HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 20, 2022

LEGISLATIVE CHAMBER

Virtual Care Nova Scotia

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Public Accounts Committee

Hon. Kelly Regan (Chair)
Nolan Young (Vice-Chair)
Dave Ritcey
John A. MacDonald
Melissa Sheehy-Richard
Trevor Boudreau
Hon. Brendan Maguire
Claudia Chender
Susan Leblanc

In Attendance:

Kim Leadley
Acting Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

Kim Adair,
Auditor General

WITNESSES

Department of Health & Wellness

Craig Beaton,
Associate Deputy Minister

Angela Purcell,
Senior Executive Director - Physician Services

Jill Casey,
Executive Director - Data Governance and Management

Doctors Nova Scotia

Dr. Heather Johnson,
President

Dr. Leisha Hawker,
President-Elect and Chair - Doctors Nova Scotia e-Health Committee

Nova Scotia Health Authority

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

Doris Grant,
Senior Director - Innovation

HALIFAX, WEDNESDAY, APRIL 20, 2022

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIR
Hon. Kelly Regan

VICE CHAIR
Nolan Young

THE CHAIR: I now call the Standing Committee on Public Accounts to order. My name is Kelly Regan. I'm the MLA for Bedford Basin and chair of the committee. A couple of reminders to everyone: please place your phones on silent or vibrate, and please keep your mask on except for when you are speaking.

We'll start with a round of introductions. To my immediate left, MLA Chender.

[The committee members introduced themselves.]

THE CHAIR: I will note first that we have officials from the Auditor General's Office, including the Auditor General herself, the Legislative Counsel Office, and Legislative Committees Office. With us today, pinch hitting for Kim Langille, is Kim Leadley. Welcome, Kim, to this role at this time.

On today's agenda, we have officials with us from the Department of Health and Wellness, Doctors Nova Scotia, and the Nova Scotia Health Authority, regarding virtual care in Nova Scotia. I will note that Dr. Hawker is attending virtually.

I'm going to ask the witnesses to introduce themselves, beginning to my immediate right with Mr. Beaton.

[The witnesses introduced themselves.]

THE CHAIR: I will invite the witnesses to begin their remarks, beginning with Associate Deputy Minister Beaton.

CRAIG BEATON: On behalf of Ms. Purcell, Ms. Casey, and myself, we are pleased to be here in attendance with representatives from the Nova Scotia Health Authority and Doctors Nova Scotia to answer your questions on virtual care in the province.

Before we get into the discussion, I would like to provide some background information around virtual care in the province. Virtual care is often associated with computers and video calls on platforms like Microsoft Teams or Zoom. We are all too familiar with this type of interaction in our workplaces and see the flexibility that it can bring, but virtual care is much more than that.

The 811 system, as an example, has been in place in Nova Scotia since 2009. This service has assisted thousands of Nova Scotians. When you contact 811, you speak to a registered nurse. This is a form of virtual care. When you schedule a medical appointment online, like your COVID-19 vaccine booking or blood collection appointment, this is also a form of virtual care. The booking of medical appointments online has been a staple in some of the allied health professions for years.

Although not new, government has been working with our partners, stakeholders, and the health care system in pre-pandemic times to enhance virtual care options in Nova Scotia. Due to the pandemic, we had to move quickly, and saw the rapid and successful expansion of virtual care services in our province.

Here is some of what has happened to date. Since 2020, all non-procedural insured services that patients would normally need to see their family physician for can be provided virtually. We ensured that billing for virtual care services were at the same rate as in-person visits.

In 2021, the Nova Scotia Health Authority launched the VirtualCareNS pilot, a voluntary service to address the care needs of people without a primary care provider who are on the Need a Family Practice Registry. The program has been rolled out province wide. Virtual visits by phone or video conferencing, delivered by providers to unattached patients, have been supported by the Province and the Nova Scotia Health Authority.

The Nova Scotia Health Authority is piloting a proof of concept in Colchester East Hants called Virtual Emergency Nova Scotia, where lower-acuity patients who present at

the emergency departments may be seen by a virtual emergency physician. This pilot is in its infancy and we look forward to hearing more about it soon.

Government recently announced $14.5 million in the 2022-23 provincial budget to support virtual care initiatives this year. We have conducted consultations and evaluated virtual care options in our province. Evaluation for VirtualCareNS is ongoing and what we learn will help improve the system going forward.

We have received lots of positive feedback from both patients and providers. Since the pandemic, the move into virtual care has been expedited and we have seen the benefits. That being said, we know that virtual care is not a replacement for in-person care. It may not be for everyone, and we recognize that. Virtual care is one of many tools available to us to increase access and timely care to Nova Scotians.

As we continue to look forward and enhance virtual care offerings, we do so with solutions in mind to ensure as many people as possible have the option to choose virtual care. This means working on innovative partnerships such as the one in Pictou County, where three libraries in New Glasgow, River John, and Westville now have a private, dedicated space for those to use VirtualCareNS. People who are eligible and have enrolled for VirtualCareNS can go to these locations and access the technology and the support they need to log on and receive care.

We know that in collaboration with our partners, there is still very much more work to be done, and we are excited about the opportunities. In closing, I want to acknowledge and thank the many partners across the province - some of whom are present today - for continuing to support virtual care options in Nova Scotia.

THE CHAIR: Now we will move on to Dr. Tomblin Murphy.

GAIL TOMBLIN MURPHY: Thank you so much for this opportunity to join you today to answer questions and have some dialogue.

Having timely access to a primary care provider, to a family physician, to a nurse practitioner, is incredibly important to Nova Scotians so they receive care in a time that is meaningful for them and relevant. Access is incredibly important to all of us.

We also know that accessing a primary care provider for Nova Scotians has been an ongoing challenge. There are 88,000 people in Nova Scotia who have told us that they need a family practice, and we know the list has been growing because we’re a growing province in terms of the population, in terms of the demands for health care, and the fact that we some of our health status indicators are not favourable at this end of the country.

We take this very seriously at the Nova Scotia Health Authority. We work very hard to meet the needs of people who are aging and the increased demands, especially those

who we have seen during COVID-19. We are working hard with our partners to recruit family physicians, to retain them in the province - and also nurse practitioners and other healthcare providers. This continues to be a priority for all of us.

We know that there are many options to enhance access to Nova Scotians for primary care. That's why we started VirtualCareNS about one year ago through the generous funding of the Nova Scotia government. This is an opportunity for those people who are on the registry to have an online appointment to access care with a provider. As of this month, more than 66,000 people on that registry now have access to VirtualCareNS and over 12,000 virtual appointments have actually taken place.

We've heard from patients, we've heard from Nova Scotians - they really like it. They like it and they access it for different reasons, similar to our in-patient medical or health appointments. It's available on demand. Patients simply log into an account that they have registered for. After a brief wait online, they're connected with the next available family doctor or nurse practitioner. It's timely access in the comfort of one's home on their phone, a tablet, or the computer.

To quickly paraphrase what patients have said what they like about this, they find it very convenient to access care online. They appreciate not having to travel to appointments in the ways that they've had to. They also like that the local doctors, as well as nurse practitioners, understand them and are very helpful, and they get their care needs met.

The types of things that they oftentimes come for are things like mental health consultations, prescription renewals, pain in hip, knees and other joints, as well as infections - ear, throat, urinary tract infections - things that one needs pretty quick treatment for. Those are the top reasons.

We've been evaluating on an ongoing basis. We're really pleased that the evaluation so far in this proof of concept is very positive at this point. We are hearing very good news stories. I hope I will have the opportunity to share with you during our dialogue today, from patients, about why it's helpful through VirtualCareNS.

We're very optimistic about virtual care in this province. We believe it's here to stay. Going forward, I don't think we'll go back to not having virtual care options in this province. It's providing the much-needed primary care options for Nova Scotians who do not presently have a family doctor or a nurse practitioner or a primary care provider. We believe that this is important. In addition to that, by the end of June, all Nova Scotians on the registry in all zones will have access to VirtualCareNS.

THE CHAIR: Thank you, Dr. Tomblin Murphy. Now we move on to Dr. Heather Johnson from Doctors Nova Scotia.

[9:15 a.m.]

HEATHER JOHNSON: Thank you for the opportunity to appear before the Standing Committee on Public Accounts this morning. I'm here today in my role as president of Doctors Nova Scotia, but I'm really a family doctor from Bridgewater who's been there for 20 years in a collaborative practice.

