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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, November 23, 2022

COMMITTEE ROOM

Impact of Government Expenses on ER Understaffing

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Public Accounts Committee

Hon. Kelly Regan (Chair)
Nolan Young (Vice-Chair)
John A. MacDonald
Melissa Sheehy-Richard
Tom Taggart
Kent Smith
Hon. Brendan Maguire
Susan Leblanc
Kendra Coombes

[Kent Smith was replaced by Chris Palmer.]
Kendra Coombes was replaced by Suzy Hansen.]

In Attendance:

Kim Langille
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

Kim Adair,
Auditor General

WITNESSES

Department of Health and Wellness

Jeannine Lagassé - Deputy Minister

Tanya Penney - Senior Executive Director

Nova Scotia Health Authority

Eileen MacGibbon - Vice President, Operations for Central Zone

Eric Coates - Director, Clinical Transformation, Central Zone

Bethany McCormick - Vice President, Operations for Northern Zone

Dr. Tanya Munroe - Physician/Senior Medical Director, Access & Flow

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, NOVEMBER 23, 2022

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIR
Hon. Kelly Regan

VICE CHAIR
Nolan Young

THE CHAIR: Good morning, everyone. 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. Just a reminder to everybody to put your phones on silent.

Before we do introductions, for folks who have no life and like to watch Legislative TV, I just want to explain that we'll be holding our Public Accounts Committee meetings in here for probably the next year or so, is what we're hearing, while some renovations are undertaken. We're meeting in the Committees Room for the foreseeable future. The percussion is being provided by I don't know what in this building, but we do have musical accompaniment today. (Laughter)

With that, I will ask my fellow committee members to introduce themselves, beginning with Mr. Young.

[The committee members introduced themselves.]

THE CHAIR: I would note that we have officials from the Auditor General's Office including the Auditor General herself, Legislative Counsel Office, Hansard, and the Legislative Committees Office here in attendance as well.

On today's agenda, we have officials with us from the Department of Health and Wellness and Nova Scotia Health Authority regarding the impact of government expenses on ER understaffing. I will ask the witnesses to introduce themselves, beginning with Deputy Minister Lagassé.

[The witnesses introduced themselves.]

THE CHAIR: I will invite Deputy Minister Lagassé to make her opening remarks, and then Ms. MacGibbon.

JEANNINE LAGASSÉ: Thank you, Madam Chair and members of the committee. I would also like to thank all of the witnesses from NSHA and Ms. Penney for being with me here today.

Emergency departments are one of the most well-known areas of our health care system. Most of us, and arguably most Nova Scotians, have likely found themselves needing care in an emergency department at some point in our lives.

The reality we face in Nova Scotia and across our country is that our emergency departments are facing more demand than ever before. It's not as simple as adding more staff to existing emergency departments. Our health care system is complex and interconnected. Easing the pressures at emergency departments across the province requires changes in several areas. That's where strong partnerships and a full system response become critically important.

As committee members are aware, the department and the Nova Scotia Health Authority each have different accountabilities and fulfill a different role related to the health care system and emergency departments in particular. There are also other partners with us in the system, and we are all committed to making changes that will improve the health care Nova Scotians rely on. I greatly appreciate and value all of our partnerships.

Our emergency departments need to be there when people have an emergency. That's why we're working together to make changes that will ease the pressures we are facing. One of those changes includes a new program called single paramedic emergency response, which allows paramedics to treat low-acuity patients on scene without transport to hospital. That means those patients don't have to go to the ED at all.

It may include a temporary, after-hours unit near an ED for those who need care but not emergency care after they've been triaged. That is something our colleagues at the IWK have been working on. It may also include care at a new mobile primary health care unit, or at one of the four urgent treatment centres in Parrsboro, Annapolis Royal, Northside, or Baddeck where people can seek care for unexpected, non-life-threatening health concerns that require same- or next-day treatment.

It means providing care for Nova Scotians that is ready, responsive, and reliable when they need it. It means improving how we bring people into our hospitals and through them, and how quickly we get them back home or into other levels of care if they need it. It means improving placements for home care, long-term care, and more long-term care beds. Most of all, it means training, recruiting, and retaining health care staff.

These are simple things to say, but they require a huge lift from the entire health care system. I can say that together we are working on every single item I've mentioned today. All system partners are committed to change.

Over the past few weeks, Minister Thompson, Nova Scotia Health Authority Interim CEO Karen Oldfield, and I have been going to communities across the province to engage in conversations on health care with members of the community. Nova Scotians have told us about the frustrations and challenges they've experienced while accessing and receiving care. They've asked about streamlining recruitment, about working past retirement, about creating teams of professionals to provide better care in communities where they live. They've demonstrated an understanding of the challenges before us and acknowledged it will take us time.

The challenges and solutions that they put forward are informing how we are working on our priority items identified through our strategic plan, Action for Health. These include:

- improving access and flow across the system;
- addressing health services and models of care;
- modernizing our physical and digital infrastructure;
- addressing inequities in our system, both for diverse communities and diverse health care workers; and
- transparency and accountability.

While I'm proud of the work that has been done so far, I am very aware that there is much more to be done to create a health care system that Nova Scotians need and deserve. We are learning from our challenges to create opportunities, to do things differently, to offer better care. The way we have always done things is not working. The time for change is now.

I want to thank all of the workers across our health care system and through government for their dedication and their efforts to help us find these solutions. Together, we will transform our health care system.

THE CHAIR: Ms. MacGibbon.

EILEEN MACGIBBON: Thank you, Madam Chair, and members of the committee. We're very pleased to be here with you today. We're here to speak about emergency care in the province. To begin I'd like to acknowledge the many people doing that work right now and every day: nurses, paramedics, pharmacists, doctors, and many others caring for the people of our province on their most difficult days. Early in the pandemic, they were publicly celebrated, but they remain just as deserving of our thanks today.

Nova Scotians want and deserve reliable access to care, both for their day-to-day needs and unexpected situations. Across the system and with our partners, we are working to ensure they have those options in their communities and an enhanced ability to benefit from resources across the province. We know that uncertain access to primary care has meant that for some, emergency departments were the only option to see a health care provider. A year ago, we introduced Nova Scotia's first urgent treatment centre in North Sydney.

Urgent treatment centres provide care for those with unexpected, non-life-threatening health concerns that require same- or next-day treatment, and are available to people with or without family doctor or a nurse practitioner. In its first year, the North Sydney site has seen more than 6,700 patients. Providers say that the care is rewarding, and patients are happy with this option.

Surveys of users to date that indicated that 97 per cent are very satisfied or satisfied with the service, 80 per cent indicated they would otherwise have to wait for their family physician appointment or go to the emergency department, and 99 per cent indicated that their health care needs were met. We have since expanded that model to sites in Northern and Western Zones of the province.

In rural communities of Neil's Harbour and Canso, we are trialling virtual physician support via the EHS medical communications centre physician to allow emergency departments to remain open when local coverage is not available. Virtual physician support allows both EHS and Nova Scotia Health Authority to use existing resources to continue to provide service in rural communities instead of needing to close the emergency department.

Elsewhere, we are piloting the use of virtual care at Colchester East Hants Health Centre to reduce wait times for Nova Scotians visiting the emergency department with health concerns that can be appropriately treated through a virtual visit. VirtualEmergencyNS is fully integrated with in-person care at the facility, and patients requiring further assessment are treated by the onsite emergency care team. This option is now offered at Yarmouth's emergency department as well. We have also opened virtual access to VirtualCareNS to all people on the Need a Family Practice registry. While we understand that demand is high, it offers an alternative to having to visit an emergency department for some primary health care concerns.

Of course, conventional, in-person emergency care is critically important, and we are working every day to support and enhance it. The biggest factor behind the overcrowding seen in our emergency departments is often the hospital's inability to admit patients to beds inside the hospital, rather than anything occurring inside the emergency department.

We are addressing this at local and system levels. For example, through the Care Coordination Centre known as C3 currently operating at the QEII which will be expanded across the zone and the province. The Access and Flow network, co-led by Dr. Munroe who is with us here this morning, is focused on optimizing our policies and processes to ensure that every day a person spends in hospital contributes toward their recovery and discharge.

Staffing and ensuring physician coverage for our emergency departments has often been difficult and required hard choices, but it is a priority. I want to assure you that budgets have not been a limiting factor - we have the funds available to fill vacancies and ensure shifts are fully staffed. It's the actual human resources that have been scarce.

At times, it's necessary to use nurses and other staff from external staffing agencies either to fill gaps or to ensure our own staff are able to take a much-needed vacation. This comes at a cost, but we believe it is the right thing to do to be able to offer care when other alternatives have been exhausted. In the same way, we often use locum physicians to provide the coverage required for some smaller emergency departments to be open.

Our system is in a period of transition, and, like other parts of Canada, there are strains that are affecting our staff, doctors, and patients. However, we believe the actions we have in motion are creating the foundation for a reliable and sustainable emergency care system in Nova Scotia. We look forward to your questions.

THE CHAIR: Thank you so much. We do have one introduction that we haven't made yet. With us is Ms. Hansen.

SUZY HANSEN: Thank you, Madam Chair. My name is Suzy Hansen, and I'm the MLA for Halifax Needham. Welcome.

THE CHAIR: How this works is each party will question for 20 minutes. When that 20 minutes has elapsed, our witnesses may be in the middle of an answer. I'm not being rude, but I'm going to interrupt you and we'll move on to the next party, just so you know.

