HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 5, 2017

Legislative Chamber

Department of Health and Wellness
Emergency Department Accountability and
Collaborative Emergency Centres

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

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Mr. Chuck Porter
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Mr. Joachim Stroink
Mr. Tim Houston
Hon. David Wilson
Ms. Lenore Zann

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Nicole Arsenault
Assistant Clerk, Office of the Speaker

Mr. Michael Pickup
Auditor General

WITNESSES

Department of Health and Wellness

Ms. Denise Perret, Deputy Minister
Ms. Emily Somers, Interim Executive Director, Acute and Tertiary Care
Dr. Andrew Travers, Provincial Medical Director

Nova Scotia Health Authority

Ms. Janet Knox, President and CEO
Ms. Paula Bond, VP, Integrated Health Services, Program Care 1
Ms. Tanya Penney, Senior Director, Emergency Services

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, APRIL 5, 2017

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN (Mr. Iain Rankin): I'd like to call the meeting to order. Welcome to the Public Accounts Committee this morning. We have with us today as a witness, the Department of Health and Wellness. I will remind those in attendance this morning to place their phones on silent and vibrate.

I ask the committee members to introduce themselves, starting with Mr. Maguire.

[The committee members introduced themselves.]

MR. CHAIRMAN: As I said, we have the Department of Health and Wellness with us with respect to emergency department accountability and the Collaborative Emergency Centres as a topic. At this time I'll ask the witnesses to introduce themselves.

[The witnesses introduced themselves.]

MR. CHAIRMAN: Thank you, now we can proceed with the witnesses. If you'd like to make opening remarks - Ms. Perret.

MS. DENISE PERRET: Thank you very much for the invitation to be here. We're talking about emergency room accountability and Collaborative Emergency Centres so we appreciate the opportunity to address your questions. I'll make my opening comments brief.

What I want to do is pick up a bit from the last time I was here and talk about the need for change because these topics lend themselves to that issue. We know that health systems in Canada - as in many parts of the world - are in the process of making significant changes and the reasons for that are increasingly clear. Despite relatively large investments that its taxpayers make in health care, Canada is not seeing the level or type of service or the health outcomes that the investment warrants.

To get better value out of the system we have to make system shifts. That requires that we move from a system that is relatively fragmented and disjointed today to one that is more integrated and coordinated. We need to move from a system orientation that's relatively introspective today to one that is much more collaborative and adaptable. This is the important piece - we need to move from a very narrow concept of primary care to a more robust and broad-based view of primary health care where the focus is on the health and well-being of individuals, families and communities. This means that people and systems have to organize and work differently.

There's a growing body of evidence and discourse about the need for these shifts. Increasingly we're seeing the public and health care providers reinforcing the need for change. I think we see an increasing number of discussions about access, about emergency department wait times, about overcrowding, about the rising impact of chronic disease. These are issues that have been hampering the system for years, so the discussion we are going to have today is not a new discussion. We've been having this discussion probably for well over a decade and it is happening in other provinces across the country.

Despite demands that we can address these things by just simply making more investments in the health care system, provinces and territories increasingly know that simply adding incremental money to the system is not the answer. Doing the same thing is not the answer. Working in the same way is not sufficient. We need to change our investment strategy.

Despite the prevalence, complexity and protractive nature of the issues we're addressing, I submit to you that the people of Nova Scotia have reason to be hopeful and that is for several reasons. What is new, I think, is that we have a heightened sense among the public health care providers system governors of the need for change and increasing impatience and willingness to make that change. There is a much more focused discussion and discourse about the complexity of the health care system and an increased momentum for change. I would point to the recent code census report from the NSGEU as part of that discussion - front-line staff stepping forward to take the time to put their experience, concerns, and recommendations forward. It's that type of initiative that builds the momentum for change.

There's also an appreciation - and you see it in the NSGEU report and in the surrounding commentary - that this is not a unique situation. It's important to understand that as well. We're dealing with very complex issues, and there are systems out there that have been trying to make these shifts and have not done it successfully. We need to understand that these are complicated matters that require a really focused and intentional commitment to the change. But I think what's encouraging is that increasingly the awareness of that complexity and the need for change is there.

A second point I would make on why we should be hopeful is that Nova Scotia has a robust health professional workforce. We have over 40,000 health professionals - that's a good supply, and they want to work to their full scopes of practice. We know that if we enable that through collaborative team environments, we can improve access, we can improve care, and we can improve a focus on what patients and communities need.

Thirdly, we've got experience in how to do this, and this puts us ahead. We have seen the same type of change we're talking about today take place with our emergency health system. What I understand from the history of Nova Scotia is, we started in the 1990s with a fragmented, disjointed system of 50-odd providers. Today, Nova Scotia has literally a world-class system of emergency care. Not only does it provide incredible care so that we have a system of emergency service that's available 24/7 and a tertiary system of care and regional system of care that is open 24/7 that never closes, but we also have individuals within that system who - proactively with their own initiative - are making changes that improve community care and have put in place programs that we truly need to be proud of, that people from around the world come to find out how we've done it.

Those are programs like the community palliative care program, the work that we do in long-term care, and programs where nurses and paramedics - linked to physicians - go to people's homes and assess and treat in homes. We divert from unnecessary emergency department visits, but more importantly give people the care and attention that they need. That's remarkable, and people are to be commended.

It's a base of experience that I'm very confident positions us very well to meet the type of challenges and the type of system change and integration that we need to make today. We also have 811 systems supporting those 24/7 services that are increasingly sophisticated and connect people to the care that they need and the resources in their community.

Finally, I would point out - and I think we sometimes don't appreciate the significance of it - that a tremendous amount of effort has gone into consolidating the health care system. Very much like the emergency health system, we've gone from nine districts that competed, that fragmented - if you talk to some of the paramedics who have brought forward such great initiatives for community paramedicine, they'll tell you that back in the day, you still had to negotiate that with nine separate districts. You'll see the fragmentation of that system, where it starts in some areas but hasn't scaled and spread yet. We now have

one consolidated Health Authority. We're creating that platform for change, and I'm confident that we're actually going to move ahead as leaders in this country.

There is a lot to do, but there is good work under way, and we're well positioned to do it. I would just ask if Ms. Knox would like to make some opening remarks as well.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Good morning, and thank you very much for the opportunity to be here. I would also say that we are in a position where people across Nova Scotia have access to emergency care through a variety of different services and locations, as our deputy has described. From 911 and our top-quality Emergency Health Services system, to emergency departments at our regional and community hospitals, and our specialty emergency and trauma centre at the QEII and the IWK that care for the sickest Nova Scotians.

Our province is the right size, has incredible people and dedicated front-line providers, and the right foundational system pieces in place to establish a quality provincial emergency care network, and our leaders and physicians are actively engaged in planning based on comprehensive evaluation of what our population needs and what our data is telling us about them.

We are all working toward a vision of one responsive, effective and integrated network of emergency health care with many access points in a single collective mission. That mission is to improve patient outcomes for all acutely ill and injured people in this province. Nova Scotians can be confident of the services available to them today. For more than 20 years, we have this history of being supported by our stellar pre-hospital system.

If you have a heart attack in Nova Scotia today, Emergency Health Services and our emergency and cardiac services all work together to give you the very best chance to survive and recover. Those who are within a 90-minute radius of the QEII Health Sciences Centre are transported directly to the cardiac catheterization lab there to open up the blocked artery. Outside that radius, paramedics give clot-buster drugs in the ambulance based on certain criteria and in communication with emergency physicians and go to the nearest centre for stabilization, then on to the QEII if required. So we can get you in the right place at the right time.

In the past two years the new program has seen paramedics going into people's homes to provide palliative care, as our deputy described. What I want to talk about is that they are offering a much-needed service in a comfortable setting, in their home, and preventing visits to the hospital emergency departments where appropriate. More than 1,000 people have registered with this service since 2015, and paramedics were able to support patients in palliative crisis according to their care plans in their homes on 55 per cent of the calls. We will see more of these successes as we enhance the integrated

emergency care network, standardize our processes, and use effective monitoring of performance to drive continuous quality improvement for better results for our patients.

We do continue to see sporadic and sometimes persistent unplanned closures at some of the province's smaller facilities and Collaborative Emergency Centres. Year over year, the hours of unplanned closure are tracking to be slightly reduced for 2016-17. The situation illustrates some of the challenges of operating a provincial health care system. While there has been great success in avoiding closures at places like Roseway in Shelburne, thanks to a different approach to staffing, the regular movement of physicians in and out of our province and other dynamic factors meant we have new challenges at centres like All Saints in Springhill.

But the integrated network of emergency care in this province never closes. The emergency departments at our regional and specialty hospitals never close and the province-wide response capability of Emergency Health Sservices never stops. While it's no secret, those facilities are under heavy pressure, safe high-quality care for patients is always our first priority and we are constantly working to meet the needs of those we serve. Every initiative is an effort to optimize our response capacity to meet the changing demand for emergency service in the interest of safe and effective care.

For example, the use of code census is a procedure designed to move admitted patients from crowded emergency departments to the care location they require. Evidence shows that admitted patients fare far better on inpatient units than when waiting in an emergency department, and their movement to those units enables emergency staff to provide better care to the patients that continue to arrive in the waiting room. These are system-wide issues and in Nova Scotia, we are working to resolve them as a system.

While the volume of incoming patients continues to climb in urban areas where our population is increasing and emergency departments are where the impacts are most evident, the factors and solutions are more often found in other parts of the system. So the big strides made in improving access to home care throughout Nova Scotia, and in speeding placement in long-term care for those who need it, support the flow of patients from emergency into hospital as required and back to the community. Hospital and health system flow in efficiency is an essential part of ensuring high quality and accessible care for those who need emergency services.

So in the bigger picture, our system's approach - whole province approach - and partnership with other services and institutions that contribute to the health and social and economic stability of our citizens will reduce the reliance on the hospital and emergency care and help us reach our vision of healthy people and healthy communities for generations.

But when unexpected illness or injury do occur - and they will occur - our goal is to have the system design and integration, the quality and standards and hospital efficiency and surge capacity to meet the needs of our population. Thank you.

MR. CHAIRMAN: Thank you for those opening comments. We'll have questions, starting with the PC caucus, for 20 minutes. Mr. Houston.