With me today virtually is Dr. Hawker, who is the incoming president of Doctors Nova Scotia and Chair of our E-health Committee. She's a family physician who works at the North End Community Health Centre, does addiction medicine, and works at the Newcomer Health Clinic. We both provide virtual care to our patients in our practices.

Our invite for today's appearance focused on VirtualCareNS. We're very pleased to have the opportunity to share our support for this program as an interim measure created by Nova Scotia Health Authority and the Department of Health and Wellness to connect patients without a family doctor to primary care. The initiative is playing an important role in providing access to primary care for those who don't have any access.

Because we don't have enough family physicians, we need to develop interim solutions like VirtualCareNS to address this immediate need. Parallel to this, we need to prioritize building a primary care system that has a clear vision for how primary care is going to be delivered in this province. We firmly believe that patients need a health home where their medical history is known and understood, and where they can access timely, comprehensive, and continuous care from a collaborative team of health care providers.

In 2021, Doctors Nova Scotia undertook some research on what the future of family medicine is going to look like, and physicians have opinions on what this should be. They believe the future looks like it's primarily female and gender diverse. They want to provide care in a collaborative setting. They feel that they deliver the best care when they engage the communities, and the patients are engaged in their care and when everybody works together to make that work.

They also indicated family physicians think it's time to address the social determinants of health on primary care. Family physicians sometimes feel ill equipped to manage this because often these things have to be addressed through a social safety net, public health promotion, and community resources that fall outside our health care system currently.

While these points outline what family physicians think primary care should look like, they may not match what government or the Nova Scotia Health Authority or our patients require, and we also need to consider the opinions of the social workers and the nurses and the pharmacists who also provide care and primary care. Wouldn't it be great if we could align all of these, and create a vision for primary care moving forward?

To that end, Doctors Nova Scotia has been encouraging the health leadership council to establish a primary care action team dedicated to creating a shared vision for primary care in the province. It would be very powerful indeed if we could bring together the Department of Health and Wellness, Nova Scotia Health Authority, all of the educational schools - the medical school, the pharmacy school, all our nursing schools - and the associations that support these provincial groups to create a vision that we could work. This would allow people to receive care in person and virtually as appropriate to their needs, what they need at that time.

I want to commend the Nova Scotia Health Authority and the Department of Health and Wellness for creating innovative solutions to create access to care which is so necessary in this province right now. I'd like also to encourage all of us to collectively consider how we can develop a shared vision for primary care that attaches patients to a health home, where Nova Scotians can access the care they need that's unique to their community and that includes all primary care providers. Thank you.

THE CHAIR: Thank you. We're now going to start the first round of questioning with the Liberal caucus for 20 minutes, and then followed by the NDP caucus, and then the PC caucus for 20 minutes.

I've explained it to the folks who are here with us in person, but Dr. Hawker, I just want to let you know that even if you're in mid-sentence, I may end up cutting you off just simply because time has elapsed. Not trying to be rude, just trying to be fair.

We will start off the first round of questioning with the honourable Brendan Maguire.

HON. BRENDAN MAGUIRE: I want to thank everyone for being here today. It's good to see everybody wearing a mask. We've seen some back and forth in Question Period and also some differencing of opinion between Public Health and the Premier of Nova Scotia, so it's good to see doctors and health care professionals wearing masks. These are the people that we trust.

I want to just ask - and I don't know who this would go to, but maybe Dr. Murphy. You'd said that the list is 88,000 currently. How much has that list gone up over the last 30 days? I mean, you probably don't have that exact number on you, but maybe Mr. Beaton does. Do you have that, Mr. Beaton? Do you know how much that list has gone up over the last 30 days or gone down over the last 30 days?

CRAIG BEATON: It's roughly around 4,800 that the list has increased over the last 30 days, or it might be since the beginning of March. I'd have to check the numbers, the exact number, but the last numbers that I was able to refer to was about 4,800 that it's increased by, with about 2,400 coming off the list.

BRENDAN MAGUIRE: The reason why I started with that is because two doctors actually in my community have recently - one retired unexpectedly and one took another position. The caseload between them is estimated to be about 9,000-10,000 between them. That is just two doctors in one community that have retired.

When we hear that there are 88,000 people on that list, in your professional opinion - I mean, it has to be much higher. Let's be honest, because myself - I was impacted by that, and I just registered the other day because it took me five or six times to get through to 811. The wait time was forever, it actually hung up a couple of times. That 88,000 are just people who have registered.

In your professional opinion, it's got to be higher, right? Who wants to tackle that one?

CRAIG BEATON: The registry is there so that we actually have a snapshot of how many people are currently seeking care or want to be able to attach themselves to a primary health care provider. I wouldn't speculate on whether the number is much higher than that, but there's always going to be a portion of people who aren't seeking care so may not actually have themselves on the list.

I think the nature of the Need a Family Practice registry is that it does ebb and flow. We do know that since 2016, there have been over 200,000 people who have been placed with family physician through provision of the list, so we do know it goes up and down. There's always going to be a need.

Back to your point: when doctors retire, their panel rosters tend to be higher than what we currently see with new doctors and collaborative family practices, et cetera, so we do know that recruitment is going to be a key feature. You might have one doctor retire and we probably need to replace that with two or three.

The Office of Healthcare Professionals Recruitment has done quite a bit of work around trying to target where they need to recruit. I can say that this year alone, we've seen the highest number of recruitments in over at least the last five years in terms of the numbers that we have. I think there are over 153 compared to, I think it was 130 last year. They are actively trying to bridge some of those gaps that you'd spoken about in terms of numbers.

BRENDAN MAGUIRE: Along with the highest amount of recruits, we're also seeing the highest numbers on this list. I've seen estimates that people think it's 10 to 15 per cent of the population, if not more, that are without a family doctor. We know that a lot of people are just not, unfortunately, registering.

My next question would be for - I had a good question for Doctors Nova Scotia. One of the things that you spoke about was collaborative care. I know that was started under the NDP government and was continued under the Liberal government.

My question is to Dr. Johnson. I know we talked about virtual care, but let's be honest, a lot of things that happen cannot - when it comes to family doctors, virtual care is not going to give you physicals, it's not going to do certain things that you really need done at a family doctor, whether it's shots, things like that.

Collaborative care, and our nurse practitioners in particular, are a very important part with our doctors. How many new collaborative care centres will be opening this year? I don't know if that would be for you or if that would be for Mr. Beaton. I'm looking around going like, who wants to field this one?

GAIL TOMBLIN MURPHY: I'd be happy to speak to part of this question, but then I will defer to ADM Beaton around the number.

What you have outlined is the importance of understanding health needs of Nova Scotians and the team of providers who need to be involved in the care of Nova Scotians. That includes family physicians, it includes nurse practitioners and nurses, it includes social workers, pharmacists, chiropractors, as well as many other providers of care.

When we talk about a number of a registry, the number is only as good as those who actually report. If we use that only as a metric of success in this province, then I think that we would be overlooking some of the other factors. What I mean by that is Nova Scotians need to access care through collaborative practice teams, for instance, and even if we go to the family practices that, of course - I think that was what your question was getting at.

What we have found in some of the research, the evidence, is that if we bring some efficiencies like administrative efficiencies for instance, and if we have providers - you gave the example of family docs working with nurse practitioners and having nurse practitioners work to their full scope of practice - then we start to see some outcomes for Nova Scotians definitely being met.

In terms of the numbers of collaborative practice clinics, I would defer to my colleague, the ADM.

CRAIG BEATON: Thanks. You may be aware that we have 95 collaborative family practice teams right now in the province. We're still working on developing what the appropriate number is. We don't have a targeted number for this year to be able to provide to you right now.

BRENDAN MAGUIRE: I'll let Mr. Beaton know, as the associate deputy minister, that during Estimates, the Minister of Health and Wellness said that there will be zero new collaborative care centres opening this year. I'm a bit confused as to why.

This is a model that has been celebrated for the last 12 years in Nova Scotia. It's celebrated worldwide, and we have a panel of six people here who are singing the praise of collaborative care. Let's be honest, our doctors in Nova Scotia - I mean, they're a lot of things, but they're not social workers. They have their areas of specialty and expertise, and they're being asked to do everything. That's where collaborative care comes in.

