians regardless of where they work. As far as I can tell, there's just as much incentive to work in the Central Zone as a family doctor as there would be to work outside in other parts of the province in more rural communities.

What we were trying to achieve is to make it more palatable to work in that longitudinal family medicine where you're looking after a person from the start of their life to the end of their life, which is what we've been missing in primary care for a little while. It's been so hard for family physicians to keep a practice open because there are so many other areas of need and other places that physicians can work. They've tended to be drawn to other hospitalist roles or other types of medicine.

The idea with this new contract for family physicians was to try to provide them with some overhead support and a model that will allow them to appropriately capture all the things that they do in primary care so that they can be remunerated for that and make it viable to keep a practice open. That applies to all of the primary care physicians across the province.

We also know in terms of specialists that there's a problem maintaining specialty service outside of Central Zone. That's not to say that we couldn't use more specialists in

Halifax. We're constantly trying to recruit anaesthesiologists in my department, but we know it's a much bigger problem outside of the Central Zone, and there were some very specific targeted incentives to stabilize rural specialists. That would include internal medicine, general surgery, ICU - I'm probably missing one or two. But the idea there was to stabilize those areas so that you have consistent coverage across the province, so there was an intentional incentive outside Central Zone for that type of medicine.

[2:15 p.m.]

RAFAH DICOSTANZO: I'm a little confused here. Right now, if a new doctor is coming in or graduating and wants to start in Halifax, the incentive is exactly the same as starting in Truro or in New Glasgow. Family doctors is what I'm asking for. I understand you've increased the pay if you're taking seniors or if you're taking people with - not acute care - anyway. I know that there was an incentive that was removed. What is the incentive for family doctors when they're starting a new practice outside of Halifax or in Halifax? Is there a difference, and what is the amount?

COLIN AUDAIN: I am not aware of there being a different incentive to work outside of Central Zone for family doctors right now. Is there a specific one that you're referring to that I'm not aware of?

THE CHAIR: MLA DiCostanzo - the ADM is thinking he has an answer.

RAFAH DICOSTANZO: Please.

CRAIG BEATON: I think what Dr. Audain was trying to get at is really that the incentives we have currently right now, while there is an attraction incentive to outside of the Central Zone currently, and that is an incentive for a five-year return of service. It's $125,000 for a physician to set up practice outside of Central Zone.

I think what Dr. Audain was referring to is that we went to great lengths to make sure that those who are setting up family practices - really, the earning power that they have is designed within the contract. The contract outlines a number of ways in which physicians will get paid, and that really is that they get paid based on the number of patients they see, on the hours they work, and in terms of the billings they serve. They're compensated fairly to do that.

For those who are interested in setting up in Halifax, as an example, where there is a large population, their patient rosters are going to be full quite quickly. That's a component of that, but there are some additional pieces as well in terms of attachment fees that we have for fee-for-service physicians. It really depends on the model. The contract is quite complicated in terms of the number of ways that people can be paid.

The specific answer to your question, currently right now, outside of Central Zone, $125,000 for return of service of five years. However, I will say that we always look at how best to utilize return of service agreements in all areas of physician compensation.

RAFAH DICOSTANZO: Perfect. Can you tell me, in your opinion, that the $125,000 is not making a difference when we're having these enormous numbers in just the last two years, that Halifax is without doctors? The lineups at the walk-in clinics in my constituency are incredible. I was always so happy because we had doctors, more than anybody else in Halifax - people want to live here. There is something that's preventing them from settling in Halifax. It's gone five times, or 300 - 600 per cent. How is that possible without doing something to prevent that in the contract? I don't understand.

CRAIG BEATON: I would say that the incentive we currently have is making a difference outside of Central Zone. Just to be clear, I do think that it has, in terms of the numbers.

The other factors that you do talk about, I think - pieces we look at from the department's perspective and with our partners at NSHA - there's been significant population growth in the last two years in Halifax. We take those factors into consideration. I would also outline that in terms of the increased access, as the deputy minister and the CEO outlined earlier, a whole-system approach. Over 60,000 more monthly appointments available for access to primary care - I think those are other pieces as well that go into the consideration when we're talking about.