We first begin with the Liberal Party. You have 20 minutes, so you have until 9:34 a.m. We begin with Mr. Maguire.

[9:15 a.m.]

HON. BRENDAN MAGUIRE: Thank you, Madam Chair. As I always start out, I have a lot of questions, so I ask that the witnesses keep their answers direct please.

Currently, what is the average wait time for a child in the IWK emergency room to be seen?

JEANNINE LAGASSÉ: I don't have the exact wait time number, but I do know it's considerably higher than it has been in previous years. They're seeing an extremely higher volume than usual right now.

BRENDAN MAGUIRE: What is the average wait time for emergency rooms across Nova Scotia?

THE CHAIR: Dr. Munroe.

DR. TANYA MUNROE: They're far too long most days, in all honesty. I don't have those exact numbers in front of me because they are highly variable depending on system demand, and, actually, even day of the week.

BRENDAN MAGUIRE: In the last month, how many hours were ERs closed across Nova Scotia?

THE CHAIR: Ms. Penney, do you have that information?

TANYA PENNEY: The ED closure report, from an accountability perspective - I think it's being tabled sometime before the end of the year, as per the legislation. I do know that 19 out of 38 emergency departments were open for their entire 100 per cent of their scheduled hours, which was on par with last year's report, and a further 12 emergency departments were open for at least 75 hours of their scheduled hours.

BRENDAN MAGUIRE: The question was, how many hours were ERs closed across Nova Scotia in the last month - not how many met the 75 or 100 per cent. How many total hours were ERs across Nova Scotia closed in the last month?

TANYA PENNEY: I apologize. I didn't specifically answer the question and I don't have that level of data, but we can certainly get it for you. I have a general idea from the last year.

THE CHAIR: I will ask the clerk to make a note of that particular item.

BRENDAN MAGUIRE: How many notices of overcapacity has the department released over the last month?

THE CHAIR: Ms. Lagassé.

JEANNINE LAGASSÉ: I don't believe we've released any. The department would not release those.

BRENDAN MAGUIRE: Okay. How many notices of overcapacity have come to the public for emergency rooms over the last month?

THE CHAIR: Ms. MacGibbon.

EILEEN MACGIBBON: Are you speaking of public service announcements indicating that? I think over the past month there would have been one. I'm aware of one that we made through our communications group.

BRENDAN MAGUIRE: Are you saying that NSHA has only released one, or are you saying that only one has been released to the public?

EILEEN MACGIBBON: Yes, I believe that there was one in the past month.

BRENDAN MAGUIRE: I can tell you that I've retweeted and all that stuff more than one over the last month, from overcapacities and warnings.

How many notices have been put out encouraging people not to visit the emergency room because of it being overstressed or overstaffed in the last month?

THE CHAIR: Understaffed.

BRENDAN MAGUIRE: Understaffed, sorry. Overstaffed would be nice. Understaffed.

EILEEN MACGIBBON: I'm sorry, I'm not sure. I'll have to check to see how many we would have indicated. I thought we had one for Central Zone. Maybe there have been more outside of Central, but I'm aware of one for Central Zone in the past month.

THE CHAIR: I will just say that we have a series of questions here that have been unable to be answered. I'm assuming that your comms teams are watching these, so perhaps if they could send the information to you so we could get that information at the meeting today? That would be great.

Mr. Maguire.

BRENDAN MAGUIRE: These are very simple questions that I would argue individuals in senior management positions within the Department of Health and Wellness and the Nova Scotia Health Authority should be able to answer. I think there's an issue

when we can't get a definitive answer in this committee on things like emergency room closures, access to emergency rooms, the IWK, and things like that. I think there is a big issue.

I will note that we did ask for the CEO, Karen Oldfield, to attend this, and again, not here. No offense to Ms. MacGibbon, but Madam Chair, the response was Central Zone, and we're asking questions for the entirety of the Nova Scotia Health Authority. We're unable to get the simplest of answers.

I'm not blaming individuals in this room, but I think you should be more prepared, when you're coming to the Public Accounts Committee, to answer some of the simplest questions. It's troubling to me that my first six questions that I put toward this committee, I can't get an answer and we have to wait and wait and wait to get these responses. But I'll continue on.

I attended the press conference with Dr. Lynk and Dr. Strang. He said that the IWK Health Centre emergency room is ". . . at historic levels I had never seen before in my career here since 1990 as a young pediatrician." He was pretty blunt about the current situation at the IWK and saying that unless your children are in acute or extreme emergency care, please don't come to the IWK.

Is that acceptable health care service? Ms. Lagassé, you said earlier that the way we have always done things is not working, it's time for change. Over the last year, what kind of change has happened where Dr. Lynk has said the IWK is the worst he's ever seen?

JEANNINE LAGASSÉ: I think there are a couple of things that I can respond to on behalf of our colleagues at the IWK. The first thing there in relation to the emergency department redevelopment project is currently underway, has started now at the IWK from an infrastructure perspective. That is new.

Also, in response to the very high volumes at the IWK over the last little while, again, from a system response perspective, we've put the mobile unit out for two weekends in a row. Last weekend most recently it was out at Cobequid, and information has gone out through IWK networks that people can now access care through the mobile unit. That is new; we're helping to relieve pressure off the emergency department.

Our colleagues at the IWK are also looking at, as I said in my opening remarks as well - when someone is triaged, a determination is made as to what level of care they require. They're looking at and they're instituting a new clinic for more primary care-like requirements once a patient has been triaged at the IWK. They will set up a separate clinic area in the IWK to move those patients into a different area and to get them the level of care that they need that might not be needed to be done right in the emergency room.

Those are examples of things that are being done currently at the IWK that are new and different.

BRENDAN MAGUIRE: While I appreciate the response, quite frankly, Dr. Lynk is on the ground and has said it's the worst it's ever been. Those were his words, not mine. It's the worst it's ever been. The question is, what are you doing to alleviate that? He actually said that before the press conference he walked though the IWK, and he's never seen anything like that. Obviously, you're saying going forward, these are the things that we're doing. I'm asking, what has been done over the last year to prevent the current situation that we're in now?

JEANNINE LAGASSÉ: The items that I've spoken to already have been in planning over the last year. There have been a number of different things that have been taken. They're also looking at increasing scopes of practice, as with all of our areas within the system. We're looking at recruiting and retaining as much as we can. There's been reassignment of individuals where they can, within the facility, to look after this, but we've been planning a whole bunch of different things to provide people with care that isn't needed in the emergency department.

BRENDAN MAGUIRE: The words you're using are planning and looking at. Those are future-tense words. That's what you said, we're planning and we're looking at. Again, I will say that Dr. Lynk said that this is the worst it's ever been. We've just gone through years of COVID-19. We knew the impact that it had on the system, so we had years to plan. We have one of the worst, if not the worst influenza season coming up. We have very limited access to vaccines - no matter what government wants to say. If you go online and you try to book a vaccine, I was told to go Guysborough. That's where I was told to go with my three kids.

I have had people from my community tell me they had to go to Cape Breton, they were told to go to Yarmouth and Lunenburg and all these areas. Just because somebody is told they can go tomorrow to Lunenburg is not access. Again I will say, what was done over the last year to prepare for the current season, and why is it not working?

JEANNINE LAGASSÉ: I think when I answered your earlier question, Mr. Maguire - you asked what we had been doing over the last year. As I said, we'd been planning and implementing over the last year the items that I have already outlined for you. I can tell you that our colleagues at the IWK and across the system at the NSHA every day are looking at new things that they can do, and they're shifting where they can.

One of the limitations that we do have is human resources. We know that that is a limitation, and that's one thing that we are working very hard at from a recruitment perspective, that that is one thing that we cannot immediately produce but there are a number of different things that we have done to try to provide more primary care access for individuals so they don't have to seek that at the emergency department.

BRENDAN MAGUIRE: While I appreciate the response, in your opening statement you contradicted that by saying this is simply not about adding more staff. That's what you said. You said that this is simply not about adding more staff, and you just said that this is a human resource issue.

What I'm asking you is, how come we're in the current situation we are right now at the IWK? What happened to put us in the current situation where Dr. Lynk said this is the worst he's ever seen? I just need a simple answer. Where did things go sideways or where did things go wrong? This isn't about the people that are working on the ground. I know a lot of people who are working at the IWK and in the system who are working their tails off.

The planning and the management of this is extremely important, so what would you change? What do you think was done right, and, we'll say, what was done wrong? More importantly, what was done wrong to put us in the current situation at the IWK?

EILEEN MACGIBBON: I just wanted to add to what the deputy minister has already provided. When you ask, what has gone wrong, what did we do to not prepare - I think what's the most important to remember is that what we're facing here in Nova Scotia is exactly what every other province in this country is facing. Children's hospitals across the country are connecting like they never have to talk about strategies to deal with the current surge that they're seeing. It's at a time - as the deputy minister said - that we've seen a scarcity of human resources like never before. The challenges on health care in general across every jurisdiction in this country are significant.

As she's mentioned, we've been partnering in ways that we haven't in the past to ensure we're as collaborative and innovative as possible in supporting the demands of the system and the strains that we have on our workforce. It's all of those factors that are colliding, so to speak, in our environment and every other environment in health care across Canada. I think another benefit that we have had in the past year is talking through with our colleagues in other provinces, as well as as much as we can with every partner in Nova Scotia to talk about the strategies that we can deploy to support and respond as best we possibly can, but I don't believe anything in Nova Scotia is different than what we are seeing everywhere else in Canada right now, unfortunately.