I would like quick answers. I'm wondering why the sudden 180 degrees from "let's pump out collaborative care centres," seeing the results of our nurse practitioners and our registered nurses, to "let's not open any new ones." Again, those were the words of the Minister of Health and Wellness: there will be no new collaborative care centres opening this year.

THE CHAIR: I think we'll send that to ADM Beaton, but before I do that, I just want to let you know, Mr. Maguire, that your time is up at 9:38.

CRAIG BEATON: I think planning for primary health care continues. We're working closely with our health partners, including NSHA and their primary care network, in terms of building what the long-term plan will look like for primary care. Part of that is that there will be a launch of a strategy around health care that is going to be coming soon. Government's committed to doing that.

Part of that is also looking at what our integrated health services planning will look like across the province in individual zones. Some of that is right down to the local level. That will give us a good understanding of what the gaps in the system are and where we need services.

That work will continue throughout the year. We'll build off of that to help inform what our primary care models will look like going forward.

BRENDAN MAGUIRE: I appreciate the comments, but what I'm hearing today is: metrics of success, integrated, different strategies, and things like that. It's more planning and work behind the scenes, but it's less boots on the ground. It's less doctors and it's less - we're not trying to reinvent the wheel here.

That's what I don't understand about the comment. Collaborative care systems work. They work. We know that new doctors want collaborative care systems. They don't want to work 70 or 80 hours a week. They want a work/life balance.

This is a system that is on the brink of being overloaded. We have a lot of older doctors who are about to retire. We have a lot of older doctors who are feeling the stress.

When those doctors retire, it's going to take three, four, or five doctors to replace their caseloads. We've heard from Doctors Nova Scotia. We've heard from young doctors who are graduating. They come to our caucuses and we say, "What do you need? What do you want?" The first comment out of their mouths is: collaborative care is what we want.

[9:30 a.m.]

We have an abundance of knowledgeable, experienced nurse practitioners and registered nurses - nurse practitioners in particular - who are being underused, underutilized, in this province. Now we've got them going, and now they're part of our frontline health care. I just don't understand why we need more planning, why we need more consultation, why we need more thought into this when the system has already started to yield results. It's almost like a pause was put on a great idea to try to invent their own great idea. I'm saying that government paused the great idea only to say that they need to come up with their own idea that they can put our stamp on.

It just doesn't make sense to me that we need more consultation on this. Why do we need more consultation? We know where health is needed; the Central Zone, Cape Breton, and I could go down the list and tell you where people need family doctors. Why do we need to put a pause on this stuff only to do more work behind the scenes?

THE CHAIR: I think that's an Associate Deputy Minister Beaton question.

CRAIG BEATON: I think there is absolutely innovative work that's happening at the same time. I'll look at the nurse practitioner walk-in clinic and partnership that we have in New Glasgow that the Nova Scotia Health Authority, through Dr. Tomblin Murphy's team, had helped stand up. I think that's absolutely a new innovation that we're trying to look at.

The other thing that I will pick up on, which Dr. Tomblin Murphy had also raised, is that we are looking at how we can better support some of these collaborative teams to be able to create some efficiencies. If I look at the partnership that we're working at right now with Dalhousie with their existing resources and maybe adding some administrative efficiencies, we think that they're able to attach up to 3,500 more patients to that particular clinic. That really takes some of the administrative load off of the physicians and the nurse practitioners.

Looking across our 95 collaborative family practice teams, we'll be working with our partners and with the health authority to look at if there are opportunities there. I wouldn't say that that's all planning. That's also a part of how we may be able to build additional capacity and efficiency.

BRENDAN MAGUIRE: I don't mean to continue to throw questions at you, Mr. Beaton, but you're just in my direct line of view. I apologize. You mentioned the number

3,500 and that's maybe probably about half the roster of an older doctor who is going to retire. The numbers sound great, but it's really troublesome that we're getting to the point where these older doctors are going to retire. Replacing 3,500 is just a drop in the bucket. We know that.

I know everybody's working extremely hard. I know it's not an easy job. I know this is an issue that's nationwide and worldwide. That's what troubles me: we're competing not just against the Ontarios of the world, but the New Yorks and the Londons and the other places where people have a lot more resources than Nova Scotia.

The issue with virtual care is that we are hearing from graduating doctors, and it's their words - this isn't political, this isn't the Liberals or the NDP, or the Conservatives. This is young doctors saying: collaborative care or the highway. If we're not giving them the option of collaborative care, it doesn't matter how much recruitment we do, those young doctors are out the door.

They're going to places where they feel better supported. They're going to places where they don't have to put in those long hours, and they can have a normal life. They can have a work-life balance. It wasn't, to be frank with you, when I speak to young doctors and I have a lot in my community, they don't talk about pay. They don't talk about pension.

I've never heard one of them, and maybe Dr. Johnson can correct me on this one, but I've never heard a doctor say to me that if you give me a pension, I'm staying in Nova Scotia. What the young doctors have said to me is: If you give me a nurse practitioner, a mental health expert, if you give me a social worker, if you give me a space, and you give me regular working hours, then I'll stay in Nova Scotia.

What do you say to those young doctors who are hearing directly from the Minister of Health and Wellness in Estimates that there are none opening up, and that we're going to continue to do research and look. In the interim, we're going to have young doctors graduating, so what do you say to them? They're saying: I'll stay if you give me collaborative care.

CRAIG BEATON: I think I would go back to what I had said earlier in terms of the provinces, for the first - at least, I'd say, in the last 10 years developing a provincial strategy around health care which I think is really exciting. I know in talking to some of our stakeholders that they're excited about the opportunity to have a defined plan about what it is that we need to go forward in the future. Absolutely, more recruitment and retention is going to be key and central to that.

We do know that Dr. Orrell and his team have been working really hard to try and create space for new recruits, not only just doctors, but all allied health professionals because we know HHR, as you've alluded to, is a significant issue across the province, but also in the country, as well. We're competing for resources on a global scale.

What I would say is, there are going to be doctors retiring who are a part of collaborative family practice teams. We're going to be looking at efficiencies, and as we get through our clinical services planning and see where the gaps are going out into the future, I think there are opportunities for doctors here in Nova Scotia.

BRENDAN MAGUIRE: So what I would say - no offence to Mr. Beaton - but I bet you if I was an MPP or an MLA in a different province and I was sitting in their Public Accounts Committee, their associate deputy ministers and their deputy ministers would be saying the same thing.

We see and hear from different provinces when it comes to health care, what they're saying is, we're mapping out a strategy. We're making it more attractive to come here to P.E.I., to Vancouver, to British Columbia, to Manitoba, or whatever. What we're hearing today is really what every province is saying, and every state is saying, and every jurisdiction in the world is saying. We're mapping out, we're trying to figure out where our pressures are and where our resources are, and what we can do to attract more doctors.

Again, I will say that there is a very low-hanging fruit: young doctors are saying we will stay in Nova Scotia if we have collaborative care, if we have our own collaborative care system with registered nurses, with all the resources we need. What I'm hearing today and what we heard in Estimates is, it's just not going to happen in the near future. There's nothing opening this year.

If my son or daughter were graduating from medical school today - actually, I have a good friend who's graduating from med school. There's a good chance he and his partner who's also a doctor are going to leave Nova Scotia because they want collaborative care and they're just not going to be able to achieve it. I think that it's great to have a long-term plan, but it doesn't seem . . .

THE CHAIR: Order. The time for Liberal questioning has elapsed. We will now move on to the NDP, and you have until 9:58 a.m. Ms. Leblanc.

SUSAN LEBLANC: Thank you very much to all of you for being here. The last time I spoke with Mr. Beaton was discussing operating grants for arts organizations, so it's been a long time. Nice to see you. (Interruption) Oh, that's true, but I mean in person. I mean, like, you know, before I did this job.

I just wanted to say especially thank you to Dr. Johnson and Dr. Hawker for your work on the ground caring for people, and Dr. Tomblin Murphy.

I wanted to say, when you were speaking, Dr. Johnson - you were really, truly speaking my language around collaborative care. This is something that I am extremely excited about and something that I've been working on in my own community of Dartmouth North, which is exactly what you're talking about, a community with very

specific needs. Collaborative care in Dartmouth North in my view and in the view of many residents there is exactly what has to happen. We're working hard, and love to have an offline conversation with you about it some time.