One of the biggest pieces, I would suggest, is that population growth has been significant in the last two years, and we consistently are re-evaluating how we monitor our incentive programs going forward.

RAFAH DICOSTANZO: Because of the increase in population, we should be ahead of the game in actually giving them a bigger incentive because they're coming to Halifax. Why aren't we doing that? If people are moving to Halifax, and we know that, it's more than half of the population of the province, we have zero incentive to give them to come to Halifax where the population is. We have a brand-new outpatient centre . . .

THE CHAIR: Order. MLA Leblanc.

SUSAN LEBLANC: I just wanted to, Ms. Lagassé, re-ask my question about physician assistants and the plan for expanding the program. I had asked what the plan was and the answer was, We're training our own. Can you be more specific? Is there an actual plan? Is there a budget line for new physician assistant hires coming up in the next budget? If so, where are they going to be hired?

JEANNINE LAGASSÉ: I can't speak to next year's budget at this point in time, but I think maybe if Dr. Boutilier would be willing to speak a bit about where potentially the

sites would be that they would expand to, because that would be with the NSHA and not with the department.

NICOLE BOUTILIER: We've had the opportunity to have a pilot site in each zone for the physician assistants, and they were listed before. We had the ability to hire up to four in each of those emergency rooms. We also have physician assistants on a budget line for 20 to add to primary care and have had proposals in there. Our biggest problem with expanding a new thing like physician assistants is actually getting them here and having them to fill. We recognized that really early on last year and had the proposal in for Dalhousie University to start the program in January.

The other thing that we are exploring now, similar to how we've done with other professions, is we're looking internationally and planning a trip internationally to recruit physician assistants.

GARY BURRILL: I wonder if we could go back to where to we started speaking about emergency room closures. I have a question for Ms. Oldfield or Dr. Boutilier. We spoke earlier about the situation in the Valley and Middleton, and you spoke to that. I'm thinking also about the South Shore. One day last week, there was closure both in Shelburne and Liverpool, so the drive to an ER would have been over an hour. I think it's important to register all the time the depth of concern in communities when this is the case.

I want to ask you: Do you share that concern that in those kinds of circumstances, as pertained, say, last week in Shelburne and Liverpool, that people may not in fact get the help they need in time?

KAREN OLDFIELD: Two things: First of all, to reiterate yet again what Dr. Boutilier has said about our emergency health system, 24/7 as a system, and then specifically, I talked maybe 18 months ago to Dr. Al Doucet in Liverpool at Queens General Hospital. He shared with me that day that Queens General, that particular hospital, is not used to seeing an emergency closure. The community is not used to it, and he was very passionate and eloquent, and if you know Al, you know that he definitely would be.

Yes, these things - I speak to people. They tell me the same as they tell you. I'm always concerned about it, and that's why all of the things that we've talked about here today - there's no magic wand. There's no magic recipe. We are trying everything to recruit in the first instance and to make sure that our people are treated fairly. The contracts that have been spoken to, with respect to physicians, to nurses, to paramedics, and all of the things we're talking about here - there's no one thing. It is a true system. I think broadly, yes, we have a system, and specifically, we work very hard to make sure that we do the best we can for Nova Scotians.

THE CHAIR: MLA Burrill, do you want Dr. Boutilier to comment?

GARY BURRILL: Only if you wish to.

NICOLE BOUTILIER: I think I can say that the physician leaders in the province, the zone medical executive directors and the department heads for emergency medicine and the site leaders - it is a 24/7 job keeping everything staffed and making sure we have the best situation every single day for the people of the province that we have with the resources that we have.

Christmastime is always a stressful time for us. People are busy. It's the start of the respiratory season, and things like that. I can tell you that there won't be many people on my team who get a break over Christmas, both working in and trying to keep them staffed. They do miraculous things every day to make the most of the resources they have.

I just wanted to take the opportunity to shout out my colleagues who do these leadership jobs, not because they are better than their day job of working in health care, but because they care about their communities and put their time into making the best for their community that they can.