BRENDAN MAGUIRE: While I appreciate that, this was a government that was elected on health care and spent a historical amount of money on health care. Respectfully, I don't mean to be obtuse, but I'm not really concerned about Ontario, or New Brunswick, or P.E.I., or those other provinces or territories. What I am concerned about is that I had a constituent whose son broke his arm, and they were there for 14 hours. He now has nerve damage because he wasn't seen. These are issues that parents are facing now.

When you talk to parents and people that need to go to the emergency room or go to the IWK emergency, if you ask them, a lot of times they're not going because they know

they're not going to get the care and the timely care. This has nothing to do with the people on the ground. They're working their butts off.

[9:30 a.m.]

Surely, over the last year, there must have been issues that could have been improved on, and that's all I'm asking. We're in this situation now, and I'm asking where could the Department of Health and Wellness have improved on so that we're not in this situation? We have a 10 per cent uptake in the influenza vaccine. That was from Dr. Strang - the lowest it's ever been.

We've had Premiers in the past and MLAs in the past who have promoted, get your vaccine. If you go on the Premier's Twitter account and social media, it's nowhere to be seen. We've had rollouts from Communications Nova Scotia in local papers, in local media, and online, encouraging people to get vaccines. We're not seeing that this year. We had probably one of the most important health care press conferences of the year - probably the most important - and again, the Premier nowhere to be seen. It's important. We need the leaders of this province to step up.

Whose idea has it been to not do a full communication rollout on getting your vaccine? I can see some confused looks, but the truth is if you go on social media, nobody's seeing it - if you ask people if there's been advertising. We're not seeing the level of communication we've seen in the past, and that's extremely important.

I think people are a little vaccine weary right now because of the last few years, but it's extremely important that they get this influenza vaccine. We've heard from the health care professionals at the IWK and the emergency room that this is going to have a massive impact on our emergency room, and this could be one of the worst influenza seasons we've ever had.

Whose idea has it been to not have a full rollout like we've had in the past? Why don't we have it?

THE CHAIR: Before we go to Deputy Minister Lagassé, Mr. Maguire, there are two minutes left in your time.

JEANNINE LAGASSÉ: As with anything we do, we always look at our strategies. I had a discussion with Dr. Strang just yesterday, talking about communication and other efforts that we might be able to make - he himself being made available again for media to talk about the vaccine uptake and rollout. We're always reviewing our communication strategies to make sure that we are reaching the broadest audiences. As I've said, Dr. Strang and I had a conversation as recently as yesterday to ensure that we are making the broadest reach and getting the message out to people as much as we can.

BRENDAN MAGUIRE: I appreciate the answer, but we're in the middle of influenza season. Do you not think it's a little too late? Should we not have been doing this before flu season started?

JEANNINE LAGASSÉ: When the vaccines were originally available, we would have had our communication program started at that time and ongoing, so we have been having ongoing communication about it, not the communication that you've been talking about, press conferences and such, but there has been ongoing communication to ensure that Nova Scotians know the vaccine is available.

THE CHAIR: Mr. Maguire, you have 35 seconds left.

BRENDAN MAGUIRE: Quick question: When was the vaccine first made available? What date?

JEANNINE LAGASSÉ: I'd have to confirm, but I'm pretty sure that it was near the end of September. The first appointments were made available for booking - they started being available to book for a week or two out at the end of September I think, but I'd have to confirm.

BRENDAN MAGUIRE: We've had months to roll a communication plan out, and yet here we are.

THE CHAIR: Order. The time for the Liberal questioning has elapsed. Ms. Leblanc.

SUSAN LEBLANC: Thank you. I just wanted to make a couple of comments on things I've heard in the last 20 minutes before I ask my prepared questions.

I want to say I'm glad to hear the deputy minister say that there's an acknowledgement that things needed to change. I know that there is work going on, and I will be acknowledging all of the things you said in your opening comments. I'm going to ask some specific questions about emergency care.

I have to just echo my colleague's disappointment about those short-snapper questions. It would be great to be able to get those numbers quickly. I'm wondering in general, a system-wide thing. We do get published numbers on a number of things every month, but I'm wondering in terms of ER numbers, if there is a way to start seeing those numbers more quickly, and those detailed things about how many people show up, how many people leave, how many people have been treated, and what the wait times are.

I also just want to say quickly about the IWK. I was at that press conference too with Dr. Lynk and Dr. Strang. It was deeply concerning, especially a number of us have kids, and of course we represent folks with young kids.

I'm wondering about the clinic - whatever it's called, that other room where people who aren't super acute go in to get treated. I'm wondering if there's a plan for that to stay. We learn things from crises, and I'm wondering if there is any thought that that is just a stopgap or just a measure that is being taken for this crisis, or will we look at having that all the time?

JEANNINE LAGASSÉ: Right now, it's starting for a 12-week trial period. The idea is that it would be open, or they would have that option, during the peak hours when they're seeing the highest volumes coming through the emergency department. Right now that is between approximately 5:00 p.m. and 11:00 p.m. That's usually their peak time, so that's why they would institute this particular option during these periods.

The goal is for it to run seven days a week. They are just getting started. I think later this week is when they hope to actually have it open. Seven days a week will depend on staffing. That will be the only limitation is if they can have enough staff to run it seven days a week.

So a 12-week trial period, but as with everything we do, if the need is still there and it's working as they hoped that it would, then I would say that there would be an opportunity for it to continue.

SUSAN LEBLANC: Thanks. I also just want to say something about the kids' booster thing. I find it deeply concerning that it is very difficult, in the HRM at least, in Central Zone, to get a child's booster shot right now for COVID. I have been trying for a month, and my colleague, the Leader of the NDP, has been trying. We would sit there in the Legislature and try to book booster shots for our kids. It was virtually impossible.

For a month now we have been communicating with the Minister of Health and Wellness's special advisor, who literally said, "Thanks for letting us know about this issue" - which is surprising, right? One would think the department knows about this issue. Then at the conference the other day, Dr. Strang said there are more boosters added. I literally just checked this moment, plugged my address in. There's one appointment this afternoon on Quinpool Road, and the next available appointment is December 23rd. Then the other pharmacies that are in sort of our locations, the next available is December 23rd.

What is happening? I want my kids to be boosted. I want them to be fully protected. I want them to stay out of the ER. It's impossible if we don't have those options. I know Dr. Strang's answer the other day was, well, you can drive to Tantallon or you can drive to Kentville or whatever.

It's like, fine, I can do that, but most people can't take time off to get their kids boosted an hour away. Anyone got a comment on that?

JEANNINE LAGASSÉ: Thank you for the question. I've asked our Public Health colleagues if they can send information, hopefully while we're in here today. Every time I check on it, I've been told that there are sufficient appointments. You're clearly telling me that there aren't, so I'm following up on that as we speak.

THE CHAIR: Thank you, deputy minister, for actioning that while we're sitting here. Ms. Leblanc.

SUSAN LEBLANC: Thank you. In terms of the continuum of care and the flow of care, we know that there is primary care, we know that there are EHS services and all the issues with paramedics. Then there's, of course, the acute care bed issue, and then there's the long-term care bed issue. It seems like we need to work on all of those things. But today I want to ask some really specific emergency department questions.

To Deputy Minister Lagassé, in April of this year, it was reported that $500,000 was being spent on virtual care platforms with Maple. I'm wondering if you can provide an updated figure on what we're spending with Maple and what portion of it is for the Virtual Emergency Nova Scotia program?

JEANNINE LAGASSÉ: I'm going to ask my colleagues at NSHA if they know specifically on the Virtual ED part of it, but I do not know how much of that funding. I'd have to look into it, how much of that $500,000 was specifically for that program.

SUSAN LEBLANC: Is the $500,000 still the same number, or is it changed? Could we get those answers? Is there a difference between the $500,000 first amount that was reported in April, and what portion is for virtual care?

My next question is: What is the average cost of an ER visit using Maple, and is the department or anyone able to provide a cost comparison between an in-person appointment at an ER and a virtual care emergency appointment? This is important information because we need to know if there is a cost benefit to have virtual care emergency? Is it cheaper to have in-person emergency, or are we saving tons of money with having virtual appointments?

I want to get at this question. That would be really important for us to have those answers ASAP. I'm assuming no one can give me those answers right now, but maybe I'm wrong.

JEANNINE LAGASSÉ: I can't provide that level of information, but I'd like to say to you that the reason for introducing the virtual in the ED is to help provide better access, right? There will be a cost to some of that. I think I understand what your question is - understanding the cost differential - but really, it is another way to provide better access to Nova Scotians to have that service available in the ED so that some people don't have to wait as long for their service. Do you want to add anything to that?

DR. TANYA MUNROE: I can add a little bit to the value question, although I can't give you the dollars and cents. The value to the patient is that they have the ability to be taken out of what is an unacceptably long line for care some days, and if they consent to being seen in a virtual platform, I as a virtual emergency provider can already start talking to them about their concern that brought them there, formulating a differential diagnosis. I can order up-front treatment.

