HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, May 22, 2024

COMMITTEE ROOM

Health Infrastructure Projects

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Public Accounts Committee

Lorelei Nicoll (Chair)
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Susan Leblanc
Lisa Lachance
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[Danielle Barkhouse was replaced by Hon. Trevor Boudreau.]
[Melissa Sheehy-Richard was replaced by Hon. Steve Craig.]

In Attendance:

Kim Langille
Committee Clerk

Sherri Mitchell
Administrative Support Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dana MacKenzie - Deputy Minister

Colin Stevenson - Chief, System Integration

Derek Spinney - Vice President, Corporate Services, Infrastructure & CFO, Nova Scotia Health

Department of Public Works

Peter Hackett - Deputy Minister

Gerard Jessome - Chief Executive of Engineering, Building Infrastructure

Tonya McLellan - Executive Director

Build Nova Scotia

David Benoit - President & CEO

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, MAY 22, 2024

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIR
Lorelei Nicoll

VICE CHAIR
Danielle Barkhouse

THE CHAIR: Good morning. I call the meeting to order. I am Lorelei Nicoll. I'm the Chair, and this is the Standing Committee on Public Accounts. I'll remind everyone to have your phones on silent, and I'll ask the committee members to introduce themselves, starting to my left.

[The committee members introduced themselves.]

THE CHAIR: To my left we have the member from Counsel.

[The Legislative Counsel introduced himself.]

THE CHAIR: To my right.

[The committee clerk introduced herself.]

THE CHAIR: I also note that sitting in the corner is the Auditor General's Office. I welcome you as well. On today's agenda, we have officials with us from the Department of Health and Wellness, the Department of Public Works, and Build Nova Scotia with respect to Health Infrastructure Projects.

I'll ask the witnesses to introduce themselves, starting to the left.

[The witnesses introduced themselves.]

THE CHAIR: Welcome. I will now invite Deputy Minister MacKenzie to give some opening remarks.

DANA MACKENZIE: Thank you for the opportunity to be here today. Nova Scotia's health care system is complex and interconnected. Issues in one part of the system often have root causes in another. Action for Health is government's plan to address these issues in a comprehensive way.

Making sure we have the right infrastructure to deliver the services Nova Scotians need is integral to this plan. Replacing and renewing aging infrastructure not only improves patient outcomes and experiences, but it also helps attract and retain health care professionals.

The 2024-25 capital plan designates over $555 million dollars, over one-third of the Province's capital plan, 37.1 per cent to health infrastructure. These investments will see the expansion and renovation of emergency departments across the province. They will add more in-patient beds and operating rooms. This will improve our ability to respond to the surgical wait-list in a very positive way.

They will create dozens more dialysis stations. They will provide the most advanced tools and equipment available for our health care professionals, in many situations making us national leaders. They will provide modern, well-designed health care spaces for our health care workforce to deliver the high level of care they want to provide, and the care Nova Scotians expect and deserve.

Investments like these, combined with the efforts in recruitment and retention, are making Nova Scotia a destination of choice for health care providers. It gives them the right tools and spaces to deliver the best care possible to their patients. The capital plan also reflects the ongoing work and current phases of multi-stage, large-scale projects.

The Halifax Infirmary redevelopment is a generational project that will serve the province for decades to come. That project recently reached a major milestone with work on-site now under way. This project, along with the Cape Breton Regional Municipality Healthcare Redevelopment project, will see an investment of over $300 million dollars in 2024-25.

These two projects alone help to address infrastructure needs in two of our largest health care facilities in two of our most heavily populated areas. In addition, there is over $108 million for construction and renewal of other hospitals and medical facilities, including projects in Bridgewater, Pugwash, Yarmouth, Amherst, and the IWK Health Centre.

State-of-the-art facilities create environments that foster innovation that will keep Nova Scotia on the leading edge in health care for generations to come. This includes investing in digital infrastructure like One Person One Record. This year's capital plan sees over $53 million earmarked to advance this important work.

Nova Scotians expect the health care system to be responsive to their needs regardless of what door they walk through to access the care they need. Having access to a patient's records improves the care that can be provided, and allows the individual to make more informed decisions about their own health care journey. We believe the issues facing our health care system can be solved while providing a better, more convenient experience for patients and their loved ones.