GARY BURRILL: I think this point, Ms. Oldfield, that you've made, that retaining people has an awful lot to do with people being well-treated at a deep structural level - I think it's really true. I think it's a key issue throughout health care provision in the province. I'm thinking about the vacancy rate for a moment in both of the health authorities. I understand that the current rate is over 5 per cent higher than it was two years ago.

What does this say overall, in the authorities, about where we are with morale, job satisfaction, and working conditions?

KAREN OLDFIELD: I think the real answer comes from data. I'm just getting Matt to check on the 5 per cent. I can talk about nursing vacancies and I can talk about all of those things, and I will, if that's what you'd like. I'd just like to share an anecdote, however, prefaced by the fact that Nova Scotia Health Authority has not done an employee engagement survey since 2019, and that is on the agenda to be done, for these very reasons.

I first went around the province in September of 2021 on the Premier's Speak Up for Health Care tour. I was really very worried and concerned about what I was hearing around the province, but definitely in the Western Zone, and particularly, on that particular tour, at Yarmouth Regional Hospital. The morale was really poor. It was very evident. That's a fact.

I went around the province. I have visited all zones since July, but the most recent visit, as I mentioned, was to the Western Zone three weeks ago. I went to Roseway Hospital, Yarmouth Regional Hospital, Digby General Hospital, Bear River & Area Community Health Clinic, Annapolis Community Health Centre, Soldiers Memorial

Hospital, and Valley Regional Hospital. I will tell you it was night and day. That's two years, pretty much. It was night and day. This is anecdotal. This is not data. But there were changes in leadership. People were still working in very difficult circumstances. There's no silver bullet. But the morale was so much better.

I was in as many nursing units and units as I could possibly visit - many travel nurses helping to keep our system functioning. But I want to clearly say that I was so pleased with what I experienced just with morale. Again, anecdotal, and not everybody's happy - there's no question about that. But as a general principle, it was a night-and-day tour on that particular trip, and I was very pleased to see it.

THE CHAIR: MLA Burrill with one minute left.

[2:30 p.m.]

GARY BURRILL: I just wanted to ask you about the Premier's contest for health care ideas that don't cost anything. I think this caused a lot of eye-rolling amongst health care policy people across the country.

In the few seconds that we have left, could either you from the Nova Scotia Health Authority or from the Department of Health and Wellness tell us how many actionable ideas have actually been generated by this project?

KAREN OLDFIELD: There were 2,200 ideas generated. I was thrilled to see that, frankly. We could call it a gimmick, but I think people really enjoyed it. They liked it. They did it. I've seen a quick run through of the initial group, and it's all health care professionals, up to and including surgeons. It's the whole gamut. People actually took the time, and they answered the questions . . .

THE CHAIR: Order. MLA Palmer.

CHRIS PALMER: Most of my questions have been answered here as well by this great conversation, but I just wanted to maybe make a couple of comments that might lead to one of my questions. Big shout out to Mid Valley Region Physician Recruitment & Retention group in the Valley who are doing some great things. I know a lot of you have heard me talk about them quite a bit. They're doing great things from Aylesford to the Bridgetown area, and a lot of cultural events, like you mentioned. There are a lot of great community groups, volunteer groups doing some wonderful things to retain doctors in our rural communities.

I also want to thank my colleague across the table and the discussion we've had around Soldiers Memorial Hospital today. I've been raising the flag at Soldiers, even though it's not in my constituency. It definitely serves a lot of my constituency. One of the things that I'm encouraged about is the improvement in information getting through to

community. A lot of times, that's been one of the concerns in the past. When information isn't there - there's an old expression - when the facts aren't there, all opinions are valid. There's been a real improvement in communication to community. I do want to applaud you for that as well, and also thank you for the visit to our area. We want to continue to make sure that's highlighted - in our area, for sure.

You mentioned that a new physician who will be hired out of Valley Regional Hospital will be coming to Middleton to help stabilize the ER times there - which is definitely seeing more consistency - which is something the community has been hoping for. We've already talked about the incentive program, but that in particular, doctor - could I just ask a little bit about how that's come together? You mentioned that earlier in our conversation.

THE CHAIR: Which doctor? We have a couple at the table.