If you've come in and you've got a fever, and you're nauseated, and the wait to see a physician in-person is going to be six hours and you agree to see me, while I'm sorting through my plan of care for you, I can have my virtual care assistant who's in person in the department start your treatment, start your investigations. I can order your labs. I can review your cardiogram. I can watch my physician's assistant perform your exam and glean from that signs of something more sinister or something that I can be reassuring to the patient about. We can complete that visit in less time than it would have taken them to sit in an ED waiting room waiting for care.

I can also serve patients in multiple waiting rooms. Last week, I was able to work between Colchester patients and Yarmouth patients. In a four-hour period, I believe I saw between 12 to 14 patients, satisfactorily resolved all of their complaints, completed WCB documentation, designed out-patient follow-up plans of care, sent prescriptions to pharmacies, and I felt they were satisfied.

I also provided them with appropriate return precautions: Come back if the following things happen. If at any point in time during this experience with the patient I felt they needed to be seen in-person, in the moment, by my colleague, it's simply a matter of a phone call.

By doing that, I did save 12 patients an extra wait in the emergency department. That potentially allowed 12 more patients to come into the care footprint that they needed. It also has the potential to extend the shelf life of the emergency clinician. The job's challenging. It involves shifts. I'm not getting any younger. I can do a blend of work that enables me to stay in the profession longer.

If I were a physician in the last five years of my career and given the opportunity to provide appropriate care through a virtual format in addition to maybe a reduction in shifts, I could still contribute as opposed to stepping completely away. When we are so pressured for health human resources, any strategy or innovation that extends the shelf life of any provider in our system has far more value than just dollars and cents.

SUSAN LEBLANC: I am not suggesting that there is no value in virtual care or virtual care emergency - I think that there is a place for it, 100 per cent. But this is a Public Accounts Committee where we're studying how the money of the Province is being spent. I think to ask the question to see cost benefit analysis or just the difference is very important

for us. I'm not here to say virtual care is not a good program; I'm here to ask how much it costs.

[9:45 a.m.]

What you're saying suggests to me that it's highly efficient, and that's great. But we need to see that so that we know how to move forward, or to criticize or not criticize, or whatever. But thank you for that answer, and thank you for your work because certainly, I'm the kind of person who would definitely take a doctor up on that if I were in the emergency room.

Moving on, though, at a Health Committee meeting earlier this year, representation from the Office of Healthcare Professionals Recruitment stated, "The current incentive programs" - that were for health care recruitments, so people - "don't address emergency room physicians," though there was an interest. I'm wondering if there are any updates on that. Is the government creating financial incentives specific to emergency medicine physicians, and let's just say emergency room nurses and nurse practitioners, as well? Are there any out-of-province recruited physicians now working in emergency rooms?

There are three questions there: updates on the interest in the program, are there new incentives for emergency room physicians, and are there any newly recruited physicians working in emergency departments in Nova Scotia?

THE CHAIR: Ms. McCormick.

BETHANY MCCORMICK: I'm going to start with the nursing incentive component. Certainly, when we are recruiting to the emergency department and all nursing positions within the Nova Scotia Health Authority, if we are having difficulty filling a position, we do have the ability to provide incentives upon hiring an external applicant which can include incentive return and return of service for that applicant, but, also, support for relocation allowance if they are requiring that to come to the province.

For nursing, as well as pharmacists and other individuals that support emergency care, that option is available, and as we go out across the country to recruit or are seeking applicants externally, that is something that we can apply when it's a hard-to-fill position.

SUSAN LEBLANC: And anything about physicians?

BETHANY MCCORMICK: I will defer that to one of my colleagues.

JEANNINE LAGASSÉ: The physician incentives that - the new ones are still in place. Up to $125,000 is the primary care incentive, and then there's also the specialist incentive that is the same amount for outside of the Central Zone. Those are the incentives.

There has been a minor change, I know, in the program related to some doctors who do provide some ED coverage, but I would have to get the exact detail for you on that.

SUSAN LEBLANC: The question was, is there a special incentive for doctors in emergency departments, emergency room physicians, and are there any newly recruited physicians working in emergency departments? If you can get that information, that would be great. When I say the newly recruited, I mean - remember the press conference with the minister when she was like, 68 doctors, or whatever? Are any of those working in emergency rooms? I forget the exact number.

THE CHAIR: We will add that to the list of questions that we would like to have answered by the - oh, Ms. McCormick.

BETHANY MCCORMICK: I was able to source some of the questions asked earlier, so I wanted to provide an update on those.

SUSAN LEBLANC: No, wait for those.

THE CHAIR: Yes, because this is her time.

BETHANY MCCORMICK: Okay, thank you. I do have some of those numbers available if you would like to address them at a later time.

THE CHAIR: I think they were from Mr. Maguire, so we'll put those in Mr. Maguire's time - maybe.

SUSAN LEBLANC: Last week, the media reported on the Province's recent expenses for travel nurses in long-term care and acute care. There was a CBC article, and I also have a link to the job posting. The Department of Seniors and Long-term Care is reportedly spending $18.4 million to hire out-of-province agency nurses to fill in vacancies.

I'm wondering if you can advise if the department is also hiring travel nurses for hospital, and, specifically, emergency medicine positions? I'm not sure if that's what you're talking about, Ms. McCormick, and if that is the case, can you talk about the cost?

BETHANY MCCORMICK: The Nova Scotia Health Authority does hire travel nurses or agency staff at times. We look to hire agency staff or travel nurses after we have exhausted the internal options available to us, including offering overtime and extra shifts to our own staff. It does come at a cost, of course. We do use them in the emergency department, as well as in other areas of our hospitals and services as needed. We have spent in 2022-23, year-to-date, $11.4 million on travel nursing.

SUSAN LEBLANC: Great, thank you for that answer. A Google search for local emergency nurse positions shows that agencies are actively recruiting in the area for nurses

to work outside of Nova Scotia. These nurses would be able to make nearly triple their wages by switching to agency work, with added benefits of greater flexibility and autonomy. How is the Nova Scotia Health Authority remaining competitive with those options to ensure nurse retention?

BETHANY MCCORMICK: Retention is a very important topic within Nova Scotia Health Authority, and we are talking with our staff and out frontline managers about how we address that in the best way. We know that travel nursing provides flexibility in schedule to those employees. It also provides a higher rate of pay. Those two items are very appealing to some nurses who wish to go into travel nursing.

We are looking at a number of factors within Nova Scotia Health Authority, such as scheduling flexibility, flexibility around FTE - so whether somebody perhaps wants to work 80 per cent of the time instead of 100 per cent of the time to increase their work-life balance. We're also working very hard to ensure that we can allow people to have their scheduled and planned breaks and vacations as requested. Those are some of the factors that we know really impact a nurse or a health care provider's ability to have that work-life balance.

We're also regularly meeting with our teams to hear more from them about what will help them to be happy at work, including working to optimize scopes of practice and having the opportunity to try new areas of practice.

We certainly recognize that we don't want to lose staff to travel nursing, but for some, it's a career choice that they make for their own personal reasons.

THE CHAIR: Ms. Leblanc, you have just over two minutes.

SUSAN LEBLANC: I'll stay on that then. It seems to me that if you're spending $11.4 million on bringing travel nurses in, but then there are a whole bunch of people who are going out, does it not make sense to spend the $11.4 million on making it better for homegrown local nurses to be happy in their jobs and not have to leave? Obviously, we want people to stay in Nova Scotia.

Has there been any analysis of that done? I'm happy to hear that you're looking at flexibility, but also, wages are an issue, especially with cost of living the way it is. We need to make sure we're properly compensating our health care professionals. Any comments on that?

BETHANY MCCORMICK: Certainly, we are not approaching retention of staff without thinking of the budget as a limiting factor. If there are adjustments we can make around overtime, offering flexibility in schedules, those types of things, and there's a cost to that, that is not a prohibiting factor for us. We're taking everything into account.

We invest routinely to make adjustments to the FTEs available to individuals over and above what our planned budget amount is. If we have somebody who's working 60 per cent, for example, and they were to come to their manager and say, I really need more planned and secured hours to be able to stay here because I need more income, we have the flexibility in the organization to evaluate that and increase their guaranteed hours so that we can retain them.

I guess in short, we're doing everything we can, including being flexible with how we're spending those dollars to ensure that we're keeping people local here.

THE CHAIR: Ms. Leblanc, you have 30 seconds.

SUSAN LEBLANC: Has there been any consideration of providing child care on site for nursing staff in hospitals?

BETHANY MCCORMICK: We actually have had a number of conversations about that, and the value that that would bring for shift workers in particular and in communities where child care is very scarce. Just as recently as last week, I had a discussion with my staff at a particular hospital in my zone about the value that would bring. We're exploring it.

THE CHAIR: Thank you. The time for the NDP questioning has elapsed. We now move on to the PC caucus. Mr. MacDonald.

JOHN A. MACDONALD: Thank you, Madam Chair. I just want to clarify a couple of things before I ask. Deputy Minister Lagassé, you keep saying ED. That's what I would call an ER, correct? It's just different terminology? For the Chair's point that the millions of Nova Scotians who are watching us on Legislative TV? (Laughter)

JEANNINE LAGASSÉ: That is correct. I think there is a subtle difference, but we do tend to use the terms interchangeably, ER and ED.

JOHN A. MACDONALD: Also, in your opening, you mentioned more staffing. I don't want to speak for you, but what you mean is no additional - not the point that we have a deficit today. It's not that we need to add 5,000 nurses on top of the current nurses. We need to fill the positions we still have open. I just want to clarify that with you.