Health care facilities are complicated and unique construction projects. They require the coordination of a wide range of expertise, working together towards a shared goal over many years. This is an exciting time for health care in our province, and the Province is committed to keeping Nova Scotians up to date with the latest progress on these important projects.

Thank you again for the opportunity to be here today to provide the latest information on this work. I will now pass it over to my colleagues for their opening remarks, and then I will be pleased to answer any questions you may have.

THE CHAIR: Thank you, Deputy Minister MacKenzie.

Now we'll go to Deputy Minister Hackett for his opening remarks.

PETER HACKETT: Good morning, everyone. As I said earlier, I'm Peter Hackett, Deputy Minister of Public Works. I'm joined here today by Gerard Jessome, our Chief Executive of Engineering For Building Infrastructure, and Tonya McLellan, our Executive Director of Building Infrastructure.

Building and maintaining provincial infrastructure is a core function of the Department of Public Works, and this, of course, includes managing some of Nova Scotia's many health care infrastructure projects. Building high-quality modern health care facilities is an important part of getting Nova Scotians access to the health care services they need.

My colleague Dave Benoit is here today to talk about the large health care infrastructure projects that Build Nova Scotia is responsible for, while the Department of Public Works team can speak to the projects they are involved in across the province. These projects include the new health centre at North Cumberland Memorial Hospital, which will open soon; the expansion and renovation of the emergency department, ambulatory care services, 12 new dialysis stations, and a new MRI for South Shore Regional Hospital; the new emergency department at the IWK Health Centre; the new MRI at Dartmouth General Hospital; and many more, which we can talk about today.

Health care projects are complex, and they take time to plan and build. To add to the complexity of these projects, our economy and economies around the world have experienced a major shift. We've seen significant inflation, labour shortages, and supply chain disruptions, which have created challenges. Health care projects aren't immune to these challenges, and we're working hard to find solutions to keep these projects moving forward.

Whether it is trying different approaches to tendering or rescoping a project, we will make sure that Nova Scotians have infrastructure that improves their access to health care and helps attract and retain health care professionals to this province. These projects are going to change the lives of Nova Scotians for years to come, and the Department of Public Works is proud of the work we do to make them a reality.

Thank you. I'll pass it along to my colleague Dave Benoit.

THE CHAIR: Thank you, Deputy Minister Hackett.

We'll go to Mr. Benoit, who is the president of Build Nova Scotia, for his opening remarks.

DAVID BENOIT: Good morning and thank you for the invitation and opportunity to be here today.

Chair, it is my privilege to speak with you and the committee about the work that is ongoing in Build Nova Scotia - the Healthcare Infrastructure division, specifically. This division is responsible for delivering the largest infrastructure projects in the history of Nova Scotia, overseeing the Cape Breton Regional Municipality Healthcare Redevelopment and the More, Faster: The Action for Health Build.

In short, we are the builder who is delivering integrated construction and operational capabilities and readiness. As a Crown corporation, we provide a service to our client departments and other Crown corporations, and as we complete each project, especially in health care, we turn the keys over to the owner, the Department of Health and Wellness, and the operator, the Nova Scotia Health Authority.

These projects are so much more than about bricks and mortar. The core function of Build Nova Scotia is to strategically transform our province's lands and properties, like the health care infrastructure, in ways that drive our economy forward and improve the quality of life for all Nova Scotians. We have a growing population and aging infrastructure.

As it relates to health care, the work we're doing will not only allow for better patient care and improved clinical outcomes for generations to come, but will also provide modern facilities, which will support the recruitment and the retention of health care professionals. As the builder, we acknowledge the realities of the construction industry. There are challenges, and we're focused on solutions to deliver against these challenges.

Our projects face supply chain issues, labour shortages, and inflation to name a few, as is common throughout the industry right now, across this country and around the globe. These major investments are not just happening here - they are happening everywhere. Projects of this scale, scope, and size always have unknowns. Minor delays are not uncommon, but we are working diligently and collaboratively every single day to address these pressures and unexpected arisings, maintain cost, and schedule so that of our projects continue to progress.