I have a couple of quick, clarifying questions from all of your opening remarks. The first one is, I heard two different things. I heard Dr. Tomblin Murphy talk about how virtual care is here and it's here to stay, which I understand and that makes sense to me in many ways, but then I heard Dr. Johnson say it's an interim measure. Dr. Johnson said: our support for VirtualCareNS as an interim measure by Nova Scotia Health Authority and the Department of Health and Wellness to connect patients with a family doctor to primary care.

I just need someone to explain to me what the vision is for primary care. I think I'd like to ask this of Dr. Johnson first, because I understand that you are a family physician who also sees your patients virtually. I guess my question is: Do you see people in person and virtually, and is that something that you see continuing? In terms of the VirtualCareNS project for people who don't have attachment to a primary care provider, what does that look like?

HEATHER JOHNSON: They are very different things. VirtualCareNS is a program that was developed to help look after people who have currently no access. Everybody needs access, and they need access in a timely way to somebody who can meet their health care needs. VirtualCareNS is a great program. That's separate from virtual care as everything we do virtually, which ADM Beaton mentioned in his introductory remarks. Virtual care is booking your lab appointments online, booking all of the things that we do online.

I do virtual care, sometimes because you're calling me - it's been great for my university students who are in Halifax and who need to talk to their family doctor. It saves them from going to a walk-in clinic. We can connect virtually to talk about their issues. Psychiatrists have embraced it as a great way to stay in touch with their clients and follow them.

Virtual care continues to be another tool in our belt, but it is, as its entity, separate from VirtualCareNS.

SUSAN LEBLANC: Thank you. I will move on then to VirtualCareNS, which is the program for unattached people, as it were. In your opening remarks, Dr. Tomblin Murphy, you said that people like it and they use it for different reasons. My understanding is, this is their only access to primary care, except for if they went to a walk-in clinic, I suppose, or the emergency department.

You also talked about the top reasons why patients would make an online appointment. I get that, okay, my throat is sore. They wouldn't be able to get a swab, for

instance, if they thought they had strep or whatever. In that case, what happens? That's one question. I understand that there is someone that they can go see in real life, but I'd like to know the specifics of that.

Aside from these reasons, why else would someone want a primary care appointment? My colleague talked about general physical. What if you have a lump in your neck? What happens in those cases? Is the program seeing a little higher acuity reasons for people approaching or using the system?

GAIL TOMBLIN MURPHY: Thank you for that really important question. VirtualCareNS is an innovative solution which is, if somebody who is on the registry, they will have received an email for them to register, so that when they need access to primary care, they can access that.

They can access VirtualCareNS. They sign on and they have a wait time of about 31 minutes - that's the average wait time at this point - where they then would come in contact with a nurse practitioner or a family doctor after they have entered some of their health information, why they're there - they have a skin rash, they have an earache, whatever it is that they have.

They then can either have a virtual call where they see their provider, or if they're not comfortable in doing that, they can actually go on the phone and talk with that person. Of the people who have participated in VirtualCareNS to date, in fact around 22 per cent of them actually need to be seen in person for the reasons that you've said in that first assessment. For instance, there may be a lump, there may be something that in that provider interaction with that patient, that they believe they need to be seen by a specialist, for instance.

If they're on that platform and they require, for instance, in order to get a prescription renewal, that the provider will actually do that prescription renewal, send it to their family community pharmacy so they can get their prescription.

If it's seeing somebody in person, the assessment would be such that you need to see somebody in your community, in your primary care clinic. In Nova Scotia, we have 14 primary care clinics where it would be arranged for that person to see a provider at the primary care clinic.

SUSAN LEBLANC: When you say "14 primary care clinics" - I understand that before virtual care was really a big thing, some people who were on the registry would get attached to this clinic that was in Kearney Lake. It was like a Nova Scotia Health Authority clinic, and if someone needed to be seen - when I was advocating for people, for instance, sometimes they would get attached there. Quick answer, is that the kind of clinic you're talking about?

[9:45 a.m.]

GAIL TOMBLIN MURPHY: That exactly is the type of clinic I'm talking about.

SUSAN LEBLANC: Thank you very much. I also wanted to ask Dr. Johnson, in your opening remarks, you said, "To that end, Doctors Nova Scotia has been encouraging the Health Leadership Council to establish a Primary Care Action Team . . ." What is the Health Leadership Council? Who are they?

HEATHER JOHNSON: The Health Leadership Council is currently made up of the CEO of Nova Scotia Health Authority; the Deputy Minister of Health and Wellness; Kevin Orrell, from the Office of Healthcare Professionals Recruitment; and Janet Davidson, the board administrator.

SUSAN LEBLANC: Thank you for clarifying that. I find it unfortunate that those four people are now the decisionmakers of the province when there was a board of the Nova Scotia Health Authority that had much more diversity and much more representation on it. I'm glad for the clarification that that is now where decisions are being made.

I wanted to ask a quick question about doctors in Nova Scotia who are providing virtual care. My understanding is that with VirtualCareNS, the doctors, or the nurse practitioners, are from Nova Scotia, that they are people who live here and work here. Are they folks who are taking on extra hours in their regular practice, or are they folks who are generally not working a full-time equivalency - like they want flexibility in their work? Is there a breakdown of who's doing what, and how much?

GAIL TOMBLIN MURPHY: Overall, in terms of providers, we have 35 family doctors who are involved in this, and seven nurse practitioners. We are training others. The model here is not to take capacity away from collaborative practice or primary care units or care. Who we see providing care would be physicians who have recently retired and would like to stay involved in the system. They may be the new graduate from a medical school who doesn't have a full practice at this point but would like to engage. We would see those people as well.

We make sure that with nurse practitioners, it's adding nurse practitioners who are salaried by us, to make sure that we're not drawing nurse practitioners from other areas. At this point, indeed, you're correct. They are in Nova Scotia. They're local providers. What is important in this model is that there is the capacity to see people in person and not to take from where care is required.

SUSAN LEBLANC: Thanks, that was very helpful. From a Nova Scotia Health Authority website, in order to participate in virtual care, a person must be able to access the internet through a computer or mobile device and have a current email address on file with the registry.

Again, going back to people in Dartmouth North, there are many people who just don't use the internet, and don't have email addresses. I'm wondering, how are people invited who don't have email addresses? I guess, to Mr. Beaton.

CRAIG BEATON: I think I'll pass it to Doris. She probably can give a more succinct answer.

THE CHAIR: Ms. Grant.

DORIS GRANT: When we started VirtualCareNS, you're right. One of the requirements was that they had to have an active email address that they could use to register. However, when we started our phased rollout of the program, we did note that there were a number of people who didn't have those email addresses, so an email outreach to them wasn't going to work. What we did was a customized letter that those patients received in the mail with all of the information they needed in order to register and how to create that email address.

Now one of the things that we're working on with some of our partners, and I think it was ADM Beaton who mentioned it before, is we're trying to figure out how we provide sort of that community access related to infrastructure because not everyone has access to the internet.

In New Glasgow, we are working with the libraries to be able to provide the resources and the infrastructure that patients need in order to access their virtual care appointments. VCNS is one of the programs that they provide service to. That program just launched but right now it's incredibly positive. Even the library staff are really enjoying being able to help patients in their community.

We're evaluating that program and then trying to figure out where else we can deploy it so that again we can have that access across this province. That's just a really innovative program that was taken up by the Aberdeen Health Foundation and the libraries in that community to really help their community.

SUSAN LEBLANC: Hot tip: Dartmouth North. Again, the exact same kind of issues - not exact same, but the same issue with connectivity and our library is awesome.

I want to ask a question about how many people on the registry in general, the 96-whatever, I'm not great at adding quickly - the 88,000 plus the 4,000, all of those folks. What is the timeline for everyone on the list to be invited? Could the department provide a breakdown by zone of people who have been invited?

DORIS GRANT: In both the Northern and the Western Zone, all patients who are on the Need a Family Practice registry have been invited. We started outreach in those communities last year and right now, again, 100 per cent outreach to those communities.

In both the Eastern and the Central Zone we didn't start rolling that out until December. Right now we'll be finished of the invitations and everything going out, by June.