JEANNINE LAGASSÉ: That is correct. Unfortunately, right now we have very high vacancy rates across all of our zones and in all of our facilities.

JOHN A. MACDONALD: One last thing before I get into my questions - there was a comment on what we could have done in the last year. I believe that everybody around here would realize the best time to plant a tree was 20 years ago. The best time to deal with

climate was 20 years ago. The best time to actually deal with it would have been planned 20 years ago.

You did say that you're working more collaboratively with other hospitals to figure it out, so you're not reinventing the wheel. Is that a correct assumption in a way? Because everybody has it, everybody is now sharing, this is how we're doing it, so that you're not having to reinvent the wheel?

JEANNINE LAGASSÉ: Yes, that is correct. I know that my colleagues can probably speak more specifically related to the hospital and health authority system, but I can tell you at the government department level, that we have very interconnected federal/provincial/territorial groups that meet. Ms. Penney would participate in various groups related to policy areas that the department is responsible for. I do know from my meetings with the CEOs of NSHA and IWK as well, they are very connected with their colleagues across the country in different facilities.

JOHN A. MACDONALD: Madam Chair, just so you're aware, I emailed the clerk a list. There's a dashboard that I think might get some of the information. It won't get all. I did email the clerk, which then the clerk emails that out to all the members of PAC so they have them. The dashboard is there for some. I can't find the IWK numbers, but I am going to get to my questions now. Sorry.

Last month, there was an announcement regarding a new pilot project to place physician assistants in one emergency department in Central and in Western Zones. Can you tell me more about the physician assistants and how they're going to complement the emergency department?

THE CHAIR: Dr. Munroe.

TAYNA MUNROE: I can take a stab at that. I work in Northern Zone, so I don't have any personal experience with physician assistants, but I have been in conversation with my colleague Todd Howlett, who's instrumental in that initiative. What we're looking for is any opportunity to increase the scope of practice of any individual who can assist providing ED care.

If there are certain tasks that only I can do and I'm given the time to focus on those, it makes me more efficient. A physician assistant is essentially a physician's extender. There is a large subset of emergency work that could be done in conjunction with a physician. The faster we get the work done, the faster we get the patients to the appropriate place for recovery - whether it's home or in the in-patient units or transferred onto a higher level of care if you're in a smaller site. Anyone who can contribute to this is of value. A physician assistant is one expanded area.

We've also looked at how we're using advanced care and primary care paramedics in the emergency department. We have introduced LPN skillsets to the emergency department. We've taken steps to ensure that we've got all of the support services adequately resourced as well, including creating some additional positions so that we've got everybody shouldering the load.

JOHN A. MACDONALD: You raise a good point. You're in Northern Zone - are we looking at rolling this out more to the other zones and different ones? Is there a timeline? I'm not sure who's going to take that answer.

THE CHAIR: Ms. MacGibbon.

EILEEN MACGIBBON: That's exactly what we're doing. We're looking at the best settings across the system, but trialling a different approach pretty much across all four zones to understand where we'll get the most value. We've identified the areas where there is huge potential to introduce the scope of a physician assistant, as Dr. Munroe mentioned, to support our team in ways that we haven't in the past.

For instance, in Central Zone, we've been working with physician assistants within orthopedics, and it's been very successful. That's more in the acute care longitudinally across the system in terms of pre-surgery and after surgery, and then into clinic environments.

We've had physician assistants at Cobequid. That's been a very successful experience for the system and for the teams working there. We're now looking at the Dartmouth General, and as Dr. Munroe mentioned, within Northern Zone and then all of our zones having an opportunity to trial and understand where physician assistants can provide value.

JOHN A. MACDONALD: Sounds good. I was going to say understaffing, but I guess vacancies is the proper way to say it. To address vacancies in the ER, we agree that more health professionals are needed. Can you discuss what's being undertaken to retain more health professionals who work in ERs? For example, offering all the nurses a job. What else are we doing? What are you doing, I should say.

EILEEN MACGIBBON: Yes. My colleague Ms. McCormick already mentioned a number of things we are doing from a comprehensive understanding of what it is that our staff really want in the work setting and understanding why it is they're motivated to look at opportunities with travel nursing agencies. I think she outlined very well that it is flexibility, and it is more lucrative.

However, to the points made earlier by Ms. Leblanc, there's opportunity for us to do things differently with flexibility in scheduling. I think health care as an industry has been incredibly impacted by COVID-19. We all know that. Folks are tired. If there were

ever a time for us to look at models of care and skill mix within teams, it certainly is now. We have a huge openness by our teams to think differently about how they work and how they work together.

[10:00 a.m.]

For us right now, it's to understand what it is they want in the environment, so that if they're choosing to leave, how can we change the circumstances and the conditions of employment to make it so that they make the choice to stay with us. As Ms. McCormick mentioned, sometimes it's as simple as saying, maybe your 1.0 full-time position, if it was 0.75 or 0.8, would give you the flex to say, if you don't want to work that fifth shift, you don't have to. It's up to you. Or you can pick it up.

I think that's the flexibility that they've been afforded by way of these external travel agency-like environments - they can pick and choose. So we have to be more open to giving them opportunities to think differently about how we schedule. That's certainly a major area of focus for us.

THE CHAIR: Ms. McCormick.

BETHANY MCCORMICK: I think another important support that we're offering is through our Interprofessional Practice & Learning team. We have a very sophisticated and comprehensive training and learning support network within the Nova Scotia Health Authority, where we have practice leaders and clinical nurse educators and training programs available to staff. That's both to enhance their competency as they're entering the emergency department if they're a newer nurse, for example, but also to continue to advance skills of those who are perhaps a little bit later in their career.

This also allows them the opportunity to offer mentorship to new graduates or to new nurses coming into the emergency department as well. As you move into the later years of your career, sometimes you get that real joy and passion back by teaching others. So we have that available.

Also, the team-based approach in emergency care is very important. We have examples of pharmacists working side-by-side with the nursing team to do that medication management and offer their expertise. As Dr. Munroe said, if we can free up the nurses and we can free up the doctors to do the important work that only they can do by building the team out around them, that's very key. Things like ensuring we have ward clerks around the clock, environmental services on every hour, that you have aides who get the supplies so that the nursing staff and the physician staff's time is completely optimized. That does contribute to a better overall work environment for that team.

THE CHAIR: Mr. MacDonald, you have 10 minutes left.

JOHN A. MACDONALD: Thank you very much for that. I know a lot of nurses. My fiancée's a nurse at the IWK, and I know that those things - I'm sure all of them are enjoying it.

You mentioned going from 1.0 to 0.7 on flexibility. Is that something that's new, or is that something that's been around for a bit, or is it we're trying to find people's work-life balance?

I'm just looking at Ms. MacGibbon. I'm not sure if she's answering or not.

EILEEN MACGIBBON: A good question. I think if the position existed as part of the complement of staffing, I think staff knew that they could seek or pursue those kinds of reduced hours.

What we want to do is be more open about the flexibility we want to have, with maybe taking a 1.0 position and changing it to meet what might be the needs of the team, to say, do we have people who would be more interested in working fewer hours? How can create a complement of staff who would support the needs of the area, but also give the staff the types of arrangements with us with hours that work better for them and keep them employed with us versus leaving to gain that somewhere else?

I think it's always been a potential, but now we're trying to increase awareness with the potential for us to move more in that direction than we have in the past.

JOHN A. MACDONALD: I just have two more questions on that, then I'll turn it over to the MLA for Kings West. I look at the opposite, which is a 0.7 going to a 1.0, because you mentioned one.

The second question - and I'll just get them both to you - is: When nurses and physicians leave, do we do exit interviews to ensure we know this is why? I shouldn't say we - you. I'm not in. Does the department do exit interviews to get an idea of, here are some things that they've identified when they left to actually improve it?

THE CHAIR: Ms. MacGibbon.

EILEEN MACGIBBON: I think exit interviews were always, in any industry, a typical practice to understand the reasons for leaving. What we've shifted toward are stay interviews to understand current-state assessment information from our staff to understand what's working and what might not be, so that we don't get to a place where we're having an exit interview because they've made a decision to leave.

Stay interviews are actually more important and give us more of an understanding of the areas we may need to be augmenting or changing in any way to support staff

members choosing to stay with Nova Scotia Health Authority versus finding something else.

JOHN A. MACDONALD: I do have one last question, which I forgot. There's a new program called PatientTrak, which provides emergency department staff with real-time access to patient information. Can you talk about how you got to the decision of what this will mean for health care workers who are using it?

THE CHAIR: Dr. Munroe.

TANYA MUNROE: As an end-user of PatientTrak, I'm probably the best one to speak to that one. PatientTrak came around in 2012, when the Colchester East Hants Health Centre first opened. It was one of our local IT individuals who recognized that the days of the Sharpie and whiteboard needed to be long behind us. We've had it for about 10 years at that site. It's now rolled out across the regionals.

What it does is it enables you in real time to see who the patients in your department are, who the patients in your EHS hallway are, who the patients in your waiting room are, what their presenting complaints are, and what their triage score is - so how sick they are. It also tells you how long they have been there. It tells you who the nurse assigned to their care is or the paramedic or the other care provider, and who the physician is.

When I come in and start my shift, the first thing I do is look at the board. I look in the waiting room, and try to strategize how I'm going to approach my shift so I can get to the sickest first. When I've started my work and I've ordered investigations or treatments, the nurses then have a mechanism to flag when an investigation has returned, whether they need new orders, or if they need me for something.