I'm grateful to have this opportunity to deliver for Nova Scotians, and I am fortunate to have a dedicated, talented, and solution-focused team with whom to work. I have tremendous praise for our passionate and dedicated team which, together with industry and the trade unions, is moving as quickly as it can so that Nova Scotians can have better care faster. Nova Scotians are counting on us. Thank you very much, and I look forward to your questions.

THE CHAIR: Thank you, Mr. Benoit. As is the custom, we will go to the Liberal caucus first for 20 minutes. MLA Clark.

BRAEDON CLARK: I wanted to start today with a few questions around the QEII Halifax Infirmary Expansion Project. I believe I'll direct these questions to you, Mr. Benoit. If someone else is better suited, please refer them to that person. We're going to cover some ground that we may have covered in some other meetings as well, but it's just been difficult for us in Opposition, I think, to get accurate information about what's going on with the project, so I'll ask a couple of things here.

I think a lot of people have questions around timeline obviously and cost of this project. As you said, Mr. Benoit, this is the biggest infrastructure project - not just health care, but infrastructure project - in the history of Nova Scotia. At this point in time, is there an updated timeline for the entire project so we can say in 2027 or 2028 or whatever it might be, we can put down our shovels and we're done with the QEII redevelopment? Does that date exist somewhere?

THE CHAIR: Mr. Benoit.

DAVID BENOIT: If you recall in December 2022, we took the decision that the single project delivery model wasn't going to be achievable inside the current environment. We ended up having to look at the most critical parts of the system and focus on those first and deliver it in what was referred to as waves - we're focused on Wave 1. Over the course of last year, we started the DPA in May 2023, which is when we expected to start it. Over the course of last fiscal year and into this fiscal year, we're continuing on the design and on evolving the costs that are associated with that design.

The other thing we wanted to get started, which we did in fiscal year 2023-24, was the enabling works. We've accomplished the two main objectives that we were looking at that we needed to accomplish over this period in order to keep this project on track and continue with its forward direction. We are pressing that. We expect this work to continue into this year and to conclude this year. Then we'll have all of the information that we need in order to make sure that we've got the right project at the right time. It will be schedule, scope, and cost.

BRAEDON CLARK: I understand that work has started. There's certainly a lot of activity on the site at the QEII Halifax Infirmary Expansion Project. I realize work has started, but what I'm most interested in at this point as well is when it's going to end. You touched on the wave concept last time - I think we were talking about public procurement a couple of months ago. I appreciate we've started Wave 1. How many waves will there be, and when will the last wave crest, if I can say that? When will the last wave finish? How many waves are there and when are we done if we know? If we don't know, that's good to know too, but I'd just like to know.

DAVID BENOIT: On the wave approach, one of the main reasons why we took that direction was being able to deliver all of the things that were promised as part of - I don't remember exactly in December 2022 everything but - the constituent parts. In order to deliver them, we needed to break them into waves. Wave 1 we focused on right away. The subsequent pieces of that puzzle were given to what is known as the Central Zone planning team. That's really important, because it really gets started - the process, not just of that particular build but of all of the needs that are required in Central Zone.

The planning work is actually not Build Nova Scotia work - that is work that DHW and NSHA are responsible for. That information or those additional requirements were passed over to Central Zone planning in order to start to figure out what the best way is to put them in an order that makes sense for the system and makes sense for the needs. The commitment was that everything that was going to be part of the original build will continue to be part of that delivery, just delivered in different waves. That work is ongoing now and it isn't just about the Halifax Infirmary. I have to stress that it's about all of Central Zone, what Central Zone needs are. They're working on that now.

[9:15 a.m.]

BRAEDON CLARK: Based on that, perhaps then I'll ask a question to Deputy Minister MacKenzie or Mr. Spinney - if the first wave of the project here is under way, as we know, and Build Nova Scotia is leading through that, based on what Mr. Benoit was saying, it sounds as though through the Central Zone planning team, the subsequent waves are being planned at this point in time through DHW and NSHA. So I'll ask Deputy Minister MacKenzie, then: How many waves are there beyond Wave 1 and when will they be complete? Do we know that from the planning team at this point?