SUSAN LEBLANC: Thank you. In Dr. Tomblin Murphy's opening remarks, you said that as of this month more than 66,000 people on the registry now have access and over 12,000 virtual appointments have taken place. I'm just wondering about that ratio. I have no idea about how many people actually have in-person access to primary care and what the ratio of making appointments is. Is there any kind of analysis of that? Is that a good uptake? Is that normal? Is it the same or comparable to in-person visits?

GAIL TOMBLIN MURPHY: On average across this country, as well as elsewhere, people see primary care - physician, nurse practitioner - 1.6 visits annually. Many of those people who are registered and have access, when we asked them why they haven't used the service yet, the answer to that is, because I don't need anybody yet but I'm really pleased to have that opportunity, I'm registered and I know that I can access a provider when I need them.

SUSAN LEBLANC: I want to talk about the company Maple. A big question, hopefully we'll have time to hear the answer: Why wasn't the contract from Maple tendered? I'll ask that to the associate deputy minister.

CRAIG BEATON: I think I'll defer that to Dr. Tomblin Murphy or Doris because they actually procured the solution.

DORIS GRANT: When we began this program we had very aggressive timelines, I would say, to be able to deploy a solution for these patients. We knew these patients needed care, we needed to be able to move forward very quickly. For us we began a very intense internal diligence process related to the evaluation of over 50 commercial solutions that were on the market. We worked with our internal stakeholders, including our patients and families, to be able to narrow down the list and the requirements that a commercial solution would provide.

In the timeframe that we needed this commercial solution, there wasn't an opportunity to go to tender or an RFP. Internally, we went with the alternative procurement process. Again, we felt very confident in our internal diligence process to make sure that we have the right solution for Nova Scotians. We feel very confident in that process.

SUSAN LEBLANC: I'll just quickly follow up with that, then. You mentioned that you consulted with families and patients. How did you consult them? Who were they? Were they just people that you knew who were on the list? How did that work?

DORIS GRANT: Nova Scotia Health Authority has a roster of patient-family advisors through various programs. Through our partnership with the primary health care

teams, we found patients and their families who felt very strongly about virtual care and were very interested in working with us to help select the right solution for their communities. It was, again, through a normal process within the Nova Scotia Health Authority.

SUSAN LEBLANC: What's the total cost of the Maple contract for this year, and is the cost planning to grow next year?

DORIS GRANT: In terms of the Maple solution, we started with just the regular sort of licensing and implementation costs. We've continued to add improvements to the platform, including having the ability of our providers to add DI and lab requisitions. They're now able to refer to specialists within the app as part of this program.

Right now, our current burn, if you will, or expenditures related to Maple is approximately $500,000 for the year. Also included in that is the program VirtualEmergencyNS as part of that, but it all falls under the Maple . . .

THE CHAIR: Order. Order. The time for the NDP questioning has elapsed. We'll now move on to the PC caucus. Mr. Young.

NOLAN YOUNG: Thank you to the witnesses for being here today. Before I pass it onto my colleagues, I'll ask a couple of questions around the access to care, perhaps to Associate Deputy Minister Beaton.

When a patient is in need of primary care but is without a primary care provider, their options have previously been limited to making an appointment at their primary care clinic or visiting their local emergency department. How has the introduction of VirtualCareNS improved access and care for those without a primary care provider?

CRAIG BEATON: I think the key feature is that it provides those who don't have a primary care provider a quick and easy way to actually access an appointment. As Dr. Tomblin Murphy has outlined, the average wait time for those after they sign up is around 31 minutes. That's typically like a same-day appointment.

Now that we have more than 66,000 people able to access that, and with the roll-out of everybody before the end of June - all 80,000 currently on the list - I think that that creates definite access. It also alleviates those who previously would not have had the virtual care option of entering into emergency departments, as an example, for lower acuity needs.

NOLAN YOUNG: I think that 31 minutes is a good turnaround time, for sure. To Associate Deputy Minister Beaton again: in the latest budget, our government had invested $14.5 million to make virtual care available to everyone on the Need a Family Practice

registry. How will this investment be put to work to achieve the goal of making primary care accessible to those on the waiting list?

[10:00 a.m.]

THE CHAIR: Associate Deputy Minister Beaton.

CRAIG BEATON: Thanks for the question. Correct, $14.25 million has been invested in this year's provincial budget to go towards expanding access around virtual care. The majority of that is around completion of opening up the roster to all Nova Scotians, but there is a significant portion - I think about $6.25 million - that is also looking at how we expand out into specialty services for access, like physiotherapy, occupational therapy, nurse practitioner, et cetera.

There are also a couple of options that we're looking at, approximately about $1 million each. One would be creating a new chronic illness treatment prevention program focusing on the INSPIRED model that we have for COPD, as well as expanding that program into areas like Yarmouth, Kentville, New Glasgow, Sydney, Inverness, and Antigonish.

NOLAN YOUNG: Perhaps I'll pass it on to my colleague, Mr. Boudreau.

TREVOR BOUDREAU: Richmond being a rural riding, we certainly have our share of challenges with health care. Virtual care is certainly something that has intrigued me for quite some time as a health care provider as well.

When you hear the term "virtual", you think of internet. That's what goes to my mind. I don't believe that's the only way Nova Scotians have access to it, but for those who don't have reliable internet access, what are other ways that they can access virtual care here in Nova Scotia? I'll put it out to Associate Deputy Minister or to Ms. Grant, or …

CRAIG BEATON: I can certainly start. I think, as Dr. Johnson alluded to, virtual care is provided in primary care settings for those who are attached. Through the evaluations that we've done, the primary modality that's being used to do that is actually via the telephone. That also creates, as indicated, opportunities for them to see more patients potentially, but also less travel time for those individuals.

In the evaluation work that we've done so far - and this work continues - it's roughly around 68 per cent of family practice physicians who actually have attached patients that have used virtual care in some form over the last year, which equates to approximately about 485,000 interactions. It is quite extensively used. In terms of those who are unattached, I think Doris had previously spoken to that, but I can turn it over to Doris as well if she would like to expand on the answer.

DORIS GRANT: Again, access is one of the things that we're looking at very closely in the VirtualCareNS program, because, and we've talked about this, not everyone has access to the internet. Through the library program, we're looking at that as a model for deployment in other communities. It's established in New Glasgow, but we are looking at trying to establish a very similar type of operation in the Eastern Zone and the Western Zone in parts of the province that need these types of programs. Again, it's early - we need to figure out exactly what the model is, how we can best serve these communities.

We're evaluating and going to be making some recommendations soon, but we do recognize the need for that in our communities.

TREVOR BOUDREAU: Following up on the virtual care side of it - and I think Dr. Johnson had talked about this a little bit as well. Once a patient or a client gains access to a primary care provider - so no longer on the wait-list - is there a possibility they can continue to still receive virtual care? We talked about it being maybe interim, but for those people in rural areas, it has been useful. Is there a way for this to continue? Is this something that is going to be considered in the future?

DORIS GRANT: In terms of VirtualCareNS - and I'll only speak to that - there is an off-boarding process once patients get attached, and how the provider operates their practice is up to them. Virtual care may be part of that, but we also know that it can take a while to get a first appointment with that provider. We make sure that there's a runway, if you will, where patients can still access VCNS while they're waiting for that first appointment. We work very closely with our partners to make sure that they still have care.

CRAIG BEATON: I think I can add to that, in terms of those who are actually attached. I think the quick answer is yes. Really it would be up to both the provider and the patient to determine whether or not a virtual option would be something that would be useful for them.

Some of the work that we've been uncovering in terms of our evaluation so far is when left up to the patient and the provider to determine whether the virtual care option is accurate or appropriate for them for their appropriate level of care, the percentage in terms of the feedback is in the high 90s; both from the provider and from the patient, in terms of whether or not it was an appropriate use. I think that speaks to allowing the patient and the provider to determine whether or not a virtual care option is something that they'd be able to move forward with.

HEATHER JOHNSON: In the attached world, there're already lots of things that are going on. Lots of primary care visits are done virtually and often on the phone. You are correct: not a huge internet uptake in some parts of our province.

There's also a proof of concept pilot going on right now for eConsult. I, as a primary care provider, can send a consult to a specialist and then they can answer me back. It

doesn't require them to see the patient, but they can address my questions. Those are some of the efficiencies that we've talked about within the system that actually can improve the number of people you can see. If you can improve the number of people you can see, you can increase attachment.