CHRIS PALMER: Well, I can - I'm not sure who made the comment about that. It might have been you, Ms. Oldfield.

KAREN OLDFIELD: Just need to clarify the question. Where are they coming from? Or to tell you about that doctor?

CHRIS PALMER: Yes, about how that's come together. You said, also, it's reflective of the . . .

NICOLE BOUTILIER: I think what we were referring to is that in the new contract, there's an ability to try to create some hub-and-spoke models where people can be with other emergency physicians in different situations when they work at a regional centre. Then they can share their skills with some of the community sites.

Within the contract, there's an ability to have an incentive to sign on for more than one site. Really what it does is it stabilizes the workforce in the regional hospital where people tend to want to go to work for a variety of reasons, and least of which is having a whole group of people to interact with in terms of the same job, but also to help and go in, and supplement the physicians who are in the community and doing emergency care as well. It's kind of trying to create what we're calling hub-and-spoke models of emergency care. Ideally, what we would see is the people who - as we hire new folks, they would sign on to this and we would get a stable rotation of people who are available to go to the communities.

CHRIS PALMER: The conversation today has really highlighted for me one of the situations we all have, and that's educating our constituents and our citizens on what we are doing and what's happening - the healthy initiatives we're doing. I did a series of town halls in my constituency, and one of the big topics was health care. The comments we hear are, I didn't know you guys did that. I didn't know. I think it's incumbent upon all of us

around this table to make sure that we're all part of getting that information out there to constituents, so people are definitely informed of what all the options are and the things that are happening in health care.

One last little plug for a physician assistant at Valley Regional Hospital. That'd be great. I'll pass it over to my colleague, MLA White.

THE CHAIR: MLA White.

JOHN WHITE: Last year, government received the Golden Scissors Award from the Canadian Federation of Independent Business. That's a prestigious award that's given to politicians, public servants, different Canadians who make a real effort in cutting red tape. I'm wondering if you can tell us what specific actions were taken to reduce the unnecessary administration burden by doctors and how effective they were.

JEANNINE LAGASSÉ: I'd first like to start by saying that a lot of this work that we're doing related to red tape reduction is done with our colleagues, Deputy Minister Fred Crooks and the Office of Regulatory Affairs and Service Effectiveness. They've been fabulous partners with us in this work. Currently we're targeting - and we have a number of initiatives that have been identified that will hopefully reduce physician burden by about 400,000 hours by the end of 2024. We're around 200,000 right now. We've hit that target during this year. A number of different initiatives have resulted in those numbers, the big ones being the reduction of sick notes being asked for. There are a number of forms that have been redone and streamlined, leaned down, a lot of them being insurance forms, workers' compensation, Department of Community Services.

There are also a number of departments that are involved in this work, not just Health and Wellness and the Office of Regulatory Affairs and Service Effectiveness. It's been very good. The other one would be relating to - our pharmacists have always had a very large scope of practice here in Nova Scotia, but we're now using that to its full extent. By having pharmacists operating to the full extent of their practice, we've been able to achieve a number of other hours of burden reduction.

JOHN WHITE: How has reducing that administration burden impacted doctors' ability to see patients?

COLIN AUDAIN: I think that it's an amazing initiative. From Doctors Nova Scotia's point of view, the biggest impact it's going to have in the immediate term is in terms of wellness. It's going to allow them time to spend with their families. A lot of that work happens on evenings and weekends when they wouldn't be seeing patients to begin with. I'm hopeful that in the long term, as people free up more time, that it will also amount to more patient visits. It's really hard to quantify that at this point.

I think shortening the forms means you get more forms done, but you're still spending two hours doing forms. It's still an improvement. I think that will take some time before we know exactly what the extent of it is, but unnecessary paperwork is definitely a burden and Nova Scotia's leading the way. I know that across the country they're taking notice and looking carefully at the work that we're doing here in that regard.

JOHN WHITE: I'm an unapologetically proud Cape Bretoner. We have over 400 cardiac arrests a year and 500 heart failures. To say that I'm proud to be part of a government that announced a cardiac catheterization lab in Cape Breton Regional Hospital would be an understatement. I'm just wondering if you could take the few minutes that we have left to tell us about how that lab is going to help and what extent it will be for Cape Bretoners.