DANA MACKENZIE: I'm just going to take a moment to confirm my answer. In the interests of trying to be as clear as possible, MLA Clark, the reference to the Central Zone Master Plan - and I'll have Mr. Spinney correct me or edit or add where he feels appropriate - the current contemplation with respect to Central Zone planning, which is that complementary piece to the waves that are happening and part of it, the development of the Master Plan will be completed in two components.

Component 1 is expected to be completed in January 2025. It will include the Dartmouth General Hospital, Cobequid Community Health Centre, and the existing Nova Scotia Hospital mental health and addictions campus. That part of the Master Plan we're hoping to have completed by January 2025. Component 2, expected to be completed by the next year, January 2026, will include the QEII Health Sciences Centre, the cancer care facility, the Mackenzie lab building, NSHA Rehab and Arthritis Centre, Halifax Infirmary and Maritime Heart Centre.

The Central Zone planning is conceived of as being completed in two different components, the 1 and 2, with the January 2025 and then the January 2026, to look at those pieces in that sequential way. Mr. Spinney, if you have anything to add there, I'd welcome him to do so.

THE CHAIR: Mr. Spinney, do you have anything to add?

DEREK SPINNEY: I think that there are maybe a few parts here. There is the expansion that's currently going on at the Halifax Infirmary, and that early work has started. That's the construction that we're all seeing, thankfully. That particular project has started. That's the early work that we've talked about. That final contract isn't finalized yet with the vendor. When are those tractors going to go home and the first patient go in to the new 216 beds, the 16 operating rooms, the expanded emergency department? I don't think that there's a date for that at this point, if that's your question. That's logical given that the final contract isn't signed. Until that's done, it would be hard-pressed for either party, I think, to determine that.

In addition to that, going back to the December 2022 More, Faster plan, there were two other parts of that that require master planning. That's the Phase 1 and the Phase 2 that

Deputy Minister MacKenzie just talked about, and that Phase 1 master planning is due to be delivered in January of this coming year, 2025. That will address Dartmouth General Hospital, Cobequid Community Health Centre, and mental health. Then the second phase of that, which includes the lab at the Victoria General, and the other components that the deputy minister mentioned, would be following a year after, so January 2026.

BRAEDON CLARK: Sorry to hammer away on this, but it's obviously a big thing, and there are a lot of moving parts, so I want to make sure I have the timelines and everything straight in my head. I'll just ask to make sure I understand.

January 2026, Component 2, as you mentioned there - the Victoria General lab, different pieces - that January 2026 date is for the master planning work. This is a quick question. I assume that would include design - detailed design of those projects, or no?

THE CHAIR: Deputy Minister MacKenzie or Mr. Spinney.

DANA MACKENZIE: Those dates are actually based on having the infrastructure investments identified by that time. The detailed design work would probably follow on after that, because once the needs assessment and the planning took place, the requirement for the investment in the infrastructure would be identified, with detailed design to come thereafter. That's my understanding, currently, of the plan.

BRAEDON CLARK: If by January 2026 we have master planning, then we have to get into what the cost looks like, approvals for all that sort of thing, detailed design. That's very complex. That takes months, I think, at least.

When does the department - or perhaps Build Nova Scotia, whoever would have the ability to answer this - think that we will actually break ground and have construction on that Component 2? If the master planning is done by January 2026, is it even reasonable to expect construction work would begin that year? Is that possible? Or are we looking into 2027, at a minimum?

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: I'll ask Mr. Benoit to take this question.

THE CHAIR: Mr. Benoit.

DAVID BENOIT: I would just start by saying that this is the best way to plan projects: to identify the need early and then to go through the process of how it fits into your actual overall plan. Once the need is identified, you have to confirm that it's an infrastructure requirement. You don't want to build infrastructure if you can fill that need in some other way. If you can recycle, reuse something else, if you can find another way

to deliver whatever the need is - infrastructure should be the last thought, because it is expensive to build and takes time and is expensive to maintain.