MR. TIM HOUSTON: Thank you for the opening comments. I'd like to ask the deputy, when the House is in session, do you watch Question Period or do you get a report on what questions were asked to the minister?

MS. PERRET: I haven't had the opportunity to watch Question Period since I've come but I do get a report on the questions that are asked, yes.

MR. HOUSTON: You probably know that on February 16th I asked the minister a question about the Dr. Horne situation. I asked the minister very specifically how much the province has spent in legal fees in their continuing fight against Dr. Horne.

We know that before the minister became the minister that in the prior government there was $1 million spent but that was three or four years ago. We know there's a lot more spent. I asked the minister if he would tell the House how much of taxpayer money has been spent in their pursuit of Dr. Horne, let's call it. The minister said that he agreed that taxpayers have a right to know how their money is being spent. He said he would inform us in due course, but despite various letters, we haven't heard anything back.

I'd like to ask you today if you can tell us how much taxpayer money has been spent in the Dr. Horne case.

MS. PERRET: My understanding, and the Health Authority may have some additional information, is that certainly the legal issues affecting Dr. Horne are insured issues. It is covered by insurance and the taxpayers are not paying for that.

MR. HOUSTON: Are you willing to say how much the insurance claim will be?

MS. PERRET: I don't have that information.

MR. HOUSTON: Is that something we can get?

MS. PERRET: We'll make that inquiry but I'm not sure.

MR. HOUSTON: And who would you make the inquiry of?

MS. PERRET: The insurers involved are the insurers of the Health Authority, they are not provincial insurers. We don't have a relationship with the insurers so the inquiry will go to the Health Authority.

MR. HOUSTON: You'll ask the Health Authority and, Ms. Knox, will you be willing to tell us how much was spent on the Dr. Horne case?

MS. KNOX: Thank you for the question and thank you for the opportunity to clarify this issue. As you know, this is a long-standing issue. Yes, we will be able to do that.

I can tell you that because of the timing of this situation, it is a fully-insured issue so our insurers are leading that. We didn't talk about it. As you might appreciate, when you have a fully-insured situation happening you need to contain that discussion. I think it is important for the taxpayers to know that it is fully insured.

MR. HOUSTON: And the amount, though?

MS. KNOX: I don't have it right here with me but we can find that.

MR. HOUSTON: Can we get the amount before the week is over?

MS. KNOX: I'm not sure if I can do that before the week is over. It's an ongoing case and so you would be talking year to date, but we probably can do that. I'll do my very best.

MR. HOUSTON: Okay. These types of situations, I hear many of them where the province continues - I'll use the word "vicious" - pursuit of a citizen of Nova Scotia well past. I've seen it with many organizations where they've lost at human rights and all kinds, and they just keep appealing and appealing.

At some point the foolishness has to stop, so I'd just like to know if we could know how much money was spent on the foolishness in this case. If you're willing to do that before the end of the week, that's great. Thank you.

I'd like to ask the deputy . . .

MR. CHAIRMAN: The request, just to clarify, there isn't a timeline on the request but our clerk will follow up with the department and seek out a written response for the committee.

MR. HOUSTON: The timeline, from my side, is by the end of the week and I think . . .

MR. CHAIRMAN: There has been no committal for a timeline on it. You've made the request, and the clerk will follow up with the department.

MR. HOUSTON: I'll try again, can we get a committal on a timeline for when we can get a response to this?

MR. CHAIRMAN: Again, as Chair, the question has been asked and they will clarify in due time. You're not going to set a timeline for the department to respond.

MR. HOUSTON: No, with respect, Mr. Chairman, I'm asking the question of the witness, if they would provide some kind of a timeline . . .

MR. CHAIRMAN: The witnesses will seek clarification on the question that you've asked. The clerk will follow up with the department.

MR. HOUSTON: Sorry, do the witnesses need clarification on the question I've asked? That's your understanding, but I'm asking the witness if they need clarification on the question that I've asked.

MR. CHAIRMAN: Again, it's not your role to set timelines for when the department gets a response back to you. I recognize that you want the response by the end of the week. The witnesses will do their best to provide the response to the committee. Thank you.

MR. HOUSTON: I'd like to ask the witness how long they think it would take them to respond to the request I've just made.

MS. KNOX: Thank you for the question. As I said earlier, this is in the purview of the insurer so I don't know what their capability is to be able to give us this information. I will check with them in terms of how long it will take for them to give us that information.

MR. HOUSTON: Okay. It's my understanding that the way insurance works is that an insured party makes a claim against their insurer. The insurer then determines whether or not they'll pay that claim.

The question I'm asking you is - you're suggesting you made a claim - I'm asking you how much that claim is. It's not up to the insurer to tell me how much for a claim, I'm just asking you how much you've made a claim for, that's the question I'm asking. That should be in your scope of knowledge; if you made a claim, I'm asking you how much you made the claim for.

MS. KNOX: Thank you for the question, I hear you.

MR. HOUSTON: Thank you. I'd like to ask the deputy how many confirmed cases of measles are in Nova Scotia, as we sit here right now today? I understand that yesterday around lunchtime it was about 13; the media last night suggested it was 20. I'd like to ask you how many confirmed cases of measles we have in Nova Scotia as of right now.

MS. PERRET: I don't have a report on the outbreak of measles this morning. I'm just looking at Dr. Travers as to whether he might know.

DR. ANDREW TRAVERS: Thank you for the question. I don't have any intelligence on the current prevalence or incidence of measles within the province.

MR. HOUSTON: What's the most recent number you have?

DR. TRAVERS: It's in the purview of EHS. We're only now beginning to open up those linkages with Public Health Services and the conversations regarding measles preparation for it. Unfortunately, I don't have information on it.

MR. HOUSTON: Are you aware that there's measles in Nova Scotia at the moment?

DR. TRAVERS: I am, yes.

MR. HOUSTON: Okay, but you're just not aware of how many people have been confirmed cases.

DR. TRAVERS: Correct. As of this morning, I am uncertain of the number of measles cases.

MR. HOUSTON: Well this is interesting, we're seven minutes in and we can't get an answer as to how much you spent or how many cases of measles there are. Week after week it's pretty unreal to me, to be honest.

Can anyone across the way explain to me what you would do if you would like to get the measles vaccine? What do you do today, right now? If I would like to get the measles vaccine, what action should I take?

MS. KNOX: We have a couple of options; you can call Public Health Services and we can provide that number. In fact, it is in the press release that came out from our organization. If you had a concern, we would ask the people of this province to call Public Health Services or . . .

MR. HOUSTON: What I did yesterday is I called 811 to see what I would do to get the measles vaccine. It was suggested that I call my family doctor. What if I don't have a family doctor, then what do I do? They suggested that I go to a walk-in clinic. What if I live somewhere that I don't have a walk-in clinic? It just goes on and on. I don't think there's a clear answer as to what I would do to get the measles vaccine today.

How quickly do you think I could get it if that was me on the phone yesterday and I was told to go to my doctor that I don't have, go to a walk-in clinic that I don't have, maybe go to emergency they said but they might not have the vaccine, they might have to order it. That might take a couple of days. How quickly could I get the measles vaccine right now, if I wanted to, under those circumstances? What's your thought on that?

MS. KNOX: I would have to check that for you. What I would like to say for the people of this province is that our risk is very low. We do have a measles outbreak. It has been well-described in the public. The importance of having this conversation with the

people of the province is to say that we need, on a proactive basis, to be paying attention to our immunization.

We have very good coverage, about in the mid 90s per cent coverage for our population. That puts this measles outbreak at a very low risk to the population. So everywhere in this province we have access to our Public Health Services offices and those are the people who, if you don't have a family physician, will help you get a measles vaccination. The issue that we want . . .

MR. HOUSTON: How long would it take?

MS. KNOX: I will find that out for you. My point, though, is that it is not critical that we get it today. We are not in a high-risk situation here but we are in a situation of transparency that when these kinds of things happen, like communicable diseases, we need to tell the people of this province so that we are all educated in terms of the importance of immunization.

So I really appreciate you asking me this question and giving me an opportunity to say, this is sort of like the wake-up call. These things do happen. Immunization and preventive health care is really important for the people of our province.

MR. HOUSTON: In December 2015, Premier McNeil was in the media; there was a negotiation with doctors going on. He called doctors greedy, and he then tried to retract that, but he definitely used the words "unconscionable" and "pay" to describe doctors in the same sentence.

Flash forward to current day. Last week we learned that the department owes family doctors $6 million, and this is money that is owed for services that were rendered - things like home visits, nursing home visits, baby care, general things that you really want your family doctors doing. Some of the services that they're owed for go back to 2015. The amount from what I understand is generally paid out in January.

Can you tell me if that $6 million that was reported in the media last week has now been paid?

MS. PERRET: You're correct, they are not a payment for the service per se. The payment for the service is made in the normal course as physicians provide it. This is a top-up payment and you're correct, to date it has been made - there is a process for assessing the claims for the payment and working it out, and there is a lag time where it's paid either at the end of one year for the previous fiscal year, or in January.

Two things have happened. One, in the negotiation it was determined and agreed upon by the parties that they would switch from this type of lag time to simply adjusting the fee so that it was a more immediate payment, and those fees were agreed on by an expedited group in September last year. Doctors Nova Scotia wanted it to go to the full fee

committee and those fees were determined by the fee committee recommendation that they reached agreement in January. So the hold-up in the top-up payment was made simply to align with the new fees taking place. So I think there was a bit of miscommunication on that front.

On the Wednesday that I was informed by Doctors Nova Scotia that this was an issue, by the next Tuesday we confirmed with them that the direction had been given to Medavie for the cheques to go out. So whether they're in their hands, I'm not quite sure, but that was done within that time frame.

MR. HOUSTON: Was that last week, you mean? I'm not sure which Wednesday.

MS. PERRET: I think it's about two weeks ago - before you saw it in the news.

MR. HOUSTON: So you believe that they've all been paid as we sit here today.

MS. PERRET: I know that the direction for the payments to be made went out. I don't know if they've received them.

MR. HOUSTON: You referred to the NSGEU report on the code censuses and I've talked to a few emergency room physicians over the last few weeks in particular and I asked them, what is it that can make your life better? More options for patients is what they talk about all the time because people are crowding emergency rooms because they don't have a family doctor - probably afraid they have measles now too. Do you agree with that report that the number of code censuses is increasing?