There's asynchronous care, where you can send me a private message and I can send you one. That's not something that we've gone down the path of investigating, but it's probably something that's very valuable for patients to be able to communicate with us in a way that lets them ask the question and saves them from having to come into the office to see me. So there are lots of ways.

This is just the first kick at virtual care. We have lots of ways to improve efficiency and we're going to see that over the next years, but that's part of that vision for primary care that we need. If we don't have a vision for how we're going to deliver it, then we are going to be doing all these little things and never really integrating that into how we're going to care for the people of Nova Scotia.

TREVOR BOUDREAU: Thank you, and those are great answers. I think everybody kind of reached a little bit of a different perspective on it, but it also shows that as you are going through this model it allows you to find those efficiencies, find those places where it might be useful and figure out where it also isn't useful and then follow it down that way.

Those were my questions with respect to rural access. I will pass my time over to my colleague MLA MacDonald.

THE CHAIR: Mr. MacDonald

JOHN A. MACDONALD: Thanks for being here for Hants East, just to realize it's more rural than urban but it borders on the HRM. It's there, so don't forget about it.

Just to pick up on Mr. Beaton, can you elaborate on some of the feedback you've been hearing from patients about service care they receive through VirtualCareNS?

CRAIG BEATON: I think in terms of the specific feedback, I know that my health colleagues at the Nova Scotia Health Authority have quite a few and they've been posting those to Twitter. It has been very public, so I'd let Dr. Tomblin Murphy elaborate.

GAIL TOMBLIN MURPHY: Thank you so much for that very important question. In terms of the patient testimonials, we're hearing some very positive things - like that VirtualCareNS is very user-friendly.

Now, knowing that it's an ongoing evaluation, at times we have learned from our patients and families about ways that we could enhance the user friendliness. That includes,

for instance, helping with education sessions and training and figuring out how to use it on your tablet and that kind of thing.

They've also really enjoyed the opportunity to have their prescriptions refilled. People living with chronic diseases, for instance, who have prescriptions coming up that they need filled. In fact, to date, many patients who have been seen have had their prescriptions filled in their community pharmacy.

In addition to that, many of these patients who are seen through VirtualCareNS and are deemed to need to be seen in person, so again in a primary care clinic in a community, they are also linked through VirtualCareNS to a specialist. If, indeed, there is something of concern and the physician or nurse practitioner knows that this patient needs to be seen by a specialist, that those specialist referrals are actually made.

What we are hearing overall - and another thing I would share - is that it really saves time from travelling, waiting, having control of when I'm going to be seen. Those would be some of the stories that we've told - how they can have things done efficiently and the savings in terms of their time. Those would be many of the positive things that we're hearing.

JOHN A. MACDONALD: I only have one more question, then I'll defer to my colleague. The question is for Dr. Tomblin Murphy, I'm pretty sure. In your opening remarks you mentioned that virtual care is one of the most successful platforms in Canada. I would just like for you to tell us why and share your thoughts on what led to the success.

GAIL TOMBLIN MURPHY: Thank you so much for that question. What we're really proud of in Nova Scotia is that we have, through partners, an innovation hub and the health leadership team has asked us to think about innovative solutions. That's what we're doing.

As we start any proof of concept, which is literally ideas that are tested, and tried to determine the impact that they can have on patient care and on systems as well as health outcomes for people, we arrive at a good idea, we test them, we try it.

This proof of concept always begins with the evidence. Where are those North Stars? Where have people had successes? We look across this country and we look globally. For instance, a lot of people have used virtual care and we know that COVID-19 helped us to reach out in ways that might not have been so creative.

The reason that we are seen to be successful in this end of the country is because there are about six jurisdictions that are using a platform like ours. Two of them, us being one - what would be said about our platform is that it's patient friendly as Ms. Grant has indicated. It has helped that it is to be co-designed in terms of the process and how this happens with patients and families and many stakeholders which is incredibly important.

What we also hear is that nowhere before had they done it this quickly. Contrary to spending a lot of time on the planning pieces, the evidence, and the solution that we chose helped us to move quickly in terms of its implementation. Moving quickly in implementation means that we had, and continue to have, very strong evaluation frameworks: What does success look like?

Then we measure those processes and outcome indicators and on an ongoing weekly or daily basis, we can tell you what that data is actually telling us. The time, the efficiencies, the use, and what we're hearing in terms of the outcomes to our evaluation are being watched by many in this country and elsewhere, so we're pretty proud of that.

DAVE RITCEY: This question is directed to Associate Deputy Minister Beaton. It's pretty exciting for my area in Truro. You mentioned earlier in your opening remarks that VirtualCareNS has led to a new pilot in the emergency department at the Truro Hospital. Can you tell us a little bit more about that?

CRAIG BEATON: Thanks very much. That is an initiative that's under way through an extension of VirtualCareNS, which is being led by the Nova Scotia Health Authority. I think Dr. Tomblin Murphy is probably best to give you a bit more detail on how that's rolling out.

GAIL TOMBLIN MURPHY: Thank you so much for this opportunity and thank you for the question.

We're really pleased. As Ms. Grant had talked about earlier, learning a platform like this has helped us to enhance its use. We know across this province every day that there are for instance, people with lower acuity - CTAS IV and CTAS V, for instance, maybe CTAS III - who are sitting in emergencies waiting to be seen.

Because of some innovative ideas that came from your colleagues in your constituency, for sure, we are testing an emergency solution for Colchester East Hants Health Clinic - we call it VirtualEmergencyNS. We have about 19 providers who are engaged in this, so patients and their families who come into emergency and are assessed are triaged into an opportunity for them to participate in VirtualEmergencyNS.

They would be taken into a different room - and a comprehensive assessment being done by a registered nurse - to MLA Maguire's point, nurse practitioner, licensed practical nurse, many providers who can do that assessment.

If the patient chooses - and again this is all about choice - then they are actually seen through this virtual emergency program. If it's deemed that they need to be seen in person, then arrangements will be made.

[10:15 a.m.]

We are seeing how an innovative idea that came from a physician who just was trying her very best to provide access for her patients has spiralled into a really good idea that we're evaluating. Early comments around the evaluation is that people really like it.

THE CHAIR: Mr. Ritcey, you have two minutes.

DAVE RITCEY: Thank you, Madam Chair. That's great news. I've heard some good things about it in my community. That specific physician as well has spoken quite highly around it. Thank you for that answer.

My next question goes back again to Associate Deputy Minister Beaton - what lessons have we learned so far from the implementation of virtual care that have benefited Nova Scotians?

CRAIG BEATON: I think some of it has been alluded to already in terms of that there are definitely pros, and there's a lot of uptake in terms of the access to virtual care. To what Dr. Johnson referred to earlier around asynchronous care and synchronous care, we obviously need to think about how we use this in future uses - whether they're secure messaging, text based, et cetera.

There are different modalities that we will be looking at in terms of how we provide broader care to Nova Scotians. I think the overall benefit so far is that Nova Scotians do like it. It is definitely another access point. But we also know that it's not the only way to receive care, and it will not replace in person.

THE CHAIR: Mr. Ritcey, you have 30 seconds.

DAVE RITCEY: In my past employment experience around pilots and innovation, I can tell you this is exciting. Virtual care is exciting. Again, I just want to thank you for answering my questions today.

THE CHAIR: We'll now move on to our second round of questioning. Each caucus will have eight minutes, beginning with the Liberal caucus - Brendan Maguire.

BRENDAN MAGUIRE: We're hearing a lot of numbers around patient attachment to virtual care, access to our front line, but the truth is the list is going up. It's the highest it's ever been. Wait times for procedures are going up.

We just saw an article where, once again, because of the mishandling of this current wave of COVID by the government - not by health care, but by the government - elective procedures and surgeries have now been postponed in our hospitals. We're hearing from

frontline health care workers that they're unable to take vacation, that they're stretched to the limit, and that they're exhausted.

The government wants to paint a rosy picture of health care and say that this is a health care budget - which, I will also add, only saw a 4-per-cent increase in health care spending. Let's be honest, for everybody around here, a 4-per-cent health care budget increase is a drop in the bucket. It was supposed to be an historic health care investment.