In certain cases, there will be the requirement for infrastructure. It's at that point that the planning team would say to the other departments, Okay, we have an infrastructure need now, and it needs to get built. We need somebody to take the lead in order to do that detailed design work. That does take a while. You need the input of the clinical staff. You need the input of the patients. We need the input of the families. We need the input of the specialists who are in the province, and often - I mean, I'm leaving out lots of people who actually get consulted in this process. There are teams and teams and teams of folks who are working every day on the Halifax Infirmary project, just as an example.

Some of that work does get done in the early planning. It isn't just like somebody just decided, Okay, let's put a box here and put that in there. They actually have conversations in order to suss that out with the clinical staff, with all those stakeholders. It isn't just, Oh, we need something. There's more detail to it than that. But the actual detail about where things are going to go, how they're going to get placed, what's needed in each room, what does the room look like, what the layout of the room is, all of those questions need to be answered before we break ground. That does take time.

As part of the process, just to bring it back, once the planning is done, then that would get handed over, and then people would start to work on that detailed design.

BRAEDON CLARK: I appreciate that, Mr. Benoit. I know that's true. I remember being in a room six or seven years ago with former health ministers - I think Deputy Minister Hackett might have been there - moving giant LEGO pieces around to say, This is where this building will go, this is where that building will go. Seven years later, and I don't mean this to be disparaging or critical, but I think it's hard for average, everyday people to think that we've come through that time period, and we still don't really know when everything is going to be done and how much it's going to cost. I think those are big questions - that's why I raise them today. I appreciate the answers I got.

I also wanted to ask: One of those components, one of those LEGO pieces that was being moved around, was the Victoria General and the Dickson Building. We all agree that those buildings are well past their best-before date. This is not on any particular government, but it's not a good situation to have people in there. I think we would all agree on that. The plan at that time was to get people out of those buildings as soon as possible. I think we can all agree that would be the moral and right thing to do.

Do we know when those buildings are going to be decommissioned? Is the plan still to decommission them? If so, when do we think that might happen?

DAVID BENOIT: I think the question just underlines the importance of Wave 1. That's because Wave 1 was focused on what the most critical needs of the health care

system immediately are. A lot of those needs are captured in the Victoria General. As far as I know, as the builder - and maybe I wouldn't be the best person to answer the question about when it would get decommissioned or how - because even after you put up a new building, even if your plan is to transition everyone, there's still time that you'll need to transition over from the old building to the new one. As far as I know, the plan is still, at least on the Victoria General, that it would get decommissioned, because part of that need is being encapsulated into Wave 1.

BRAEDON CLARK: Perhaps I'll ask Deputy Minister MacKenzie or Mr. Spinney: Is there a timeline for this piece of the project in terms of moving people out of the Victoria General and into a new facility? Do we have a window for that important part of the project?

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: I like the first part, that as soon as possible. I agree completely. I couldn't agree more. There is no specific date that all of those buildings are coming down and something new appears. There is no date for that. What we are doing is we're going through the master planning process that's been outlined to understand what the needs are and where those needs can best be met.

In the meantime, while we're doing this, one of the things that we are doing - which is important to understand - is decant what we can and fortify what we can't. By that I mean get out whatever can get out. There are some functions in those buildings that don't necessarily need to be in those buildings. They could be satisfied other ways. A really good example of that would be the West Bedford transition to community facility. There are patients in there - on the fourth floor in particular - who don't need to be there. They could be someplace else. That's one of the reasons why we at the Nova Scotia Health Authority are very pleased that some of those patients will be able to move within this calendar year, and even more after that.

There are other functions like ophthalmology procedures that take place in the Victoria General building that don't need to be there, so a few years ago, we started a private partnership with a private entity that has operating rooms that we send publicly funded cataract surgeries to. They are thankfully doing a fantastic job there as we work with them on that. Our physicians, our patients, everybody is quite pleased with that. We are looking to move things out.

Another easy example in a professional practice would be leads. We would have clinicians who help train and mentor other clinicians. They may not need their office space in that building, so anything that we can move out, we are. We're using the Bethune Building for that. We actually had media enquiries a few weeks ago that, Well, we've heard you're getting the Bethune Building ready to put patients in. No, we're not. The activity

that's actually taking place there is we're trying to get people out of the Centennial Building, out of the Dickson Building and move them where they could best be fit.