MS. PERRET: I would look to the NSHA on the trend on code censuses. My understanding is yes, there has been an increase in the code census.

MR. HOUSTON: What is the solution to that?

MS. PERRET: The solution is what I referred to in my opening remarks . . .

MR. HOUSTON: Yes, but how long is that going to - there was a lot of talk about planning and vision. We've been hearing about this for so long.

MS. PERRET: For decades - and across the country. It's a complex problem. It is people like those that undertook the NSGEU report and the people working in our emergency departments that are informing how the shift needs to be taking place, but it's a shift that affects everyone in the nature of how we work and how we approach work. So if they were easy changes, you would have seen the changes happening by now in many jurisdictions.

MR. HOUSTON: But if the village keeps flooding, you can try and rebuild the village as many times as you want, but at some point in time, somebody should go up the

river and figure out what's causing the flooding. What's causing the flooding is, we don't have enough family doctors. It's as simple as that in my mind.

In this province, when we have a Premier who goes to the media and says doctors are greedy and want unconscionable amounts of pay, and then we have payments being - you tried to rationalize the delay in the $6 million, but doctors were pretty worked up over it. When you have all these things happening, it's got to make recruiting pretty hard. These things don't help.

Planning and vision and all those things are great, but what we actually need is execution. What Nova Scotians are wanting to see execution on is access to primary health care. So it's always back to that in my mind and I could sit here today - well, let me ask. We saw an announcement last week for a collaborative care centre in Digby. You're familiar with that announcement?

MS. PERRET: Yes I am.

MR. HOUSTON: When will that open?

MS. KNOX: Yes, that's a very good example - Digby and the surrounding areas - of whole-system development, working with partners in local communities and finding a solution for a broad base of population. Those physicians will all be in place by September.

MR. HOUSTON: September, okay.

MS. KNOX: In the meantime, it has been a very good source of support from other physicians in the Western Zone supporting that area and working together in a way that supports the population. The nurse practitioners have come in earlier, and . . .

MR. HOUSTON: Thank you. So that will open in September. What about the one in Sydney? There was a collaborative care centre announced for Sydney. The minister was down there, there was a big public meeting - that was October. When will that one open?

MS. KNOX: I think when we were here the last time, we talked to you about the 22 nurse practitioners and family practice nurses that we were fortunate enough to get funding to hire. The Sydney collaboratives are part of that solution. All of those interviews have happened now, and we're getting very close to being in a position to announce those practitioners. We're very encouraged.

MR. HOUSTON: You're encouraged. It's coming.

MS. KNOX: Yes. The big thing, as we talked about earlier, it's not as easy - we don't just go in and say to a group of physicians, we have a solution for you. We need to work with them and plan how we work together, how we bring in with them new practitioners, what kinds of supports they need as a team, all of that.

It takes a lot of time, you can appreciate. Many of our physicians come from a very independent practice, and we need to honour that and work with them. It can't just be that we offer a model and say, this is the way it's going to be. It does take time. The hiring process does take time, and we really wanted to do it all together so that people would get in the right place for them and not be moving around to positions.

MR. HOUSTON: So with the benefit of hindsight now - we don't have that Sydney one open yet - was it announced too soon?

MS. KNOX: What we announced is that we had support to go forward. We had an opportunity with the additional resources to ask other physicians and physician groups to participate. I don't think so. I think people need to know how long it takes to develop this. In our past, oftentimes we made solutions by telling people what would be good for them.

MR. HOUSTON: That's exactly what happened here. The people of that community were told in October, maybe even before that, that this was going to be opened, and this was the solution. Everyone stood at the podium and said, isn't this great? Now we're sitting here today, it's April, and we still don't have it. It may be coming. The hiring is happening. That's the type of false hope that I think people are tired of.

When we talk about all the planning and the vision and the wonderful things that are going to happen, it's time to stop with that false hope. If you announce it in Digby in April and announce that it's opening, and that's great, and everyone takes a bunch of pictures, and then the reality is, it's going to open in September, maybe that's not too long. Maybe that's shortening it up a little. Certainly people's understanding when they hear this is that it's happening. It's ready to cut the ribbon, and it's coming. I'm going to have access to a doctor now. It's really important to people that they have access to primary health care in particular.

I just think that we know why the towns are flooding. I don't know, as I sit here today, when that is going to be addressed, outside of some people standing at podiums and talking about wonderful visions and changes that are going to come. I don't know when that is actually going to be addressed. The real problem is, we don't have enough access to primary health care in this province. That is the problem that we have.

MR. CHAIRMAN: Ms. Knox, 10 seconds to respond.

MS. KNOX: We support that we need to be focused on primary health care. In every instance, that is our focus, absolutely.

MR. CHAIRMAN: Order. Time has lapsed for the PC caucus for that round. We'll move to the NDP caucus for 20 minutes. Mr. Wilson.

HON. DAVID WILSON: Thank you all for being here on an important topic. I was glad to be able to bring this topic forward for discussion, emergency department

accountability and Collaborative Emergency Centres. Nova Scotians are concerned not only about access to primary care but also access to emergency care.

This is not something new. This didn't happen overnight, in the last year, or in even the last three and a half years of the current mandate of the current government. This has been a concern for Nova Scotians for decades.

That's why, shortly after the election in 2009, the Emergency Department Accountability Act was introduced on the floor of this Chamber. It was passed in that first session. What it was meant to do was to hold government accountable. It doesn't matter the stripe of the political Party in power or not. It requires the government of the day to bring forward annual reports to identify where we have issues of emergency room closures around the province. Not only that, the onus is on the government to ensure that they are acting and reacting to areas of concerns.

Over the four years of the previous government, I was glad to say that emergency room closures were down 21 per cent in four years. Between 2012 and 2013, closures were around 15,555 hours. In 2015-16 that jumped by 45 per cent, to 22,505 hours, an increase of about 45 per cent. That year just wiped out the benefit over the four years of seeing yearly reductions in emergency room closures.

One of the requirements under the Act is that the Health Authority - of course, as we talked about, it was plural at that time, the nine district health authorities, but that Act would also pertain to the new Health Authority and the IWK - consult with communities if we see an increase or an issue of closures of emergency rooms. I would like to ask maybe the deputy - I know the deputy is new but the information should be there - has there been any consultation with the public, with the communities that have seen a spike in ER closures over the last three years? Are you able to provide us what has taken place through the district - or districts, prior to amalgamation - on the consultation with the community as per the legislation that was passed in 2009?

MS. PERRET: Thank you for the question. Mr. Chairman, with your indulgence, I'll just confirm that there are 13 cases of measles in the province right now. We've just had that confirmed.

To the question, I don't have that information. I'm going to ask if Ms. Knox can comment on community consultation.

MR. CHAIRMAN: Thank you for that. Ms. Knox.

MS. KNOX: It's a very important part of planning with the community, so I can say yes. For instance in Shelburne, we have created a relationship with the community advisory group, with the local leaders. That would be part of our consultation, with many meetings.

In areas like Springhill, there were public meetings. I'll just give a few examples. In places like Pugwash, we've had public meetings. We have advisory groups in the community to work with planning around resources. Our community approach to planning would include the discussion around the access to emergency services. It's really a very important component of the work.

MR. DAVID WILSON: That's why we put it in there. I'll ask that the Health Authority provide us with a list of those meetings because it's good to say, yes we're meeting with advisory groups, yes we've met with community - but the reason for the legislation and that requirement is so the public can see that there are opportunities. If you could provide that - you may not have that with you today.

The interesting thing is when we heard the opening statements, we heard things like "fragment" and "disjointed" and "whole system development" and other terms that I think often, when I hear that it's almost trying to justify the amalgamation of the district health authorities in the province. What I didn't hear are solutions.

We're here to talk about emergency department accountability. We're here to talk about Collaborative Emergency Centres. I didn't hear anything about how important the Collaborative Emergency Centres are to rural Nova Scotia. I look back - I know what was mentioned a few minutes ago, that it takes some time. I agree with that, but it doesn't take a full mandate to address emergency room accountability, access to Collaborative Emergency Centres, access to collaborative clinics.

In 2009, an election was held. Within two years, by July 2011 - the election was in June 2009 - the first Collaborative Emergency Centre was open in Nova Scotia. That was a complete change in model of care and delivery of rural emergency health care. The government of the day asked Dr. Ross - a well-known, well-respected emergency room physician - to come up with how we move forward to address an issue in front of us. I know Dr. Ross worked in every single emergency room in this province and was able to consult with local physicians, local health care providers, and the community to come up with a plan - within two years opened the first one and within four years, eight Collaborative Emergency Centres opened up in this province. That's in one mandate.

We're three and a half years in now and I think the first real clinic or new clinic will supposedly be in September - probably after the next election. We know the last time that the department and the Health Authority was here they mentioned there were eight clinics now. We tried to get what ones those are. Are there any new ones? I believe that the case was, no, there were no new collaborative clinics in the province - and actually used the North End clinic for one, which had been open since, I think, the 1970s.

I don't take the excuse that it takes time. There should have been action from this government. I believe the thing that's driving the delay is cost, so I would like to ask, what is going to be the cost to the province to open up these collaborative clinics in the province? Do you have that in front of you? Is there a number figure? I can only imagine that it's

going to be costly. The province is going to bear the overhead costs of these collaborative clinics. That's a shift from the current system where physicians themselves now cover that overhead cost.

Do you have any data, any financial costs of what this will cost the province and taxpayers? Is that one of the reasons we're three and a half, almost four years, into the mandate and we haven't seen one new collaborative clinic open up in the province?

MS. PERRET: I don't have cost information for you today and we'll have a look at that, but it's not just one cost figure to set up a centre. There are 50 in the process of being stood up across the province; I think we confirmed that eight of those are already set up, so they're being built over time. They're being built in response to the specific regional and population needs of a community, so they're not all the same configuration.

I would add - because I don't want Nova Scotians to feel that everyone is standing still and looking around, wondering what to do - there's a tremendous amount of activity out there that's collaborative, that's driven by front-line health professionals that I think we need to acknowledge, that is really working on the problem from the upstream side and the downstream side. We've referred to it in brief, but the details are really compelling. When we talk about paramedics, working with nurses, linking into physicians on their own initiative, how they're coming forward to solve problems and how we are keeping people - providing care in communities in home and keeping them out of emergencies. They're not small numbers, so . . .