All the metrics are trending in the wrong direction. That's the problem that we have here. Yes, we're seeing more people attached to virtual care. It was the Premier himself, when he was in Opposition, who railed against virtual care, who said it wasn't a solution, that it will never replace primary access and health care access, and that it was a band-aid solution for a government that had no solution - I think those were his words at the time. It's ironic to me that the government is touting this virtual care as a solution when they spent months and years railing against it.

I am concerned that because of the handling of the current wave of COVID-19, we're going to - and we've heard this from health care professionals - that there's going to be a tsunami, was the word that was said to me of people that are missing out on colonoscopies, they're missing out on procedures that are going to be potentially life threatening. I use colonoscopies as an example - we're hearing it's years now to get access to a colonoscopy.

I know my questions are long, but I only have eight minutes, so I need short answers (Interruption) I know. I guess my question is: What is the impact of a doctor shortage, no collaborative care systems opening up, and procedures being postponed? What is going to be the impact on this health care system, but more importantly, what is going to be the impact on Nova Scotians that should be getting those procedures right now and are waiting longer, and in some cases are being postponed? Who wants to take that one on?

CRAIG BEATON: I appreciate the question. You've alluded to the last two years working in health care, and I think all my colleagues can attest. Certainly, even much more from the administrative side, we know the stress and the strain on the practitioners on the front lines. That's evident.

I think that virtual care has provided some relief to some of that, particularly for those that are unattached like we have been able to see - previous to 2019, only about 1 per cent of all encounters were really being seen virtually. Now we're up to 35 per cent. We haven't really seen any impact on the appropriateness level of care, which is what I think I've talked about earlier. Patients are saying that actually it's appropriate to get the care that they're getting through virtual.

There's no doubt that there's stress and strain on the system. I think you've alluded to it, as well, that stress and strain from the pandemic is not just a provincial phenomenon,

it's national. We're obviously concerned about the human resources and the impact it takes on our frontline practitioners, so people are working hard every day to try and figure out solutions, and I think virtual care is one of those. Like Dr. Tomblin Murphy alluded to earlier, the speed at which they were able to pull this together was unprecedented to really meet the need at a time when the needs were urgent.

BRENDAN MAGUIRE: And no doubt, all of you and the people around you, and the people in the health care system, have done an incredible job. But the truth of the matter is that you can't get a life-saving diagnosis from virtual care, and those things are being postponed and that is going to be a massive issue. We are now seeing a prolonged period of access to those procedures and surgeries being pushed off because of the handling. We literally went from first in the country to worst on the continent when it came to COVID-19, and that's an issue.

I know that people are tired of talking about it. I know people don't want to talk about it, but the truth is that those stresses and things that you talk about are no longer stresses. They're cracks and they're holes, and that's what we're seeing now. It's the pressure that's on this system. It's no longer coming, it's here. I know health care practitioners who are saying I've had enough, I can't do this anymore, I want out.

That is saying something. They're fed up with being told that COVID-19 doesn't exist anymore and that it doesn't have an impact on our health care system, and that it's not impacting things, and that virtual care and things like that are going to replace some of the stuff when it's really not.

I'm going to pivot for one minute.

THE CHAIR: Good, because that's all you have. (Laughter)

BRENDAN MAGUIRE: One Person One Record. What is the total cost right now for One Person One Record? How much has it increased? What's the timeline for One Person One Record to come online?

JILL CASEY: Really, all we can say about One Person One Record now is that we are in an act of procurement. Once we are finished that procurement phase, then we'll have a better idea of that cost to the system for implementation and the total cost of ownership over that time, but right now we can't comment on that.

BRENDAN MAGUIRE: We do know that millions and millions of dollars - approximately $7.4 million - has already been spent on One Person One Record, so the question is: When will this come online? When is the timeframe?

JILL CASEY: We should have a better idea by the end of June in terms of what implementation could look like.

THE CHAIR: Mr. Maguire, you have 20 seconds.

BRENDAN MAGUIRE: I know it's been a stressful two years. It's probably going to be a few more stressful - I'd guess four years. Listen, you've all done an incredible job, your staff have done incredible jobs, and to the doctors and nurses and everyone, from the technicians and the cleaners on up, we thank you from the bottom of our hearts.

THE CHAIR: Order. We are now moved on to the NDP caucus. Ms. Chender.

CLAUDIA CHENDER: Thank you. Eight minutes?

THE CHAIR: That's correct.

CLAUDIA CHENDER: Thanks a lot for being here. I have eight minutes, so I'm going to jump right in.

I want to go back to your opening comments, Dr. Johnson. I think we've been sliding back and forth between VirtualCareNS and asynchronous care in this conversation, so I want to go back to the clarification, which is VirtualCareNS is for unattached patients. I concur with Ms. Johnson, who is the only one in her presentation who has referred to this as an interim program. We certainly hope that VirtualCareNS is an interim program and that everyone will be attached to primary care. That asynchronous care sounds like it should continue in some form, but I'm hopeful that everyone agrees.

To that end, I want to come back, Dr. Johnson, to your opening comments. We know that in the last seven or eight months, we have seen the entire board of the Nova Scotia Health Authority fired. We have seen the leadership of the Nova Scotia Health Authority fired. We now have an interim CEO who might be there forever, and a leadership council of four people that is not transparent, not accessible, so it's very difficult as Opposition politicians or human beings or Nova Scotians to understand actually what's going on.

Against that backdrop, my real question is your question, which is: What is the long-term vision? If the interim plan is VirtualCareNS, which sounds like it's successful, what is the long-term vision that you say you've been lobbying the leadership council for - such as it is now - around primary care in this province? Do we have that plan? I guess your answer is, we need it. Can anyone else tell us what the plan is longer term, to actually get people attached, and what that looks like and how it's been developed?

CRAIG BEATON: Similar to, I think, what I had mentioned to one of the members earlier, part of this is around the larger plan for health care, which we know will be unveiled shortly, but at the present time right now, we have the local level that are currently working through the NSHA on integrated health services planning, which is really important. That's going to tell us about the standards that patients need within a certain area, the current

resources we have to be able to provide that. From that, we will continue to build out what a plan will look like for primary health care.

[10:30 a.m.]

At the same time, there is a lot of work happening right now in the space of primary care. Virtual care is obviously one of those components, in terms of how do we create additional access. I can't tell you right now what the actual plan is, but I can tell you that there is a lot of work under way to look at all of the components that go into that, including things like HHR planning.

CLAUDIA CHENDER: Well, I hope that's true. I hope we'll see a plan, and I hope that plan isn't going to be sort of a piecemeal gap closing, and I'm not casting aspersions on anyone in the room. I'm just saying, from where we sit, I'm inspired by the work Doctors Nova Scotia is doing and what we heard this morning and what we've heard in the past - which is to say, we actually need a whole new way of looking at primary care. Let's put all our cards on the table and talk about what that is. We have not seen that. We hope to see that, but frankly, I just think it's important to have that context.

The stopgap is kind of working. The idea that people like it, that's good, but what's the alternative? No doctor, no primary care. Of course, people like it. They want to be able to get a doctor. They want to be able to talk to someone who can help them with their health care.

It's good that it's functioning. It's necessary but not in any way sufficient. The tens of thousands of residents across HRM and across the province who don't have a physician - we are really eager to hear that plan. I hope that's coming.

Just to transition, there was mention earlier of connecting to specialists via VirtualCareNS. I'm wondering, is there a plan that that would expand? If so, would that project be tendered? Will it just continue through Maple? Maybe Dr. Tomblin Murphy could comment on that.

GAIL TOMBLIN MURPHY: I'll get started and around the tendering I will pass it to Ms. Grant to speak about. If I set it in perspective, VirtualCareNS is one innovative solution to enhance access to primary care for Nova Scotians.

I also believe strongly that a strategy comes from engagement of many stakeholders: number one, people in communities, many of whom you are here representing. In addition to that, our frontline providers who have a lot to say, as well as many other stakeholder groups. I would agree that a strategy means that we have many stakeholders engaged in that.

If I speak just to VirtualCareNS. Over the last 12,000 online visits that have taken place, numbers that might make sense in terms of the specialists, there have been 1,000 specialist referrals done within that piece. That helps people to get the access that they need without waiting for a diagnostic imaging, without waiting for some kind of a diagnosis - it can help with that as well, in terms of getting lab services, diagnostic imaging and that referral to a specialist. That has been very helpful.