[9:30 a.m.]

THE CHAIR: Thank you, Mr. Spinney. MLA Clark has 30 seconds left.

BRAEDON CLARK: Sorry, Mr. Spinney, I didn't mean to cut you off. I was just running up against the clock and I just wanted to get this question into people's heads before the 40 minutes. I also wanted to ask about some concerns about a project related to the Cape Breton Medical Campus, which I think is a worthwhile initiative but doctors in recent weeks have raised concerns around capacity and being able to actually manage that, so I just wanted to throw it out there. I'll come back to it in 40 minutes.

THE CHAIR: Excellently done. I will now go to the NDP caucus and MLA Leblanc.

SUSAN LEBLANC: I would just say that in terms of old hospitals, my theatre company created a show at the old Halifax Infirmary after it was abandoned in the library, and it was highly successful. I don't recommend that in the Victoria General, necessarily, but there are other uses for buildings.

I just wanted to pick up a little bit on the planning of the waves - the whole wave discussion we're having. Mr. Spinney, you mentioned that we can't have a date for when the first patient moves in because we don't have the contract finalized. When will that contract be finalized, and then when will we have a better idea of the timeline?

THE CHAIR: Mr. Benoit. I'm getting used to reading nods. (Laughter)

DAVID BENOIT: To answer your question, the work that we're doing today and for most of this year and that we started last year brings us to that point where we sign the contract. It will be later this year. We expect to be able to have all the scope, all the variables known - the scope, the cost, and the schedule.

SUSAN LEBLANC: Great - so later this year. That's like - where are we, May? So within seven months - that would take us to December. Hopefully sooner than later. We know that with the Halifax Infirmary project, anyway, that aspect of all of the rebuilds and the work is a P3 project. Part of the issue that there has always been since the Liberals were beginning this project is the confidentiality agreements in place before anything can be released.

I'm wondering if you can talk a little bit about the transparency issues. How do the people have confidence in what's happening without any real information about what is happening? We know we've got a plan. We know we've got certain things available to us,

but it takes a long time because of these relationships to know exactly what we're getting into. For instance, cost - we're well into a redevelopment project without having a sense of the cost. I'm wondering if you can speak to the risks that the government is taking on when these types of agreements are being signed.

DAVID BENOIT: Maybe I'll start, and there may be others who would like to add in about the P3 in particular. The P3 - or what is known as public-private partnerships - they're one tool that we can use in order to deliver on infrastructure projects. Every project that we look at, we make the concerted effort - we look at what is the best way to deliver this particular project. One of the values of a P3 - let's focus in on the P3 - is what the taxpayer or what the state gets, what the Province gets, from the perspective of value for money and value for people. One of the tools that we use to make the decision whether P3s actually get started is that value-for-money analysis, which was done for this project and updated, and it was shared publicly.

The other thing that P3s do is transfer risk to the builder. It's really been a collaborative P3 process that we've been following. The difference between the P3 process and the collaborative P3 process, just in general terms, is that you get an opportunity to engage more proactively with the construction agent. Therefore, you get the opportunity to understand their constraints, and they get an opportunity to understand ours, and then you get a better solution, generally speaking, and at the end of it, a better outcome.

On the P3 as well, you have . . .

THE CHAIR: Thank you, Mr. Benoit. MLA Leblanc.

SUSAN LEBLANC: In terms of the Halifax Infirmary redevelopment, will the government be responsible for ongoing maintenance after the construction is complete, or will that fall to PCL Health?

DAVID BENOIT: In fact, that was going to be my next point. In P3 arrangements, often it's the maintenance, the 30-year maintenance cost that is also part of the builder's job to do. Why do we do that? It actually provides a better - I guess you could always find exceptions, but generally speaking, you get a better-quality product at the beginning, and after 30 years, you have a better asset when you get to the end of that arrangement. In which case, that allows the state or the province to decide, Do we keep it? Do we continue to use it as it is? Do we refurbish it into something else, or whatever? The short answer is yes.