MR. DAVID WILSON: With all due respect, it is unacceptable for witnesses to come to the Public Accounts Committee - the committee of the House that looks at the finances of the province - without any kind of financial figures. To me, it's just unbelievable. It's frustrating - I know my colleague mentioned this over the last number of months, trying to get answers. I would hope that those numbers would be available.

You must have a cost figure to implement one clinic in the province. I know it's going to be different region to region, depending on the number of people involved, but there has to be some kind of planning. That is very frustrating. It gives cold comfort to that senior who is living in Weymouth or Sydney or Yarmouth who has no access to a family doctor, who realizes and sees their emergency room closed more often than not, and we keep hearing this from government.

We have a plan in place from years ago, a model that did exactly what the department has talked about over and over for the last three and a half years - engaging the community, making a change that will improve access to not only emergency care but also primary care. We haven't seen any action from this government.

A lot of the initiatives that have been mentioned today had been enacted under the "fragmented and disjointed" system of the nine health authorities - the 811 system, eight Collaborative Emergency Centres across the province, paramedics working with long-term

care patients to hopefully keep them in long-term care and not visiting the ER. I can go on about these initiatives. They're all good initiatives. They've been going on for a number of years under a fragmented and disjointed system.

What is not seen, I think, is a priority placed on what the real issue is here and how we move forward. Cost has an effect on how to implement these new changes. So I find it unbelievable that we can't get costs as to how much it's going to be to see these new clinics open up.

In the media, not just recently but over the last year or two, I know another well-respected emergency room physician, Dr. Campbell - who is the chief of staff, I believe, at the Halifax Infirmary - in July talked about the issue of patients not only in the ER but in the hospital who are there because they don't have anywhere else to go. They need long-term care.

Since this government has taken over, I know how many new long-term care beds have opened up. Maybe I'll ask the deputy - I know you're recently new to the position, but are you aware of how many new long-term care beds the current Liberal Government has opened since they took power three and a half years ago?

MS. PERRET: I would have to check on the number of new beds that are open. I can tell you, because there's a lot of proactive activity on this front, that since 2015, the wait-list for long-term care has been decreased by 54 per cent. As we know, people actually don't want to be in long-term care as much as they want to be cared for in their home and stay in their home community as long as possible. On the home care support front, the wait-list is almost eliminated. It has been reduced by 91 per cent since 2015.

MR. DAVID WILSON: But the people in the hospital, the people in the ER, those frail Nova Scotians that Dr. Campbell talked about - they don't need home care. They're past that point. They need long-term care placements.

I believe the number is zero. There has been a moratorium placed on new long-term care openings here in the province. That's having an effect that is hurting not only access to emergency care in Halifax and around the province but also the ability of emergency room physicians to do what they're trained to do: take care of emergency situations. Now we have patients who are in the department who should be either admitted to the hospital, which they can't do, or placed in long-term care. We've seen this cycle over and over and over again.

Back when I first got elected in 2003, the Progressive Conservative Government for years and years denied the fact that opening more long-term care beds would address the issues that we see in our hospitals. They saw the light at one point. I think they initially said they would opening up 1,500, and that was a major issue going into election after election with people waiting on wait-lists and finally the government addressing it and opening new long-term care beds. This is the first government in about 10 years that has

said, no, that's not an issue, we're going to put the emphasis on home care - which is extremely important. I know how important home care is, but there is a point when people can't stay in their homes any longer. They are ending up in our ERs, if they're open, and they're ending up in our hospitals when they should be taken care of in a long-term care facility.

Have you looked at the eight Collaborative Emergency Centres that have been opened up since 2011? Would you agree that they have been positive, that it was a positive change to do that, to address a need in rural communities? Have you looked at the report that was commissioned by this government and previous information around how important Collaborative Emergency Centres are to communities like Pugwash, Musquodoboit Harbour, Musquodoboit Valley, New Waterford, Parrsboro, Springhill, Tatamagouche, and Annapolis Royal?

MS. PERRET: Yes, I absolutely agree. I think that what's important, and what I understand from the Collaborative Emergency Centres and what the evaluations have demonstrated is the collaborative care that has come out of them and the problem-solving.

I would also point out, with respect to your comments on long-term care, that it's that type of collaborative capacity in the community that's solving a lot of other problems. The wait-list for long-term care is now turning over. In 2016-17, we're able to turn over that wait-list. We're placing people as fast as people are coming on.

There has been incredible progress on that front and a move to community care. Again, I don't want people to feel that there's no progress. I think there's very positive progress. I'm not going to argue that it's fast enough for what people are coming to expect.

MR. DAVID WILSON: Are you able to provide the committee with the most up-to-date wait-lists for people on long-term care and the time that they are actually waiting? We know the exercise the minister took to eliminate people from the wait-list. If they weren't going to take their first placement, they were being told that within 24 hours they would be off that list. That was a good way of eliminating a bunch of people on that list. I wonder if you could provide us with that. I don't need it right away.

MS. PERRET: I would be happy to do it right away. Let me do it. On March 29th of this year, in the community there were 945 individuals on the wait-list, and in hospitals there were 191 people on the wait-list.

MR. DAVID WILSON: What's the average time for those 945 people? What's the longest someone has been waiting? Do you have that number?

MS. PERRET: No, I don't have the longest number, but I do know that those wait-list statistics are down by 54 per cent from 2015.

MR. DAVID WILSON: That's great when you put it on a chart, but it's no good for the 945 people who are waiting. If you are still waiting two years, you're waiting two years. It doesn't matter if the list dropped by 1,000. That's what we're missing here. That's what government is missing. It's great to throw those numbers out. It's great to have the talking points. But those 945 people, many of them end up in the emergency department down the road here, in Sydney, and in Yarmouth. That's what's contributing to the overall crisis we see in our emergency departments. That's why we have the report from one of the biggest unions here about code census in Nova Scotia.

It's interesting to see that in just 13 or 14 short years that code census - in the last year of my service on the ambulance I don't recall a code census. Some 13 years later, it's an hourly thing now, I think. That should be concerning to the government, and we should be listening to people like Dr. Campbell who know exactly what's going on in the emergency department.

You and I are sitting here in the Legislature, we're in our offices, we take phone calls, and we get all the paperwork and all the data to go through. But people like Dr. Campbell and others are on the front line, and they know. I don't believe the current government is taking that knowledge from those experienced, professional people who are providing care and trying to provide adequate care - we're not taking it seriously enough. To sit here and say, three and a half years into a mandate, that we still don't have a new, collaborative clinic for access to primary care in the province - I know you said eight, and I don't know if I've actually even received the eight that were mentioned about a month ago or a couple of weeks ago. Do you have those eight that you keep mentioning, which ones are open now that people are utilizing?

MS. KNOX: I think the number you're referring to were eight collaborative care centres that are fully functioning in a total inter-disciplinary perspective. We did provide that information. I didn't bring it today, but we can provide that.

MR. DAVID WILSON: I might have missed it, but I'll look for it . . .

MS. KNOX: I think we did already provide it the last time we were here.

MR. CHAIRMAN: The time has expired. The clerk has noted the information the member has asked for. We'll move to the Liberal caucus for 20 minutes, starting with Mr. Porter.

MR. CHUCK PORTER: Thanks for being here today. This is a very important topic as we've been hearing about this for a long time. You suggested in your opening statement - the deputy has - that this is a decade-old problem and I would agree, probably more than that, having come from a world previous to this one that was in health care. I saw Dr. Travers this morning for the first time in a very long time. It's nice to have you here as well, especially given the role that you're in - a very important role.

We hear a lot of talk about the primary care and I would like to ask, to start with, how many people - Dr. Travers, maybe you can speak to this or the deputy, or anyone for that matter, but you may be more aware than any. How many people in Nova Scotia who are sick - and you know the description of "sick" that I'm referring to - who are sick or in need, emergencies, how many go without?

DR. TRAVERS: Can I please clarify "go without"?

MR. PORTER: As in they are not seen immediately. When people are sick in the Province of Nova Scotia, how many people are not seen immediately to be treated?

DR. TRAVERS: If I can answer that in the context of EHS, I believe they don't go without when they call 911 and they build an emergency call from the community to hospital. I think Nova Scotians should be very proud of the fact that the 911 system is the first point of medical care for every single Nova Scotian, regardless of their emergency. There is a chain of survival that is built from the community to the hospital.

If I may take that hat off and I'll put on a physician hat of working as a staff physician in the emergency department, I don't feel that patients go without for the types of patients that I see in a very busy tertiary or quaternary emergency department here at the Halifax Infirmary. I think that the places we're practising are always being tested from the stretcher to a hallway to an ambulance stretcher, but I'm confident that patients don't go without. As a staff physician, when the team in the hospital is in the emergency - nurses, paramedics, social workers, and pharmacists - we collectively are working aggressively to meet that patient's needs and doing it safely.

MR. PORTER: I couldn't agree more. This is taking me to where I want to go with this initially so prior to the amalgamation of the ambulance service in this province, I had the pleasure of working in the old system as well, and I know others in this Chamber have as well. I would also have made the same statement at that time. Although things were different, there were 50, 52 operators, whatever it was, when we were called, people got the best care that they could be provided and they got it instantly and they were taken to a hospital either in their community or the QEII - the VG in those days - or wherever, and were given immediate treatment. Nobody went without treatment.

That took time. That started quite a few years before it finished. That was a lengthy gap in the beginning. I believe Dr. Jim Smith may have started that in the mid-1980s or so, and it carried on through with Dr. Hamm as Premier, and it carries on today, even building, and it took well past the year 2000 before every part of that ambulance service had changed and become what it is today. There are a lot of steps in that.

We have seen our nine district health authorities now come into one. That is a large transition as well. We are a million people - less than a million people - and what we do know is the larger transition of those 52 ambulance operators at the time came into one and it took time, but it only got better as it went along, until it reached a peak of being one of

the very best internationally. It has been recognized, as we well know, as an accredited service with very, very good people working in that system that, by the way, worked in the old days in that system and helped build that system into what it is today.