KAREN OLDFIELD: It was a very exciting day when that was announced and a very important thing for Cape Breton. It started in the Spring, and we are looking at 2027-28 for that to be up and running. It will definitely improve patient outcomes locally. People won't be carted to Halifax, and it will reduce wait times for cardiac services provincially, and it will free up hospital beds.

I think one of the biggest things is that Cape Bretoners, even you, will be able to receive treatment closer to home. That can never be underestimated. It means fewer costs. It means so much more comfort, being in your home community. At the end of the day, it will be a better outcome for Cape Bretoners and for Nova Scotia. So yes, a very important announcement and a very important addition to our health care system on the Island.

THE CHAIR: MLA White, with 30 seconds.

JOHN WHITE: Thirty seconds. I'll say this: long-term care is health care. All the beds that we're announcing around the province - how has that had an impact on the beds in hospital?

THE CHAIR: Ms. Oldfield, 29 seconds.

KAREN OLDFIELD: We have 500 alternate level of care patients in the hospital. The sooner we can get them out to long-term care, if that's where they need to be, then the freer our hospitals will be.

THE CHAIR: All right, I'm going to call that one nine seconds.

Who has closing remarks? I'm going to start with Dr. Audain, since I finished with him, to save his voice.

COLIN AUDAIN: I just wanted to thank you for giving me the opportunity to speak here. I wanted to say that I think we are making strides with primary care and

emergency room closures, but it's going to take some time. We need to be patient with that. I also think there's more that can be done, and hopefully we'll work towards that.

I also wanted to apologize to MLA DiCostanzo. I didn't quite understand what she was getting at with the return for service contracts. Just to quickly say I think that the return for service is for a different reason. I don't think the problem in Central Zone is attracting people to Central Zone to work. The problem, at least with the family physicians I spoke to - they're not leaving Central Zone. They're just leaving primary care, the longitudinal family medicine, and they've gone to do other things. I encounter them in the OR, where they're doing things like surgical assists. They've given up their family practices. They're not gone, most of them. They're still here. The incentives, I think, in the new longitudinal family medicine model, will hopefully - at least the feedback they've given me - will make it more likely for them to return to that type of practice or not leave it in the first place.

KAREN OLDFIELD: Just to conclude, a tip of the hat to all of our ER physicians and staff across the system. They've been working tirelessly for Nova Scotians. I want to acknowledge that and thank them for their service.

JEANNINE LAGASSÉ: Thank you for having us here today. We've come a number of times. CEO Oldfield and I are usually here together, and we talk all about the whole system. I think a number of the questions that came out today and a number of the answers we've given really do show that this is a whole-system response that's required. We can talk about a specific issue, but it really is all of the various initiatives that are under way that will help us solve these very complex problems.

THE CHAIR: I'd like to thank you all for being here. You're all excused.

We have committee business. However, we're going to take a three-minute recess.

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

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

THE CHAIR: Order. I call the meeting back to order. We have committee business. We have a motion that was left on the table. For Hansard, I'm going to read it: that the Chair write, on behalf of the committee, to the Minister of Health and Wellness, to the acting CEO of the Nova Scotia Health Authority, and the CEO of the IWK Health Centre, to let them know what we heard about the need for Mi'kmaw representation in higher levels of the health system and asking for an update on the hiring practices of what we discussed.

That is the motion as it was amended. Any discussion on the amended motion?

All those in favour? Contrary minded? Thank you.

The motion is carried.

MLA Regan, you had a motion that you were going to send off that was discussed.

HON. KELLY REGAN: I had indicated that I wanted to make a motion about what we heard at the last meeting. This is relating to that - what we heard from the various witnesses on that particular date.

THE CHAIR: This is the motion that you were talking about that was long that you were bringing forward?

KELLY REGAN: Yes. Should we read it?

THE CHAIR: It has to be read for the record.

KELLY REGAN: I'm so sorry.

THE CHAIR: That's no problem, MLA Regan, because it's better for everybody to have read it. Has everybody had at least one chance to read it before? (Interruptions) If you want to speak about it and not to the motion right now, MLA Regan, then as soon as they're ready then we'll do the motion, if that's okay.