We can also put in all the necessary symbols that tell you if a patient has infection control issues - very important in the triple threat of RSV, COVID-19 and the flu. (Interruption)

THE CHAIR: Sorry, it's my timer. You haven't done 20 minutes. I was trying to change it so it wouldn't be so annoying and interrupting. My apologies. (Laughter) Please continue, Dr. Munroe.

TANYA MUNROE: The long and short of it is that PatientTrak is a huge improvement. It's very helpful to me and all the providers I work with. Sometimes when we do have nurses who come from a nursing travel agency, they may not even know who Dr. Munroe is. So it enables them to find the physician faster, track me down if I haven't noticed that in 10 minutes - if they've wanted me, they've flicked it to reassess and it starts to blink. If you're someone who has a limited attention span, lights blinking at you, that tends to grab you.

This has been spread across all of the regional sites. It's a bridging to the OPOR. It's very useful in the moment to try and gain any efficiencies within the department.

THE CHAIR: Mr. Palmer.

CHRIS PALMER: Thank you all for being here. It's a great conversation to have around government investment and how we're helping to alleviate pressures on ERs. I represent a constituency in Kings West where many of my constituents from Aylesford, Kingston, and Greenwood would access Soldiers Memorial Hospital in Middleton. Recently, there was a $1.7 million investment in substance abuse and addictions recovery support centres. One of those centres recently opened at Soldiers Memorial.

My question would be to the deputy minister or anybody who would like to answer. Could you speak about how this investment and the new centres like the one at Soldiers Memorial will benefit emergency departments and help support care in those departments, and how those would benefit the staff there?

THE CHAIR: Deputy Minister Lagassé.

JEANNINE LAGASSÉ: I'm actually going to ask Ms. McCormick to take that question, Mr. Palmer, because she's also the vice president responsible for Mental Health and Addictions.

BETHANY MCCORMICK: The recovery support centres are a new innovative model to provide addictions medicine care to individuals who need that support. It combines a variety of different techniques and strategies that bridge the continuum of care for that individual, providing them the right level of care for their need. It could be coming in during a day visit and having support from groups and clinical therapists, as well as pharmaceutical adjustments, and in some cases, they do have the availability for an overnight stay if they do need that as well.

There are a number of these recovery support centres across the province, and they are continuing to scale up and provide support. It's really about matching the need of the care to the patient. It's a leading evidence-based practice, and we're really excited to have that growing in the province.

CHRIS PALMER: I'm not sure who this next question would be for, but, I guess, Mr. Coates or the deputy minister. Ensuring people have the care they need before they end up in a situation where they need to get to the ER is very important as well. Can you discuss what the government's been doing? Any investments to address health promotion, and maybe ensuring people are more proactive as opposed to reactive as an approach to health? I'm wondering if there's anybody that could speak to that?

JEANNINE LAGASSÉ: Our Public Health folks, both in the department and at the NSHA work very closely together on all promotion problems. In Action for Health, Solution 6, is about, really, our community wellness solution. Through Action for Health and that solution, there will be considerable work being done on community wellness frameworks, asset mapping in communities to determine what is already out there, working with community-based organizations on granting and other programs for health promotion. So, a number of different ways that we're going to be working through Action for Health on health promotion.

CHRIS PALMER: I represent a community with CFB Greenwood, the base there, and I was just wondering: is there collaboration or communication with health practitioners in areas like that to potentially work with our system to help at all?

ERIC COATES: We do partner with the Department of Defence - so, the Cobequid example with the physician assistants that Ms. MacGibbon mentioned, they were employees of the Department of Defence. It was actually an initiative to help keep their skills up when they're not deployed and actively seeing patients. It gives them the opportunity to stay fresh and current and see patients, and, as well for years in emergency departments, at least in Central Zone where I'm familiar, we've had nursing staff come support our teams. They're usually very skilled, and it's a very strong partnership that we really appreciate.

THE CHAIR: Order, order. The time for the PC questioning has elapsed. We'll now move on to the second round. Each caucus will have five minutes. Mr. Maguire, you have until 10:19 a.m.

BRENDAN MAGUIRE: With the limited time, again, I ask just for direct answers. How many people have left an ER without being seen this year?

JEANNINE LAGASSÉ: The last statistics that I have were for '21/'22, and in that year, there were 43,142 patients that visited EDs that left without being seen. There were a total of 536,666 visits in total to EDs across the province that same year, so approximately 8 per cent leaving without being seen.

BRENDAN MAGUIRE: We've talked a lot here today about working with other provinces across Canada. We know in other provinces and across Canada that the high-dose flu shots for seniors are covered, but in Nova Scotia they're not. Why?

JEANNINE LAGASSÉ: That's an item that's currently under consideration. They are covered for seniors who live in congregate-living settings, so it's not that it's not at all covered. It is covered in that. It's just not covered out in the community at this point in time.

[10:15 a.m.]

BRENDAN MAGUIRE: Again, another question about things that are happening across Canada but are not happening here in Nova Scotia. First of all, how many unvaccinated health care workers are not working right now? Why are other provinces and the federal government allowing them back to work and Nova Scotia is not?

JEANNINE LAGASSÉ: I know that out of the approximately 25,000 employees that NSHA would have - at NSHA alone - it's a very small number. I do not have that exact number here.

I can tell you that the policy is not currently under reconsideration. The policy stands that unvaccinated health care workers are not - and it's not just health care workers. It's in other high-risk settings as well. The policy applies to other high-risk settings.

BRENDAN MAGUIRE: When will we see the Baddeck ER reopen?

THE CHAIR: Ms. McCormick.

BETHANY MCCORMICK: I know from my colleague in the Eastern Zone that it's currently operating as the urgent treatment centre. They are working as quickly as they can to operationally realign it to be back open as a full level four ED. They're working quickly on that. The precise timeline is not known, but as soon as operationally feasible, it will be reopened as a level four emergency department.

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

BRENDAN MAGUIRE: When can we see the full redevelopment of the QEII hospital, which we know will attract and recruit new doctors and new health care professionals? When can we expect that project to come back online, and when can we expect it to be completed?

JEANNINE LAGASSÉ: I know that our colleagues were here within the last couple of weeks to talk about that project. Today I can tell you that you can expect probably to get further information shortly, but I do not have a further update from the last time colleagues were here.

BRENDAN MAGUIRE: I want to thank all of you for being here today. I know some of these questions aren't the easiest, but I appreciate you being here to answer them.

Obviously, the IWK situation is very pressing. Influenza season is here. We haven't yet reached the peak seasonal flu and respiratory season. How confident are you - because Dr. Lynk was not very confident, and neither was Dr. Strang - that the system can handle more patients than are already there, and that it will be able to accommodate those people?

EILEEN MACGIBBON: Thank you, Mr. Maguire. We're all concerned. I think across the system we're concerned, because we're seeing unprecedented levels, as the deputy minister has mentioned, with respect to demands on the system.

I will say that the IWK, as has been mentioned earlier, and Nova Scotia Health Authority have been extremely successful with recent clinics we've done to be responsive and . . .

THE CHAIR: Order. Time for the Liberal questioning has elapsed. We'll now move on to the NDP for five minutes. Ms. Hansen.

SUZY HANSEN: Thank you, Madam Chair. I just have a few points first before I get into my questions. I want to say that I'm really appreciative of each and every one of you here, especially as we are in a crisis time with our health care, and I know that time is valuable. I truly appreciate the work that you do and the folks who are the ground doing that work.

I also want to make a few points. First and foremost, I'm so glad that the government has taken on our idea of physician assistants. We've only been talking about this for three years. Truly grateful to see that that idea is now offsetting the wait times and, as well, doing the work that needs to be done to kind of alleviate some of those pressures. Appreciative of that.

I also want to say that what I'm hearing, because I've been listening, is that the government side is talking about their own investments. We have heard them many times in the House. I'm really grateful that you guys were able to give us that information, but we do have that information. We know that you guys are all working very hard to do that work. It's really kind of interesting to hear that, because our focus is on health care and emergency care right now.

I know most if not all health care workers are trained in crisis and pivoting to be able to adapt to that particular crisis. We know that this particular crisis is threefold now because of the viruses that are at play, but I'm wondering why it's taking us quite a bit of a time to really get to where we need to get to, considering the fact that we've just been through COVID-19 and all these things. I'm not an expert, but I just want to bring that up because I understand that our health care workers are going through so much because they're tired and overworked.

I just wanted to make a point of that because this is a hard job. By no means is health care an easy job, but we need them here, which is why it's so important for us to talk about retention.

A recent report from Statistics Canada found that 17.9 per cent of all health care workers were intending to leave their current job in the next three years. This number is

even higher among nurses - one in four. We talked about the encouragement and retention and the recruitment and such. When we talked about hiring travel nurses and the amount of money that we're putting out there for travel nurses - and I heard working with flexible hours and matching the work-life balance - are we matching those wages as well so we that we can continue to keep these nurses and the other physicians here to make sure that we don't lose them because of other competitive wages?

THE CHAIR: Deputy Minister Lagassé.

JEANNINE LAGASSÉ: I'm sure you're aware that the contract with the nurses is currently expired, so both government and the Nova Scotia Nurses' Union are obviously clearly committed to the bargaining process, and we are open to new ways of doing things. Wages is one aspect of it, but we are also wanting to look at new ways of doing things and ensuring that we're meeting all of the things that my colleagues have spoken about today and ensuring that we are meeting what nurses really need to be able to keep them in the workforce.