I find the transition, when I think about that very thing moving the district health authorities into one, a big task, no question about that; issues along the way, no doubt there are. There would be in anything you are doing when you are taking that huge administrative piece to task. But the efficiencies of that, I'm going to assume and I'm watching get better and better and that will continue as we go along - this will be a very fine running machine, not that it isn't now but as it becomes one, it becomes tighter.

Why would we be doing business differently in Yarmouth than we would be in Cape Breton or Halifax or anywhere else. That's what we saw in the old days, you did things differently - different equipment, different procurement. I remember all that very well and as we transition into one, things have to get tighter and tighter, and that means better and better. It will run and does run very well.

I think the transition to one Health Authority is a good thing. Again, we are talking less than a million people. Go and compare ourselves to Toronto, as an example, how many people in one district health authority in one of the larger, or in any city. It's many, many more but they do it and they do it well. I think there's an advantage to being there. It does take some time.

The community clinics we see around - it's something I've always believed in, long before we got into the collaborative model. I guess maybe it's still described even in those days, and I'll use the one in Windsor as an example - it's up behind the hospital, the Payzant Clinic and there were a number of physicians who owned that building. There were a number of doctors in there and there was a clinic on Monday night and every day of the week, for an hour and a half or two hours or whatever it was. People lined up, they went in and in five or 10 minutes they were out because they were ENT things. They weren't long, you know you needed a prescription for this or for that; they were minor things. That is a process that worked very well.

Recently, I think three weeks ago now, I went to a clinic in Windsor - the Lawtons clinic, I'll call it for lack of a better term. It's a new clinic, by appointment. I called that morning at about 8:30 or 9:00 and I was in for 11:00 a.m. Saw a paramedic first, did all my triage things, vitals, et cetera. The doctor came in, did our bit, thanks very much and out the door. Very timely.

When I hear about access to primary care not being available, I struggle a little bit with that because when I think of primary care I think of sick people who need to be seen, whether they are emergent sick by way of an ambulance ride or something like that or trauma, cardiac issues, et cetera, or whether they are sick for a week and it's a flu or it's whatever it is but I've got to get to the doctor and get something, I need a prescription, I've got to get something for this. I don't see great delays in that happening. Am I wrong in that

or am I missing something or are we just living in one of the best areas in the province, which I would agree we are, but we have access. I don't know, I don't hear from many people on this, not on those issues. Am I missing something here? I don't think I am. Things seem to be running.

Nothing is ever perfect and I'm the first to admit that. Anyone who thinks we are in Utopia should step back and have another look, in all honesty, because we're not. I'm just curious, what am I missing here? Is this not the model that we're moving toward? Dr. Travers you can speak to it, or the deputy or Ms. Knox or whoever can speak to it, I don't care. Is there something different in other areas of the province that we're not focused on the exact same thing? I know that was lengthy and I apologize.

MS. KNOX: Thank you very much for that. I think what you're highlighting is that we need to celebrate with Nova Scotians the good support that is available to them. There is a lot of really great work happening by very dedicated doctors and health professionals around this province.

The opportunity we do have is to learn from all of them and to spread the really good strategies across the province. I will say we know there are areas of the province that have access issues to primary health care because physicians have left. I've been in this system for a while and over the years, there would be different parts of the province that would have this big challenge. It is because suddenly we have people who are at the end of their career and are going to leave and we have to plan for that.

We need to get into a better position working with all our practitioners, to plan together about how they live their careers and how we plan to keep the positions full and address vacancies as they occur.

I thank you very much. I think that oftentimes, we don't talk about the good things that are happening and the really wonderful programs that have developed with communities, through interactions with communities and their practitioners around this province. As our deputy has said, we have great foundations. We have some challenges. As we plan and spread expertise across the province, as we plan together and have experts who are in our province and helping others learn their approaches, it's really a good thing.

MR. PORTER: That takes me to a couple of places here that I want to get to. I know that there are areas and have been for years, and they seem to be similar, for whatever reason, where there are struggles with emergencies or there are struggles maybe with getting clinics set up, I'm not sure. We hear a lot about Shelburne in the news from time to time, and they struggle with their emergency department. Okay, that's their emergency department. We understand, or there's X-ray shut down or something. It doesn't matter where I pick. We're very fortunate, as I said, where I come from.

But the plan across the province - I guess what I'm stressing here is the plan for community A versus community B, C, or D and so on - is the same. That's a question as

much as it is a statement, I guess. That planning, when we sit down and we talk about that and we're talking with physicians and we're recruiting and we're doing what have you, is it the same province-wide, or does it differ from community to community for some reason? I guess my thought is, I don't know why it would differ because a Nova Scotian in Shelburne is no different than one in Glace Bay or in Windsor. I'm just looking for some clarity on that. Ms. Knox, feel free.

MS. KNOX: Our approach to planning for community needs, we call it a community-based planning approach. We can use the information that we have about who the population is, what we know about how they access health care, what the issues are that are important to them, and what the challenges are in their local communities.

With the support of the patient-oriented research unit at Dalhousie University, they have helped us drill right down to the community level to see what the demographics are of the community and the health issues in local communities. We have been able to show that there are a couple of areas in the province that are somewhat different with a higher burden of chronic disease.

Generally, we have many of the same issues, because we have across the province a high burden of chronic illness. However, the population is different somewhat in each of our communities. Our approach is community-based support. The team-based care in local communities is the model that we believe is important. That team begins with doctors, nurse practitioners, and family practice nurses. The rest of the team needs to be up to the community, the practitioners in that community to be understanding who their community is and who else needs to be involved in the care of that local community.

I want to say there is flexibility because there needs to be depending on what the skills of the team are, and what types of skills would be needed to balance out to support a local community. By that approach, we would say then that we are responsive to the population that is there, and community members are part of that planning. We've had a very good example of that - I'll just be as brief as I can be - in looking at some of our communities.

In Digby and surrounding areas, who are the surrounding populations in those villages and in the rural surrounding areas? That may be a different solution than down the road in Middleton, where I know very well that we had long-standing issues of access to primary care for years, and we really worked with the community in terms of what the needs are and how we support practitioners to come in there. That solution would be somewhat different because it's unique to the community.

The last area, I would say, is looking at Pugwash. We went in with a community group, the physicians and community members, and talked about what we know in that community - what resources should be there and what kind of facility we need for the future. A very important piece of that information was to have a discussion about the lived experience of people. What's travel like? What's the age? What kind of supports do they

have? What other assets are in the community? I'm thankful to have that opportunity to say that we have a framework and a general plan, but we can be flexible at the local community level. That's not just the Health Authority; that's working with the community.

MR. PORTER: I've got only six minutes left. This is going by quickly here. I want to get a couple of other things in. The late Dr. Fred Akin brought me into this world. I don't know how many patients he had, but how things have changed. Fred Akin worked 24 hours a day, near as I could tell, whether it was at the hospital or his office. But we know that is changing. We know that care is still required 24 hours a day, hence the emergency system we have and so on. We could even tell you, from historical data, from when I left the communication centre - it was being measured almost when calls would come in and how many during a time of day.

I'm trying to get two more questions in here, quickly. Are we measuring those statistics in communities, as a whole, whether they are through emergency room visits, clinic visits, or doctor visits? Are we doing any of that at all?

MS. KNOX: Yes.

MR. PORTER: We're doing that across the province on a 24-hour basis? On a night basis? How is that working?

MS. KNOX: We do know, and maybe Paula Bond may want to add to this, who is accessing our emergency rooms over hours of the day, yes, over the 24-hour clock. We do know that. We also know the entire population of family physicians in this province, what their population looks like, where they live, how far they travel to see their physician. We've been at every single practice in this province talking with them about that.

Yes, we do have very good information about how people move around and access services.

MR. PORTER: We hear lots of talk about physician recruitment in the Province of Nova Scotia. Again, there are a lot of areas where it hasn't been an issue or a problem. I'm not sure what the numbers are in specific communities. I think about how lives have changed, how physicians have changed. We hear a lot about physicians today, how they want to work in a collaborative practice. Having visited that one a few weeks ago myself, I can kind of see why. It's pretty neat how it all goes. There's a lot of supports there.

In talking to younger physicians that I know, they are new, and a lot of new technologies have come along since the man who brought me into the world. They want to be able to have access to all those new pieces of equipment and something as simple as CTs and X-rays and sharing of information.

With amalgamation becoming one system province-wide, there's a technology piece that goes with that, the sharing of information. You type in my SIN, and anyone in

the world can tell me anything about me in this country. It's easy. How come I can't type my health card number in and do the same thing, but from a medical perspective? Where are we with that?

I know it's probably all part of the greater provincial amalgamation piece. I see that as great value as well. Are we on that road? Because I'm running out of time here, maybe you or Dr. Travers or somebody can speak to the investment that we're attempting to make in the recruitment of physicians. What are some of the challenges around that? Is it that people want to work eight or 10 hours a day, not 24, and have a life outside of what they do? A lot of young professionals, are they both working? It's not like it used to be.

In the Fred Akin case that I referenced, his wife, Mary, was his secretary. They spent all day, every day together. It's a different scenario.

I know I've touched on a lot. I know I've got only a couple of minutes left for you to answer, so I'll give you that. I would appreciate what you can offer.

MS. KNOX: Quickly, I will say we're very focused on what kind of working situation that young practitioners want. First, I want to say, young practitioners want to care for patients. They are very committed. The commitment of 50 years ago is still in these practitioners. We need to say that and be very clear about that.

When we are recruiting, we recruit to the kind of place that you want to live in. We are now able to take you right across the province, help understand with them the kinds of supports that are helpful to them. We've had the opportunity of talking with many physicians at various stages of their career, in terms of mentorship and support from other physicians, working with collaborative colleagues of different disciplines, and the kind of community that they want to live in and bring up their family in. We take into account all those kinds of things.

We also have incentive programs that are available because many of them come with a very big burden of debt, so some of that will be helpful to us as well. It's a whole variety of what makes this a good place to live, to work, to use the skills that you've worked so hard to develop.

MR. PORTER: Can you speak, Ms. Knox, briefly about the other part I mentioned around the technology piece? The health cards - if I go into a hospital in Yarmouth and I have some history and I'm in some kind of traumatic event or something else happens, where is that?

MS. KNOX: I'll ask Deputy Perret to speak to that.

MS. PERRET: The short answer is that's an absolute priority - having one health record for every person in Nova Scotia is a priority of the department and work on that front is moving ahead in good order.