KELLY REGAN: Do you want me to read the motion?

THE CHAIR: Why don't we just read the motion.

KELLY REGAN: I move that the Health Committee direct the Chair of the committee to send a letter to the Minister of Seniors and Long-term Care outlining what we heard at last month's meeting. The letter should note that we understand next year's budget is being prepared, and we want to bring these recommendations made by our witnesses directly to the minister's attention. This letter should outline the committee heard compelling cases made for the following improvements to the system, specifically that:

1. To improve the health and safety of Nova Scotia's home care workers and clients, timely in-person home assessments should be completed prior to initial care visits. Those first home care visits should be performed by a team of two home care workers. Until such time as cell service is extended to the entire province, in areas where cell phone service is currently non-existent or unreliable, tracking tags be provided so the locations of workers are known to their employers. Nurse practitioners be hired to ensure clients receiving home care who are not attached to a family practice can receive the timely health care they need. An increase to the budget of AWARE-NS be included in the upcoming budget.

2. To improve retention and to ensure the home care system is not being underwritten financially by our home care workers: home care providers - companies and organizations - be required to schedule and pay for continuous hours of work to those workers providing this care; an increase to the vehicle allowance be provided to home care workers using their own vehicles to ferry them to each home care client location.

THE CHAIR: It's your motion, so if you want to speak to it . . .

KELLY REGAN: This is what we heard from our witnesses last month. They were pretty open about what was going on, about the health and safety of our workers, and nurses, and CCAs, and also the fact that, really, the people who are doing those home visits were balancing the books on the backs of those CCAs. They are not being fairly compensated for using their own cars. Those are basically the reasons - the short version. That's what I took away from that meeting. If we could just bring it to the minister's attention, that would do.

THE CHAIR: Any other discussion? MLA DiCostanzo.

RAFAH DICOSTANZO: Just if we can agree to send a letter, and that is exactly what was said here. We can go back to Hansard if you wanted to make sure. It would be good to give her these points, that we're here as a team sending this information.

THE CHAIR: Any other discussion?

NOLAN YOUNG: Just so I understand this here lengthy motion, what we're asking is to get an update on things that were discussed last meeting, on things that the department's doing? Is that what you're asking?

THE CHAIR: I'm going to allow MLA Regan to comment on the motion as it's on the floor.

KELLY REGAN: I think the second sentence, the letter should note, We understand next year's budget is being prepared, and we want to bring these recommendations made by our witnesses directly to the minister's attention. That's what we're asking. We want to make sure she knows this is what they said at committee.

DANIELLE BARKHOUSE: I'm just wondering - I'd like to deal with this at the next one. We were given this five minutes ago. I want to read it, but I want to check my notes at home. I have some meetings coming up with some people who actually do this for a living. I would like to table this until next meeting, please and thank you.

THE CHAIR: Just for clarity, are you moving to table this until the January 9th meeting?

DANIELLE BARKHOUSE: Yes.

THE CHAIR: It's a motion to table.

All those in favour? Contrary minded? Thank you.

The motion is carried.

It will be tabled and be on the January 9th agenda. Just for clarity, the Legislative Counsel was confirming with me it was not debatable. That's why I didn't ask.

Any other business?

The next meeting: Tuesday, January 9, 2024 from 1:00 p.m. until I believe - is it 2:00 p.m.? (Interruption)

THE CHAIR: If this is an agenda setting, agenda setting is in public?

JUDY KAVANAGH: They are public, but they're only one hour long.

THE CHAIR: Okay, this motion will be on the agenda for that? This will still be on the January 9th meeting from 1:00 p.m. to 2:00 p.m. It's agenda setting.

Any questions? All right. Then this meeting is . . .

JUDY KAVANAGH: The committee can decide to have a two-hour meeting if they want.

THE CHAIR: I'm being told . . .

SUSAN LEBLANC: Let's not. (Laughter)

THE CHAIR: Okay. I'll leave it alone. I'll do what I was about to say.

The meeting's adjourned.

[The committee adjourned at 2:54 p.m.]