In terms of the tender and the actual Maple extension, I will pass that to Doris.

DORIS GRANT: The specialist referral is a feature of the Maple program. It isn't sort of an extra solution; it isn't anything extra. It's already incorporated into that so we're not anticipating - like right now it wouldn't make sense to do an RFP related to that. In terms of the program, the asynchronous solutions that are part of other practices - maybe you want to comment on that.

HEATHER JOHNSON: Asynchronous care is actually not something - it's something that we feel is valuable and we continue to advocate for it. It's a program and a concept that we're having discussions with the Department of Health and Wellness, about how we're going to implement that, what the best - now some people are paying extra for things within their EMR that allow them to do that already.

Nova Scotia did have a program in the past that allowed for that, where patients got their lab results sent to them and there were about probably 500 physicians signed up for that at the time. But that program went away, and it has not been replaced by anything so that's something we're working on now. It will be another virtual care piece that you will hear about coming.

CLAUDIA CHENDER: I had that for a while, I found it very confusing and distressing because I could not read them or understand what they said. At any rate, I would like to thank you all for your answers.

THE CHAIR: Order. The time for the NDP caucus has elapsed.

We'll now move on to the PC caucus with Mr. Ritcey.

DAVE RITCEY: Thank you so much, Madam Chair. First of all, for the record, I want to correct the honourable member. Our Premier has been advocating for virtual care since 2019, and even added to a bill last year, in April - virtual care as well. I just want to correct that statement, for the record.

That leads me into virtual care initiatives. This question is for Associate Deputy Minister Craig Beaton: Can you elaborate a bit more on the virtual care initiatives that have taken place?

CRAIG BEATON: I think we've spoken about a few of them, but I'm happy to elaborate. Enhancement to primary care access was one of the key features that VirtualCareNS has rolled out. A couple of the other initiatives that we've also spoken about are expansion of looking at that roster and expansion of virtual care to all people on the Need a Family Practice registry.

In addition, looking at how we can also do more in terms of accessing virtual care for specialist services, so that will be another component. A third part would be some of the pieces around expanding out around chronic disease management, specifically using the INSPIRED program model for COPD.

DAVE RITCEY: Thank you, Madam Chair. I'll pass it over to my colleague, MLA Sheehy-Richard.

MELISSA SHEEHY-RICHARD: This a great conversation. In my community, we are struggling. We don't have a clinic, so I'm excited to hear that the rollout is going to be by June. I think I've got some happy constituents that I can give that information to. Thank you for that hard work.

I'll just ask a quick question. I know we've been kind of asking the same questions, but can you share with us what makes VirtualCareNS innovative, and perhaps more broadly some of the innovative work happening at NS Health and what that tie-in might be into the virtual care.

GAIL TOMBLIN MURPHY: As you are probably aware, the Premier did announce the Nova Scotia Health Innovation Hub, which we're really excited about for a variety of reasons: to bring innovation solutions to care for Nova Scotians, but also to be seen on the world stage as being pretty innovative.

Some of the examples there, VirtualCareNS is one of them, with all the initiatives that Assistant Deputy Minister Beaton and others have spoken about. In addition to that, this is where patients and families and clinicians come together with the very best ideas, and we move those ideas with them as partners into realities.

Other examples would be things like virtual reality. As a chief nurse executive, for instance, and having interprofessional practice within my portfolio, our providers as well as our physicians are the ones who can tell us most about what's going to make sense in terms of the technology that they're using, appropriateness, affordability, as well as other things. A virtual reality lab where people touch and feel and see, we've seen with robotics, for instance, we've had some major advances as it relates to orthopedic surgery and a new Mako robot that Dr. Dunbar was highlighted, a partnership with Stryker.

When we talk about private industry, we talk about industry partners, and we're really thrilled about that. In Nova Scotia, we don't always know. We actually are seen as a

leading area and jurisdiction for a couple of things, and that is robotics, so an opportunity to enhance what we're doing in robotics as the centre of excellence.

As well, clinical trials. Nova Scotia is being watched and seen for some for the advancements that we're making on advancing drugs, as well as medical devices and therapeutics. That makes, for instance, clinical trials accessible to all Nova Scotians using some of the remote access that we're talking about in innovation.

The Innovation Hub is all about partners coming together, including government, including our patients and our families, our clinicians, our private industry partners, as well as others, to test and try innovative solutions. What we do is, we wrap evaluation around every one of those to determine whether they're working or not working. It's alright to test and try. Some things will scale, and we evaluate and have criteria for that.

There are other things that just aren't going to work, and it's good to find out those things that aren't going to work quickly, as we actually evaluate. We're really excited about us in Nova Scotia being seen and building innovation in the way that we are. Thank you for that question.

THE CHAIR: Ms. Sheehy-Richard, you have slightly less than three minutes.

MELISSA SHEEHY-RICHARD: I can feel the excitement coming across the floor, and I can see Dr. Johnson nodding. It's good to have reassurance that initiatives that are working and innovative ideas are actually what hands-on physicians and health care providers are looking for and connecting them together.

I just wanted to know what other resources Nova Scotians have been accessing through virtual care. Are there outside resources that they're using as well? I think we touched on a few of them, but is there anything that was missed earlier? I'm not sure if that would be Mr. Beaton.

CRAIG BEATON: Sorry, just maybe a bit of clarity. Do you mean different types of ways people access virtual care?

MELISSA SHEEHY-RICHARD: Have more Nova Scotians been accessing virtual care resources, I guess, is how I should have worded that?

CRAIG BEATON: I think I had mentioned earlier, but in pre-pandemic times about 1 per cent of physicians, patients, and providers were actually using virtual care as a method to provide access. Where we find ourselves now is around 35 per cent.

In addition to that, those that have - not only with the Need a Family Practice Registry which Dr. Tomblin Murphy has talked quite a bit about in terms of the 66,000

people and the 12,000 visits, we also have roughly around 68 per cent of patients having had some sort of virtual care visit. This equates to around 495,000 interactions.

THE CHAIR: Ms. Sheehy-Richard. You have one minute.

MELISSA SHEEHY-RICHARD: That was great. I'll just make a couple of comments, maybe, in the minute since there's not a lot of time left. Thank you again for appearing before the committee.

I have a nurse practitioner. I'm very lucky to have her. I went to elementary school with her and I feel very connected. I do most of my appointments virtually, but next week on the 29th I hope to be able to go in person and have one. I'm not sure if the House schedule will allow.

I think that all these innovative ideas is where the future is. We want to cut down on the travel and coming into Halifax every day. I had back surgery, but did I really need to see him just to say that I feel 100 per cent better? It may be not necessary. It could have put his time better on those things.

I'm very excited for the movement. I think Nova Scotia should be a leader, and we can be a leader . . .

THE CHAIR: Order. I would like to thank our guests for coming in today. Does anyone have any final comments that they would like to make? ADM Beaton.

CRAIG BEATON: Not so much comments, but I would just say thank you to the committee for your interest and the questions this morning. It's nice to be able to provide an overview of some of the pieces that we're working on with virtual care. I appreciate your time this morning.

THE CHAIR: Just as a note, as the mother of an adult child who has a chronic illness, for her, being able to access her appointments from her bed and not having to get up and get showered and everything and go in has been a huge boon that started during the first wave of COVID-19. Keep up the good work, thank you very much.

With that, you are allowed to go. We have committee business that's super boring. You don't want to be here for it. (Laughter)

We will now move on to our committee business. We have a number of pieces of correspondence that have arrived for us all. Ms. Leadley has kindly printed it off for all of you so that you can see it.

We have correspondence from Paul Allen, Karen Gatien, Lora MacEachern, and Judith Ferguson. These are all responses to our request that they appear regarding the topic

of Nova Scotia Power's proposed rate hikes. That's been provided for the members' information. Does anyone have any discussion about what we are seeing there?

There's also further correspondence, as well, from the Department of Municipal Affairs and Housing. That was information that was requested from the March 9th meeting which Deputy Minister LaFleche has provided to us. Is there any discussion about that?

With that in mind, I will just share with you that our next meeting is April 27th. It's an in camera meeting with the Office of the Auditor General regarding the follow-up of the 2017-2018-2019 performance recommendation and the follow-up of Atlantic Lottery Corporation recommendations.

If there is no further business, the meeting is adjourned.

[The committee adjourned at 10:44 a.m.]