MR. CHAIRMAN: We'll go back to the PC caucus for 13 minutes - Mr. Houston.

MR. HOUSTON: Just as we were speaking, I heard from a few doctors that said they haven't seen their share of the $6 million. I just ask if the deputy can report back to the committee when those cheques actually went out. I'll ask the clerk to take note of that.

Looking at the Health Authority web page today: Pugwash emergency department is closed today. New Waterford emergency department is closed today. Springhill emergency department is open today - but it was closed yesterday, will be closed Thursday, and will be closed Friday. Parrsboro was closed on Saturday. Northside General was closed on Saturday. New Waterford was also closed last Friday.

Last year we had a record-breaking year for - and I'm talking about the fiscal year for the government from April 1st to March 31st, last year, the year ended March 31, 2016 - record-breaking year for emergency room closures, 938 days. It was a report I received. Did we break that record this year? The year has now ended. Can you tell me how many days the emergency departments were closed in the year just ended?

MS. KNOX: We believe that we closed the year 2016-17 with 159 hours less of closure.

MR. HOUSTON: So not closed quite as often - a little bit better for the year, but in the same ballpark, I guess, when you're talking about 938 days, you're talking about maybe that was 935 days or something, but maybe we can get that report. I'll ask the clerk to take notice - the number of days the emergency rooms were closed.

Does it cost the province more when somebody presents at the emergency room as opposed to when they go visit their family doctor? Does it cost more?

MS. KNOX: The emergency room is funded very differently. We have staff that are there 24/7, so if 10 people arrive or 12 people arrive, we pay the same price. My understanding, depending on access to family physicians, I can ask Deputy Minister Perret to talk about that.

MR. HOUSTON: Do you have an average cost of an emergency room visit in the province? What is that average cost?

MS. KNOX: Tanya Penney can provide that.

MS. TANYA PENNEY: It actually varies according to the facility and it depends on how many staff are on, so obviously the tertiary care centre is a bit more costly than a small community facility that has two registered nurses. It averages somewhere between $89 a visit and $210.

MR. HOUSTON: And the fee code for a family doctor for a regular visit would be less than that or more than that?

MS. PENNEY: I wouldn't know the answer to that question.

MS. PERRET: That's information that I would have to get for you on an average - you're asking for an average visit cost for a family doctor?

MR. HOUSTON: Yes, there's a fee code. If you go to your doctor and you're there for whatever, he puts a fee code in and he gets paid. What is the average of that? Would it be less than $89? Would it be less than $89 or $210 - like in that range?

MS. PERRET: I'm going to get you that figure.

MR. HOUSTON: You're going to get me the average . . .

MS. PERRET: I'm going to get you a figure for an average family physician visit, and we'll have to probably explain the context that we work out the average.

MR. HOUSTON: How many people visited emergency departments in Nova Scotia last year? How many emergency room visits did we have?

MS. PENNEY: In total across the whole system - I'm not sure that I have that today. Do we have that? Sorry.

MS. KNOX: We do have a number - we can provide that to you.

MS. PENNEY: Sorry, I just don't have it here today.

MR. CHAIRMAN: The clerk is noting all this to get back to you.

MR. HOUSTON: I was wondering, how many people visit the emergency room that don't have a family doctor? That would be a statistic that should be known. That's probably marked right on the admittance form or something. How many people visit the emergency room that don't have a family doctor? Do we know that number?

MS. PENNEY: Sorry, I don't know that today, but it is certainly something that we could find out.

MR. HOUSTON: How many of the people that visit an emergency room in the province that don't have a family doctor are visiting the emergency room for a reason that they probably should have gone to the family doctor for?

MS. PENNEY: When you visit an emergency department in this province you're triaged according to the Canadian Triage and Acuity Scale. What happens is that you get

triaged at a level 4 or a level 5, depending on what brought you in that day. So those levels and separation of those levels is certainly something we can provide you with from a data perspective. It would take us some time to go into the actual Meditech and STAR systems to figure out if there is - for example, you headed to your family physician for a prescription renewal, it would take us some digging to actually get down to that level of data, but there are some assumptions that you can make from a CTAS level 5 perspective.

MR. HOUSTON: What I'm driving at is there is an actual dollar financial cost to the province for people not having access to a family doctor and are instead presenting at an emergency room. If it's more expensive to have them go into the emergency room and we have the statistics available to figure out how many times that's happening, then we can figure out the cost. Those are the types of things that I'm interested in and quite frankly I'm surprised that the department's not interested in. That's the type of analysis that I would expect is pretty common as to this is what it's costing.

I'd like to ask the clerk - maybe we can take a note of those things and we'll do the analysis ourselves, I guess. Deputy, is that not information that would be of interest – the actual financial cost to the system? There's all kinds of social costs to the system for people not having a doctor - tremendous social costs to the system. There's actually a financial cost that can be calculated as well. Is that something that would be of interest?

MS. PERRET: We're very much interested in the cost to the system on a number of fronts. Your question is an interesting one because we would be looking at - I think it's CTAS level 4 and 5 for those visits that probably could have been handled by a family physician, but I'm going to make a guess here that a number of CTAS level 4 and 5 visits are going to be by people who do have a family physician, but they're going to an emergency department on a night or weekend. As I say, the context of tracking that type of cost may be challenging, and I'm not sure what it would show us, but we'll take that away and have a look at it.

I think the other aspect of the system - and it does go a bit to my opening remarks, which were general. I wasn't necessarily talking about the Nova Scotia system, I was talking about the systems in Canada. We really need to shift to a concept of primary health care that is not simply physician focused. If we want to get different results and improve population health, we want to improve points of access and collaborative care, and we are making progress on that front so that people have access to nurse practitioners and the like that can do much of the work that a family practitioner does.

MR. HOUSTON: Okay, the time of day, if that's a parameter you want to add to the analysis - that they're visiting the emergency room because the family doctor is closed or something, you have all that. You have all those statistics. You know when somebody went there.

Last week I asked for almost 20 minutes how many family doctors there were in the province before I really even got an answer. Today we heard Ms. Knox say that not

only do they know, they know where they practise, where their patients come from, how far they travel, and all this interesting stuff. So you understand my frustration.

MS. PERRET: There are 1,000 family doctors in the province, and we'd be more than happy if you want to submit questions in advance, too, to have more precise answers available.

MR. HOUSTON: Earlier today you referenced the number 50 - I think you were using the number 50 in the context of Collaborative Emergency Centres - that the plan is to have 50. There are eight now, but there's 50. Was that the context of - it was a discussion you were having with my colleague.

MS. PERRET: What I made reference to is that there are eight collaborative care centres that are fully up and running. But in addition to that, there are 42 that are in various states of being stood up.

MR. HOUSTON: Those are collaborative care centres as opposed to Collaborative Emergency Centres?

MS. PERRET: They're collaborative care centres, correct.

MR. HOUSTON: Okay. Can we get a list of those 42, as to where they're at?

MS. PERRET: Yes, we can. I'm told that we've already provided it in a former package.

MR. HOUSTON: Great. Thank you for that.

There's an issue at the Northside General emergency room, with respect to how that emergency room is funded. Are you aware that there's an issue?

MS. PERRET: Are you talking about a fee adjustment that was made for emergency doctors?

MR. HOUSTON: Yes, the fee structure going forward as to how much people would be paid to work in that emergency room. There's a new fee arrangement that would be rolled out eventually. There's an issue with how that's going to impact the Northside emergency department. The first question is, are you aware that there's an issue with that?

MS. PERRET: I'm aware that an issue was raised about a fee adjustment, yes.

MR. HOUSTON: What it all boils down to is that that's a particularly busy emergency room in the hours that it's open. It's not open as long as some other emergency departments, but they are seeing as many patients as some other ones. It's very busy in the time frame that it's open.

The way that the fee structure has been negotiated, it doesn't really address that. I don't know if it's a mistake or an oversight or whatever it is, but as a result, that actually means that a doctor working in the emergency room at Northside General would be paid less than if they were working in some of the surrounding hospitals.

That's my understanding of the issue. Is that your understanding of the issue?

MS. PERRET: My understanding of the issue and how I was briefed is as follows: With a number of emergency departments that are relatively similar, there was a concern expressed - coming about from the consolidation - that there was a high degree of variability in the rates that were being paid. In collaboration, the department, the Health Authority, and Doctors Nova Scotia sat down to address that issue. In that context, there was an equity adjustment. Some rates stayed the same. Some rates went up. In that area, those rates went down.

That has not been implemented yet because we asked the same questions that you're asking when concerns were raised as to what the basis of the concern is and what needs to be done. So there's additional time to look at that.

MR. HOUSTON: So you have asked them to sort that out? Obviously, it's not going to make sense. Nobody is going to work in that hospital if they can get paid more working at the hospital next door, right? That's the concern of the community, and that's your concern, by the sounds of it. Would that be fair?

MS. PERRET: My concern is that when you make an equity adjustment, it should be equitable. If there are concerns that it isn't, then we should have a look at that, absolutely.

MR. HOUSTON: So that will be looked at. The action you've taken is that you've delayed the implementation of the new rate?

MS. PERRET: I believe we've delayed the implementation. Again, I want to make it clear that that was a negotiated rate adjustment. I think all parties will say, let's make sure we got it right, and if we didn't get it right, let's talk about what we need to do. Absolutely.

MR. HOUSTON: Okay. Thank you.

MR. CHAIRMAN: Time is just about to expire, so we'll move to the NDP for 13 minutes. Mr. Wilson.

MR. DAVID WILSON: The recent announcement of the collaborative care clinic in Digby - I think you mentioned that it's supposed to open in September of this year. How much is that going to cost, to open up that clinic in Digby? Do you have those figures?

MS. KNOX: I don't have the total cost here, but I can tell you what we've added in terms of practitioners. We've added two nurse practitioners and family practice nurses. The rest of the people as part of that clinic were already practitioners who were there. So it's really about how you bring the resources in that local health centre, hospital, together and work with a team three family physicians, eventually four, two nurse practitioners, and a family practice nurse.

MR. DAVID WILSON: I know this might be out there, but does the province cover the cost of the facility currently? I know that that has been the case in a number of them. I'm just not sure about the Digby clinic. Is that something the province pays for?

MS. KNOX: We were very fortunate that the community built that community health centre, with some wonderful support from the province. Is that what you are asking?