Wages are one part of it, but we think that there are a number of other things outside of collective bargaining that we may be able to do as well.

THE CHAIR: Ms. Hansen, you have a minute and a half.

SUZY HANSEN: Last Fall, the Premier reported that all nurses graduating from Nova Scotia universities and the Nova Scotia Community College for the next five years will be offered a job in the province. Can you provide an update on how many 2022 graduates have now been offered a job in the province?

THE CHAIR: Ms. Penney.

TANYA PENNEY: So 2022, from a December perspective - if you think about how nurses graduate in the province, they typically graduate in the Spring and then they graduate again in the Fall. I have the Fall numbers with me today. I can certainly get the Spring numbers for you as well.

The Fall cohort is much smaller than the Spring cohort. As it stands right now, in the last year, all 40 graduates from St. Francis Xavier University in December of 2021 were offered and given jobs and were successful. In December of 2022, just 11, but that was actually 80 per cent of the class. Smaller cohort numbers in the Fall.

THE CHAIR: Ms. Hansen, you have 35 seconds.

SUZY HANSEN: Could you clarify that? Accepted or offered?

TAYNYA PENNEY: Both.

SUZY HANSEN: This could be to Ms. MacGibbon or Ms. McCormick. The Nova Scotia Health Authority has reportedly been offering signing bonuses of up to $10,000 to recruit health care workers. Can you report on the results of this project, and has there been any feedback from physicians on the amount of bonuses compared to other jurisdictions?

THE CHAIR: Order, the time for the NDP questioning has elapsed. We will now go over to Mr. Taggart.

TOM TAGGART: I wish I had an hour. I just want to make a quick comment before I ask my question. Very thrilled to have folks here from the Northern Region. Unfortunately, I spent a significant amount of time in the emergency room at the Colchester East Hants Health Centre in the last month. As much as it's a frustrating experience for both those in the waiting room and those behind the curtain, so to speak, I watched this virtual care thing roll out and the way it took patients out of the emergency room. I just wanted to make that comment.

My question here is for Ms. McCormick. I think we all recognize one of the biggest challenges impacting emergency rooms is the challenge we face with respect to primary care physicians in the community. That's very prevalent in rural Nova Scotia. Before being elected as an MLA, I was deeply involved with health care in my community, having served as Chair of the West Colchester Medical Society. I'm very pleased to see some of the progress that has been made over the past year in my constituency. I know a lot of work has been done. Most of it's not that visible, but it's happening behind the scenes.

I'm wondering if Ms. McCormick can identify some of the changes that we're seeing in the northern region - specifically how we're setting up our area for future success.

BETHANY MCCORMICK: Investing in our primary health care system and our teams who provide primary care to individuals in our community is very important in the Northern Zone. We have been taking various approaches, with feedback from the physicians, nurse practitioners and teams to build really new and innovative spaces where providers like to come into work. It's what's called a turnkey model. The physician is able to come into a space, have their clinic, and provide the care without having to necessarily take on the setup of the building and the business aspect of it, but they really are focused in on that client care, patient care.

Another very interesting and fruitful approach is that we have a hub and spoke model where there's a primary clinic in perhaps a more populated area where health care providers are based. The team is based in this hub where they provide care, and then they outreach to smaller communities that are perhaps more rural or have less of a demand. They may go out for a day or two throughout the week with either the nurse practitioner or the physician, or both, to provide outreach.

We currently do that from Parrsboro to Advocate Harbour. We're looking at doing that at a number of other areas in the zone to make sure that we have the right resources in the right place, and really are maximizing the number of patients and families we can see on any given day. That hub and spoke model, the team model, and collaborative care practices that are ready to go for those physicians who want to come are some of the things we're doing.

TOM TAGGART: I wonder if you're able to expand more on that collaborative care model and how it will be successful in rural Nova Scotia, please.

BETHANY MCCORMICK: Primary care collaborative teams are an approach to care that includes physicians, nurse practitioners, family practice nurses, sometimes dieticians, social workers, physiotherapists, and other providers. What this does is wrap a team of professionals around the patient and family to really ensure that their needs are being met by the right professional. It also allows the family or the patient to have a connection with a series of professionals in that clinic.

Perhaps the physician isn't available on that given day, but their need is appropriate to start with the nurse. They would be able to access somebody that's familiar with them, familiar with their family history, and it's a relationship that's already established with that team.

Providers also find it very supportive in that they have a community of practice, and other team members who can support them to really optimize their delivery of care. It's being seen across the country, and certainly in Nova Scotia, as a highly successful model.

THE CHAIR: We have 20 seconds left, Mr. Taggart.

TOM TAGGART: I just want to make further that comment a little bit, if I could. I've actually worked with Ms. McCormick and others in the northern region to solve our problems. I think one of the challenges with bringing primary care physicians to rural areas is they don't want to work by themselves. They . . .

THE CHAIR: Order, the time for questioning by the PC caucus has elapsed. I want to thank everyone for appearing today. We know that you're very busy right now. We do appreciate you taking time to appear before the committee. There are a number of questions we didn't have answers - Mr. Maguire.

BRENDAN MAGUIRE: Thank you, Madam Chair. I don't mean to interrupt, but I think this was kind of on par with what you're going to say. We've had discussions over the last month about the way this committee should work and the role of the Chair. There were 15 questions put to the witnesses that were not answered - 15 questions. That might be an all-time record here.

[10:30 a.m.]

We've spoken as a committee that when witnesses do not have the answers and, we'll say, are unprepared to answer those questions, that it's within the purview of the Chair to request that they come back. What I will say about today's meeting is we did request that Ms. Oldfield be here today, and unfortunately, Ms. Oldfield is not here. We have two members from the Nova Scotia Health Authority who did a great job, but ultimately the questions that we put forward should be answered by Ms. Oldfield. We had 15 questions today that we were told they don't have the answers to.

I'm requesting that you, as the Chair, ask that the witnesses reappear, along with Ms. Oldfield, as the soonest possible date for Public Accounts Committee. Maybe we could push off one of the Auditor General's hour-long review of topics and have them reappear. I think it does a disservice to this committee and it does a disservice to Nova Scotians, especially on health care, which is the single-most expense in the province, that we have witnesses here who can't answer some of the simplest questions.

The motion on the floor will be, in the spirit of co-operation - we talked about this as a committee - that when witnesses appear before the committee who are unprepared and can't answer questions, we are to bring them back, and it's up to the Chair to do that.

I think the Chair can rule outside of a motion, so I'm asking that these witnesses appear at the soonest possible date that the committee has to come back and answer these questions.

THE CHAIR: Thank you, Mr. Maguire. Mr. Young.

NOLAN YOUNG: Just with respect to how this committee typically functions, at times when the witnesses are unable to have an answer or have the material ready for them at the time, in the past we've submitted a request to have some information submitted forward.

The topic today was impact of government expenses on ER understaffing. Perhaps some of those questions may have not been in the purview of the topic today.

I would state just that the function of the committee has been, when we haven't had all the information provided, that the Chair would follow up with the witnesses to gather the information to share with the committee. I would expect normal practice to be followed.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: Again I will say, if you think that normal practice is witnesses not being able to answer 15 questions in regard to the IWK emergency room and the QEII emergency room, then you are woefully wrong.

We've had these conversations, and the government side has asked this side of the House to trust them in these changes, and now we're doing a complete 180. Part of the discussions that we had were with the Auditor General and with the government, who agreed that when witnesses did not come prepared or have the answers to questions, we would call them back.

And now, at the first opportunity, when 15 questions went unanswered, the government is now going to vote against it and you expect us to trust that these motions - the changes that you want to make to this committee? We're asking you to stand by your word that we will be able to call witnesses back.

In fact - maybe we can have Mr. Hebb look into it - I don't even think we need a motion. I think it's up to the Chair - that's what we heard in training. It's solely up to the Chair to be able to recall them. I ask that the Chair look into it.

THE CHAIR: Thank you. So in the past, what we have seen is that we have sent a letter and we have expected responses. We're in the process of changing over to something new, so this is what I'll say. We have a number of questions, many of which were not answered here today. We want answers by the end of the week. If we don't get answers by the end of the week, we will recall the witnesses.

We have to ensure that when witnesses come before us, they can answer questions and that we get them in a timely fashion, so I'm going to write a letter outlining all of the questions that weren't answered, and then we will take our actions from there. This is a shot across the bow. I'm not having any more discussion. We have a whole lot of business to get to. We're going to move on.

Thank you very much to our witnesses. We really appreciate you coming out today and sharing everything with us that you did.

We are now going to move into committee business, which we have a lot of. Up first is the road map motion. Members have been provided with a proposed road map to build a more effective PAC culture in Nova Scotia. I'd like to open the floor for discussion on the proposed roadmap. Any further discussion on the proposed roadmap? Would anyone like to make a motion on the roadmap?

NOLAN YOUNG: I'm quite pleased with the work that the Auditor General had put within this road map, very pleased. I'm very pleased with the co-operation, collaboration and the training sessions that we've had as a team, as a functional PAC committee in some of the training.

We are in support of this roadmap. This is something that our party would support. If someone's willing to make a motion, we would happily support it.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: Maybe for people here today, the Auditor General can read the motion - or she could read the road map and specifics of it so people know.