MR. DAVID WILSON: Yes. Is there an operational cost? Do we pay the heat? Do we pay repairs, rent, if there's rent? But if it's paid for? I would assume that it's not.

MS. KNOX: I can check on that for you.

MR. DAVID WILSON: So with the announcement, there was no cost? There was no figure? I've been in that position. When you make an announcement, one of the first questions usually from a reporter is, how much does that cost? I know you're saying for the position of two nurse practitioners - three positions of nurses. You can't give me any figure - there's going to be an increased cost on those positions, so roughly?

MS. KNOX: The physicians were vacancies that we are filling. That's the really important thing. What has happened here is, we've added two nurse practitioners and a family practice nurse. The rest of the positions, the resources were already there and available. As you know, in that community we've recruited numerous physicians over the past decade, and they stayed for very short periods of time, so that's not new resources in that community.

MR. DAVID WILSON: That's kind of the frustrating part, trying to get a dollar figure on this commitment. The government is committed to 40-some potential sites over the next - I don't know how long. We're almost four years in now, so I guess they're going to ask Nova Scotians to elect them again to hopefully see those 42 offices. I don't know how much weight that has with voters, but I know that in the last election there was a commitment to increase the number of Collaborative Emergency Centres in the province. There were eight, and a number of them were announced. Stephen McNeil agreed to fulfill that. Today, as we sit three and a half years later, they haven't.

How can we believe that that's the direction of the government? I understand the position that everybody here is in. You are here to implement the government policy of whoever is in government, so it comes from the top. I blame the current government for the inaction because you can only do what they ask of you.

Why haven't we seen an increase in Collaborative Emergency Centres? I know the Minister of Health and Wellness himself - especially around the Lunenburg CEC that was announced - said there would be a definite date very shortly. That was back in October 2014. Why are we not seeing an increase in Collaborative Emergency Centres when they were identified a number of years ago and committed to by the current Premier of this province? We're three and a half years in, and we're still waiting to see what direction the government is going to take. Can you give us an answer as to why we haven't seen an increase in Collaborative Emergency Centres in those areas like Lunenburg and Cape Breton?

MR. CHAIRMAN: Ms. Bond.

MS. PAULA BOND: When the Collaborative Emergency Centres were stood up, as you know, eight were stood up. That was done in collaboration with the community partners, with physicians, and with nurses. Other community needs were taken into consideration. The lack or strengths of primary care in those communities was taken into consideration.

After the first eight were stood up there was a review done with the previous team in the Department of Health and Wellness. I actually sat on that review committee. We looked at the strengths of the CECs, of which there are many, and we looked at where we are with the primary care in the further communities, such as Lunenburg, for example.

We then decided to continue to work, as we became the Nova Scotia Health Authority, with the communities, with the extended communities as to where we would go next and what communities were ready for it. Some of what I'd like to clear up, if I may, is that not every community thought they immediately wanted to go to the CEC model. So we worked with the communities that did feel this was appropriate for their communities. Other communities said they wanted to wait and see if this works or not. We appreciated that and said we would continue to work and evaluate and decide with the communities, particularly the physicians and the nurses, where the needs were. That's what we continue to do. We are committed. There are different models, as you know, across this province. Not every Collaborative Emergency Centre is staffed in the same way, either day or night. The daytime model for Lunenburg would look totally different.

One of the issues in Lunenburg is that there is an infrastructure issue there and we're trying to work through that as to what that might look like and what changes we'd have to make in that facility in order to accommodate. We have been making some really good progress with the emergency program of care, which is now a provincial program of care of which Dr. David Petrie and Dr. Sam Campbell are part of, as well as other physicians and care providers across the province. So we are committed to continue with this and to make sure that we learn from how the other CECs were set up.

MR. DAVID WILSON: So the million dollar question is a time line - how long do we wait? How long does government wait to act? We've seen year after year an increase

in emergency room closures. Yes, supposedly 159 hours less this year, but by no means would I say that's a success. That's maybe six days.

So how long do we wait? All the evidence in front of Nova Scotians - we've seen an increase in emergency room closures, lack of access to a family physician, overcrowding in our ERs, we have the chief of the emergency department at the Halifax Infirmary indicating that there are issues here. So I don't get why we haven't seen a concrete example of - this is what we're doing to address the issues of access to care on so many different levels - from primary care or access to a family physician to emergency room access and closures.

Does money play a part in this? Have your hands been tied because the current government's attempt to get back to balance has limited the investment in health - actually reduced it in the last year, with a reduction in total health spending last year compared to the year prior, and we've seen a continued reduction in that. Has that restricted your ability to address these serious issues that Nova Scotians have? If not, then please tell me what is on the horizon to address these issues?

MS. PERRET: This is an important question. From what I've seen and determined, my answer would be no, that's not a straight line. There isn't progress being made on the building of a broad-based primary health care centre because of money, but money does matter. So going forward on any initiative on a strategic planning front, on the operational planning front, we obviously are more and more focused on getting value for investments and we need to do the value equation.

Partly what you're hearing in response to the context of these questions is that we're also trying to fashion these responses to fit community needs. So you have a very detailed lens on how to build out primary health care, how to build collaborative teams, how to respond to population health needs and progress being made that 50 of these teams are already either fully stood up or are being stood up. So I think that there's a lot of work at play and so it's not a financial barrier.

MR. DAVID WILSON: I don't believe that the government is going to be fortunate to see the position that you're in with Digby. Digby has been for a long time very engaged from a municipal level and community level - raising money, incentives that the community has brought to try to attract physicians to that great part of our province. It has been a struggle for them for the last 15 years or more.

So the government is not going to be in that position in every community - rural communities are struggling with population, with resources. So how can you say that the financial component of this is not going to be something that's at play when I see a government under-spending their health budget, reducing their health budget, and knowing that there are communities out there that cannot bring to the table what Digby has brought to the table when it comes to hopefully attracting physicians or nurse practitioners or other health care providers.

Are you concerned that we don't have 41 other Digbys that have a step up when it comes to organizing, trying to attract, and recruit and retain health care providers?

MS. PERRET: What I am saying is that we're going to approach this from a population health lens, where the need is and where the capacity is, where there is a state of readiness. There are always financial considerations in doing that, but the financial consideration isn't the lead on it. It's the planning and the preparation and the costing so that we do our due diligence to see that we have the full value equation set out in each and every case.

MR. DAVID WILSON: I know I have a short amount of time here. I would be remiss if I didn't go to Dr. Travers and ask how things are with the paramedic profession. What do you see on the horizon for that profession to continue to contribute like they have been for the last 20-some years in the transition of what we have now from what we had a mere 15 or 20 years ago?

DR. TRAVERS: I am very proud that the College of Paramedics has now been implemented. It's a self-regulating profession effective April 1st. I think the landscape for paramedicine, to keep paramedics in the province and draw paramedics from across Canada and elsewhere, is the evolving models of care that are going to be happening in partnership with nurses and in partnership with physicians. I think there are new pathways we'll be able to find provincially and regionally, new pathways of care, which will actually challenge the idea that every 911 call means an ambulance transport to emergency. That's the shift that Ms. Perret was talking about at the very beginning, and Nova Scotia is slowly moving in that direction. I think it's going to be a very exciting time for the profession, and I think the key thing for transparency is that, although we may expand the scope and role of paramedics . . .

MR. CHAIRMAN: Order. Sorry, we're running a little short on time here. We're moving back to the Liberal caucus for 13 minutes. Mr. Stroink.

MR. JOACHIM STROINK: I have a few questions that I want to have a chat about. One of them is just on the closures that occurred in Nova Scotia. At any time during this time was any Nova Scotian at risk of not getting care?

MS. PERRET: I'm going to refer the question to our emergency physician, Dr. Travers.

DR. TRAVERS: I am going to wear my hat as provincial medic director for EHS, and I feel, no, patients were not. I think for those big emergencies in those communities that had ED closures, there was safety for that community in the form of 911 and an EHS system and integration with the broader health care system. Where there was a stroke, an MI, a pregnancy, a neonatal case, that recognized emergency, those communities were able to build a pathway of care to the regional hospital.

MR. STROINK: How would that care look if there was an emergency in that situation? If there was a neonatal incident, how would that be addressed in those areas?

DR. TRAVERS: It's an excellent question. I can think of some examples. It's the same pathway. Although they may have briefly staged at that hospital, the idea is that for the emergency departments or those locations or these Collaborative Emergency Centres - when the model was built it was always built on the premise that the sicker the patient was, the faster they were going to be shipped on. During those times of closures, we worked as a system to mitigate risk to the communities by actually bringing the patient directly from the community to the regional hospitals, whether by ground or by the air medical system.

MR. STROINK: With that then, do CECs work?

MR. CHAIRMAN: Ms. Somers.

MS. EMILY SOMERS: Do the Collaborative Emergency Centres work - the eight that we have opened?

MR. STROINK: Yes.

MS. SOMERS: Yes. Those small communities were experiencing many closures and delays in accessing primary care. That model of care was implemented, and we immediately saw a reduction in ER visits and an increase in primary care visits. What it demonstrated was that those communities didn't need more emergency care. What they needed was more primary care.

We certainly identified that through the evaluation very solidly. The next step was how we then took the lessons that we have learned from opening those Collaborative Emergency Centres and build it into the future and if the future is all around collaborative care. So we've taken those learnings and are trying to build primary care as the foundation of the system. That's where we have gone with the centres.

MR. STROINK: So with that statement, do you have some stats that you can share with Nova Scotians that the shift is going from primary care. The CECs weren't emergencies - they were primary care visits. The stats - if you're saying that we need to go to collaborative care from a CEC model, then you must have some kind of anecdotal information to share.

MS. SOMERS: We track all visits to Collaborative Emergency Centres, as we do to all emergency centres. You can see we have the stats that show a reduction in the number of presentations to the emergency department because they can access primary care for longer hours into the evenings and on the weekends, when they need it. That was the shift, that those folks were not looking for emergency care when they presented to the emergency, they were looking for primary care. In the CECs, folks are triaged. If they do

go to the emergency door and they need primary care, they are immediately triaged to primary care.

We know that primary care provided in a primary care setting is far superior than primary care being provided in an emergency setting. That has been a real improvement for those communities, getting the right care in the right place.

MR. STROINK: What I'm hearing is that the CECs might not be the model that we need to go forward with, and that's why we're headed down this road - the collaborative care model is going to be more advantageous for communities like Digby. They are going to get more support within the community for the primary care versus emergency care.

MS. SOMERS: Precisely. So as we've been hearing today, we need to now design more precisely around the needs of those communities. We're learning that the needs of these communities were not specifically around emergency care. Therefore, the planning going forward that the Health Authority was talking about is around being very clear around what is needed in those communities and how we build it for those communities.

MR. STROINK: Thank you for that. I think that gives great clarity of why we might not be opening more CECs because those needs in those communities might not be addressed through the CEC model, but more through a collaborative care model.

MS. SOMERS: Correct.

MR. STROINK: With that, to me that makes a lot of sense and that's a smart way of making sure that our dollars go as far as possible and that Nova Scotians get the care they need within the community, based on a primary care model versus a CEC model. Thank you for sharing that.

I guess with that expansion of doing care a little bit different, you touched on it a little bit more but about how we're dealing with seniors who are in palliative care. That's a good news story, in the sense that people are recognizing that from around the world. My understanding is that someone is coming from another country to have a look at this. Why is this successful and why are people looking at us, Nova Scotia, as a leader in this?

MR. CHAIRMAN: Ms. Perret.

MS. PERRET: Thank you for the question. I'll let Dr. Travers elaborate a bit on the components of the program. It's an important question because Nova Scotians know, because the issues that I raised in my opening remarks were not specific to Nova Scotia, they are specific to health systems across Canada and partly around the world.

My point is that in solving them and everyone is struggling with some of these issues, Nova Scotia is ahead of the game and has a base of experience that it's putting into

play that is really demonstrating to the world how to do this. Palliative care, long-term care, the home visits, the Adopt A Senior Program are examples of this.

MR. STROINK: So you're saying that we're leading Canada in those areas.

MS. PERRET: I think in some of those areas we absolutely are and we're seeing an interest internationally in some of those initiatives. The credit goes to front-line staff.

MR. STROINK: Excellent, that's great news.

MR. CHAIRMAN: Dr. Travers.

DR. TRAVERS: I think to build on that point, for communities it's almost that they're building these toolboxes of resources that are available. Some provincial programs, like special patient programs and paramedics providing palliative care at home - there are also these regional examples where we're learning from the communities about best practices. A senior in who falls in Truro or in Bridgewater and calls 911, paramedics can make a referral to a local falls clinic.

It's that kind of innovative thinking as teams that we're all beginning to coalesce and as two large provincial systems, we're coming up with these new patient pathways. I think it goes to Mr. Porter's question about that benefit of being one large Health Authority and two systems being able to speak to each other about what resources and options are available.

MR. STROINK: Thank you. I guess that kind of expands on, I mean we're not doing it just there, I mean I think the other one is in the ER here, you have this phenomenal rapid assessment program. To me that also makes a lot of sense and I think if you can explain what that rapid assessment is. To me that's another good news story in the sense of how we're dealing with emergency care and trying to deal with backlogs, so if someone comes into the rapid assessment unit, they're not going into the emergency unit, so we're not clogging up the system with this rapid assessment. Maybe you can share a little bit about that and explain how that works.

MS. KNOX: I'll ask Ms. Penney to explain that.

MR. CHAIRMAN: Ms. Penney.

MS. PENNEY: The rapid assessment unit in the Halifax Infirmary is what you are referring to. It's a 10-bed unit off of the emergency department that has the capacity to take referrals from community or other regional sites where patients in other areas of the province require consultation to specialty services. Rather than them heading to the tertiary care centre to see the specialist, they actually go off to a separate unit. So you're right - it keeps those patients out of a dual emergency department visit, and it streamlines their care.

MR. STROINK: I've got one more, because I'm trying to wrap this up as quick as I can. Now we have another crisis coming down our pipe, which is the opioid use. How are we dealing with that? There's a reason why I'm kind of walking you through each of these.

MR. CHAIRMAN: Dr. Travers.

DR. TRAVERS: I'm very proud that EHS is working with Dr. Strang and Public Health to mitigate the risk of opioid use disorder in the province as we prepare for this pandemic wave as it sweeps across Canada. I think Nova Scotia should be very proud that we're leading the country in such forums as having just-in-time training for the take home naloxone kits that such groups as Direction 180 are giving out. It's the type of thing where if a citizen calls 911, they're actually taught how to use the naloxone kit they were given by the Public Health teams to save that person's life.

MR. STROINK: I know we've expanded that quite dramatically, working with Mainline and working with others. This is another aspect of trying to get people who wouldn't necessarily end up in the emergency room, but this is another form of treatment.

DR. TRAVERS: This is for the bystander giving naloxone. But it's more than that. It's the idea that that same program would enroll their patients into our special patient program to facilitate their entry into emergency so that they actually have coordinated care even before they arrive in the emergency department so they can get that continued re-dose of the naloxone if needed, as well as direction towards mental health and addictions counselling.

MR. STROINK: What I'm trying to get at here is, I've just walked you through four pretty amazing initiatives that this government has led in the sense of changing health care and emergency care within Nova Scotia. Deputy, you've said yourself numerous times in this Chamber, you came to Nova Scotia from Alberta because we were leading and making a plan. So this is an example of the great work that you guys have done in Nova Scotia to ensure that patients are taken care of.

I would like the deputy to expand. This is the path that we're trying to go down, is it not? This is what we're trying to do for Nova Scotia - look at things differently and expand on our emergency care so that we are ensuring that Nova Scotians in an emergency setting are taken care of with the utmost care.

MS. PERRET: Yes. When you start to learn about what's happening in Nova Scotia, there's a collaborative and innovative spirit here that's very compelling. The more you learn about it, the more you want to be part of it. I honestly believe that some of these complex issues that are challenging health care systems across the country, Nova Scotia may be the place where you solve a lot of them.

MR. STROINK: I think that's my time, Mr. Chairman?

MR. CHAIRMAN: There's less than one minute if you have anything else.

MR. STROINK: That's fine.

MR. CHAIRMAN: So we are running a little short on time, but if you would like to make brief closing remarks, we can move there for one or two minutes. Ms. Perret.

MS. PERRET: I will be brief. I appreciate the invitation here. I appreciate the discussion. I think that these are challenging and complicated issues that merit a good discourse. It's forums like this that are going to help move us forward, so thank you.

MR. CHAIRMAN: Before we move into committee business, there's a little bit of news to let the committee know about.

I want to recognize our Auditor General, who is here with us today. He attends a lot of these committees, and we appreciate that. He has been appointed to the Auditing and Assurance Standards Board of Canada for three years beginning April 1st of this year. That's a board that sets Canadian auditing standards and is made up of private and public sector representatives. He will join 13 volunteer board of director members from across Canada.

That's a great thing for us because he will be able to bring an Atlantic Canadian perspective to the board. So I want to recognize the Auditor General. (Applause)

Moving on to committee business. We have some correspondence that the members would have from the Department of Transportation and Infrastructure Renewal, which is the information requested from the February 8th meeting. Are there any comments from members? Seeing none, the next piece of business is the Auditor General briefing.

On April 12th our meeting topic includes the follow-up of the recommendations from the Auditor General from the February 2017 report relating to the departments appearing before the committee. Normally we would have a briefing in advance of the meeting. In this case it's based on the results of the follow-up report, so the committee needs to make a decision if you'd still like to have that briefing, which would have to take place in advance of next week's meeting.

So if we really want to have that briefing we just have to schedule it before 9:00 a.m. so it would have to be something like an 8:00 a.m. If no committee member feels strong about that, then we won't have that briefing.

No comments from members. We'll go forward without the briefing.

There was a motion from committee member, Tim Houston, about bringing in a witness from the last meeting. We ran out of time. I'm going to recommend that be put forward when we have our agenda setting on the April 19th meeting. So unless the member

feels strongly that he wants that motion taken care of today, that's my recommendation. Mr. Houston.

MR. HOUSTON; I think we know the way it's going to go and we'll bring it forward to agenda setting at that time, but the motion is on the floor, so I would like to bring the motion to conclusion.

I have a motion to bring Danny Graham and Engage Nova Scotia before the committee - specifically I would like to see that fill the empty spot we have on April 26th. We can go to work that day instead of taking it off as a committee. That would be my motion and I would like to have a vote on that and I'll ask for a recorded vote on that.

MR. CHAIRMAN: The motion is that Danny Graham in his capacity as Chief Engagement Officer with Engage Nova Scotia appear before the Public Accounts Committee along with appropriate staff from Communities, Culture and Heritage at the earliest opportunity, which would be in this case April 26th.

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is defeated.

Mr. Wilson.

MR. DAVID WILSON: Just thinking about the Auditor General's follow-up. It would be beneficial I think - it has been the practice to have a briefing. I'm not sure how much time - would a half hour be good enough? If that's the case, I don't know if it's an 8:30 a.m. start. We could maybe come in for half an hour, have a quick briefing from the Auditor General's Office.

MR. CHAIRMAN: We'll ask advice from Mr. Pickup.

MR. MICHAEL PICKUP: I think a half hour would be plenty of time for that, keeping in mind that - not to frustrate you, but a lot of the questions you will likely have will be directed towards the department, but we can give a brief summary of what was in the report for you. So a half hour is more than enough.

MR. DAVID WILSON: I would ask that we schedule that in and meet at 8:30 a.m.

MR. CHAIRMAN: That's fine. I don't think that requires a motion so we'll get the clerk to schedule early for that day, commencing at 8:30 a.m. with the Auditor General.

We have one minute left - very briefly. Mr. Porter.

MR. PORTER: I don't think it will take long. I will just make a motion that we would take Mr. Houston's request and move it to the agenda setting meeting, which I think is next week for further discussion.

MR. CHAIRMAN: The agenda setting is April 19th.

MR. PORTER: I would move that we move that discussion to that meeting.

MR. CHAIRMAN: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried. The clerk will note that.

The last piece of business is the 2015 annual report for approval from the committee. The draft 2015 annual report for Public Accounts Committee has been circulated. No changes have been provided to the clerk so I need a motion to pass that annual report.

MR. PORTER: So moved.

MR. CHAIRMAN: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We are now adjourned.

[The committee adjourned at 11:00 a.m.]