I will say that the very first test that we put it to, it failed. It may not have passed, but this is exactly what I was concerned would happen, and talked to the Auditor General and staff about. The reasoning behind this today from the members opposite was, well, the normal procedure is to ask for these questions and get the response. We know that we've asked for responses from Ms. Oldfield and we're still waiting over a month.

THE CHAIR: No, it was there.

BRENDAN MAGUIRE: It's in the package. So we had to wait a considerable amount of time. You're asking that we put our faith in the government's hand that everything they've asked to change on this Public Accounts Committee favours government, and yet they think it's acceptable that 15 questions went unanswered today. This was exactly what I was concerned and worried about - that we'd go down this road.

We heard the questions today from the government. They weren't exactly probing questions. They were pretty government-friendly questions which, again, was something we were told they would stop doing.

The motion's going to go. I'm also concerned that we're not going to be able to bring topics in a timely manner. I'm not going to filibust - we're going to have this vote. But I was elected to, and I'm on this committee to bring forward concerns that come forward from the public.

While I agree that some of these issues are important - they're all important - there are pressing issues. They are pressing issues right now to Nova Scotians, including climate change, carbon tax - which the Auditor General is doing something on - but also inflation, housing, all these different issues. I would argue that the QEII redevelopment, things like that - we're just not going to be able to bring them forward in a timely manner.

That's one of the concerns that I have. For the many years this committee has existed, including the nine years that I've been on it, we've been able to effectively debate topics in camera and bring forward a list of topics. Now, over the last year, we're being told that is not an effective way to bring forward topics. Those are my concerns. I'd like to register them on the record that I think we were elected to do a job, and part of that job is this committee.

THE CHAIR: Thank you, Mr. Maguire. Any further discussion? Would anyone like to make a motion regarding the proposed road map?

BRENDAN MAGUIRE: Can we get her to read the road map as requested?

THE CHAIR: Do you mean the Step 1? You don't want the whole thing read out into the record, do you? That would take forever, and we have a fair amount of business. Ms. Leblanc.

SUSAN LEBLANC: I'm not ready to make a motion on this, and I don't know if anyone else is today. I'm wondering if we could defer this to another meeting.

THE CHAIR: If it's the will of the committee, if there's no consensus on this. Mr. Young.

NOLAN YOUNG: We had countless informal discussions. We had countless training discussions. I think I've heard from every member on this committee - their intent and their feelings toward this independent road map.

It's not something that the PC Party is driving. This is something that's coming from not only the independence of the Auditor General but the CCPAC, the CAAF, and these are some of the best practices that are across the country and the world. With respect, I'd just like to hear from some of the other members of the committee to see. We've talked about these things in the past just to see where we stand.

THE CHAIR: I am going to put a time limit on this simply because we have other committee business that we actually have to attend to, that has a time limit on it. Ms. Leblanc.

SUSAN LEBLANC: The NDP caucus is in support of this road map. We want to support it. We are not putting the motion on the table. The government has the majority on this committee, and we hope that the government, if they are in support of this motion, will make a motion.

THE CHAIR: Mr. Young.

NOLAN YOUNG: Just curious on where the Liberal caucus stands. I know as the Chair, you don't normally engage in debate or Mr. Maguire, but through some of the informal conversations and whatnot in the past, it seemed to be that there'd be consensus amongst everyone. I'd just like to hear from our Liberal colleagues, perhaps.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: I think I've said enough.

THE CHAIR: Mr. Taggart.

TOM TAGGART: It sounds like we're in one of those gotcha moments that we thought we weren't going to do. There you go. I'll be frank, the idea here is that you want us to make the motion so the media can say that the PCs did their thing and they blocked this, and they blocked that. If we want to go back - I haven't been here, I'm new to the committee, but if that's what we're going to do, that's what we're going to do. It's just disappointing, that's all I can say.

THE CHAIR: Mr. Taggart, I assure you, I will not say that. Mr. Maguire.

BRENDAN MAGUIRE: I think I've been very clear. We're talking about gotcha moments - this is why you're asking me to say what I can say, so you can put it on Twitter with whatever. I'll be very clear so there's no misinterpretation of how I feel. I am not in favour of this. Everybody get on their phones and tweet that out. I'm not in favour of this, and people can say whatever they want. I'm not in favour of this. I've been very clear from day one, so nobody needs to act surprised across there. I've been very clear. I'm not surprised because I put it to the test today. You failed. (Interruption) I'm talking.

I put it to the test today on the questions, and it was a failure, and second of all, I'm not comfortable. I don't think anyone should be comfortable with giving up topics that people in Nova Scotia bring to us. It's important that we're able to bring topics in a timely manner. If we want to talk about the redevelopment of the QEII, we shouldn't have to wait two or three years to when it's not a pressing topic and we're $1 billion or $2 billion over budget. We should be able to bring those things forward in a timely manner.

I've been very clear on this. Public Accounts Committee has always worked topics. I know it's not easy, I know it's difficult to not always get your way, but that's what in camera is for. We're frank with each other . . .

THE CHAIR: Order. I think we understand where . . .

BRENDAN MAGUIRE: I'm not finished.

THE CHAIR: We're moving on to another topic. The time has elapsed. I was very clear that we are not spending the whole half hour on this particular issue. We're going to set it aside and move on to witnesses for the 2022 financial report of the Auditor General.

We'll be meeting with the Auditor General on December 7th regarding the annual financial report. The next week, December 14th, the witness suggested to appear by the Auditor General is the Department of Finance and Treasury Board, which the committee has not yet approved.

I am looking for a motion to approve the Department of Finance and Treasury Board as the witness in relation to the 2022 Financial Report of the Auditor General. Mr. MacDonald.

[10:45 a.m.]

JOHN A. MACDONALD: I move that the witness be the Department of Finance and Treasury Board.

THE CHAIR: Thank you, Mr. MacDonald. Any discussion?

All those in favour? Contrary minded? Thank you.

The motion is carried.

Endorsement of the Auditor General's recommendations from the Immigration and Population Growth Report. The committee's practice is to endorse the recommendations made by the Auditor General. This is the committee's first public meeting since the Immigration and Population Growth Report was tabled where the committee can do so, so I'm looking for a motion to endorse the recommendations. Mr. Young.

NOLAN YOUNG: I move that the Public Accounts Committee formally accept and endorse recommendations contained in the 2022 Report of the Auditor General, Immigration and Population Growth, that have been accepted by the audited departments or agencies and ask that those departments and agencies commit to and take responsibility for full and timely implementation of the recommendations accepted by those departments.

THE CHAIR: Any discussion?

All those in favour? Contrary minded? Thank you.

The motion is carried.

The 2022 annual report was circulated to members previously - I think about a month ago. It's now ready to be approved, so I'm asking for a motion to approve the 2022 Annual Report for the Standing Committee on Public Accounts. Mr. MacDonald.

JOHN A. MACDONALD: I move that we approve the 2022 annual report.

THE CHAIR: Thank you. Any discussion?

All those in favour? Contrary minded? Thank you.

The motion is carried.

Now we move on to the meeting schedule for December and January. The committee schedule for the upcoming holidays, et cetera, should be decided. Typically, the committee doesn't meet the week before Christmas, the week of Christmas, and the first

week of January. That would be no meetings on December 21st, 28th, and January 4th, and then the first meeting in the new year would be January 11th.

Is it agreed?

It is agreed.

We're all good, so no meetings December 21st, 28th, and January 4th. Our first meeting back after Christmas would be January 11th. Mr. Young.

NOLAN YOUNG: Madam Chair, I'd ask for a four-minute recess.

THE CHAIR: Okay, thank you. Four meeting recess.

[10:48 a.m. The committee recessed.]

[10:52 a.m. The committee reconvened.]

THE CHAIR: Order, I now call the committee back to order. Couldn't figure out what was going on there. We do have some correspondence here. The Nova Scotia Gaming Corporation, information requested from the October 12, 2022 meeting. There was also information from the Department of Education and Early Childhood Development from the October 26th meeting, Nova Scotia Health Authority information requested from the October 5, 2022 meeting, and the Department of Communities, Culture, Tourism and Heritage information requested from the September 7, 2022 meeting. Any discussion on any of the correspondence?

I do have a problem with this in the response from the Nova Scotia Health Authority, "The Healthcare Redevelopment in Nova Scotia website is managed by Communications Nova Scotia and questions should be directed to them." I do feel that we have no knowledge of whether they've actually sent anything there, so I do think that I probably need to write to Ms. Oldfield and request further information about her response there. I will do that.

Any other discussion on any of the correspondence? Ms. Leblanc.

SUSAN LEBLANC: In the letter, she refers to an attachment, the table of meetings, but I don't see the table of meetings attachment. (Interruption) Okay.

THE CHAIR: Oh, it may not have been printed. I think - was it sent out to people? We're not sure, but we will make sure that attachment gets sent out to you. If there are any questions that arise from that attachment, please bring them up at our next meeting. We will accept those with the caveat around that first answer from the November 4th letter from the Nova Scotia Health Authority.

Our next meeting date is November 30th. The Department of Labour, Skills and Immigration and the Immigrant Services Association of Nova Scotia will be in on the 2022 Report of the Auditor General, Immigration and Population Growth, just so everyone knows.

Is there any further business?

All right. I will now adjourn the meeting.

[The committee adjourned at 10:54 a.m.]