SUSAN LEBLANC: Outside of the redevelopment - and speaking of maintenance, we've seen a number of maintenance issues at the Halifax Infirmary. We know that there's been the broken water mains at the Halifax Infirmary, and then the flooding at the Abbie J. Lane Memorial Building, which disrupted service delivery. Do we know why routine maintenance couldn't have prevented this from happening? Were there infrastructure

updates needed or scheduled before the water main breaks? I don't know who wants to answer that.

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: At the time, the equipment's contractors and their progress had already started to replace those pipes, as ironic as that seems. That actually helped us respond so quickly, because all of the right piping and whatnot was there. It was planned, and it was under way, just obviously not complete. Yes, is the short answer.

SUSAN LEBLANC: We knew that the maintenance was needed, and it was just too little too late.

DEREK SPINNEY: Too little too late, yes.

SUSAN LEBLANC: Is there an estimated cost for the maintenance work and the remediation?

DEREK SPINNEY: There would be, but I don't have that in my head right now, but we could follow up with that for sure.

SUSAN LEBLANC: Is there a timeline for the repairs at the Abbie J. Lane?

DEREK SPINNEY: There is as well. I'm not going to quote a date just in case I get it wrong, but it is under way right now. Unfortunately, many may have basements that get flooded, and then you can see that the gyprock has had water so much, and then you have to replace the whole gyprock. That's really what we're dealing with on the sixth and seventh floors of the Abbie J. Lane. In addition, what we're doing to help remediate that is we're trying to move office space off the eighth floor and turn the eighth floor back into temporary patient beds, so that we can bring back the beds that we lost while we're doing the remediation work that has to take place.

SUSAN LEBLANC: I'm going to turn to my favourite topic of late, which is - I'm just kidding - the YourHealthNS app. Think Research was awarded a large contract worth $49.6 million through an APP. Part of the funding was for the delivery of virtual emergency care in emergency departments. Why was virtual emergency care lumped in with a larger contract to deliver the YourHealthNS app?

I guess that's for Deputy Minister MacKenzie.

DANA MACKENZIE: This question is perhaps more appropriately dealt with by Mr. Spinney.

THE CHAIR: That's what I thought. Mr. Spinney.

DEREK SPINNEY: So the original thought process that engaged us with Think Research was twofold - first-fold, I suppose, is just access to care: How do we get more access to care when we're short both in digital infrastructure and in health human resources? What Think Research was able to bring to the table was to help us quickly improve our digital infrastructure so that we can more quickly launch an app with chatbot functionality, with clinical workflows in there. If you go there and you use the chatbot, it'll ask you questions about what your symptoms are, and then based on that, it will tell you where you should go, or suggest places where you could go. The other aspect that they brought to the table was a partnership with UHN that would be able to provide physician support through virtual care.

The original thought was that all of that would be potentially packaged through the app. As we worked through that with them, what we learned and improved was that we were able to deploy those resources and that access to that UHN bench for virtual urgent care that we're now using throughout rural Nova Scotia. We used that same skill set and partnership that they brought to the table. We just used it in a slightly different way.

The general virtual care is being provided through the Maple platform, but then there are two benches, or two types of physician groups, that answer the phone, if you will - or answer the computer now when you call in. If you are on the unattached list, you are receiving care from a Nova Scotian physician who has full credentials, can order all your bloodwork, can see what you need, refer you to wherever you need to go. As I mentioned last time, 80 per cent to 90 per cent of people who phone in are able to have their needs met with that one phone call.

The other experience, which is the one that you mentioned last time, was people who are attached can use that service twice a year. When you do that, you're accessing a bench of physicians who are from across the country.

SUSAN LEBLANC: I just want to stick with the emergency aspect of it for a second. Two more things about it being in the emergency departments: I've talked to - a year ago, maybe, there was a physician here, at Public Accounts Committee or at Health Committee, who was actually providing care using the virtual aspect of - I don't know if it was this particular - the app wasn't out yet, so I don't know. Anyway. She was really excited about it, especially because she can consult with emergencies in other parts of the province.

Given that, number one, when the procurement was done, did it include computer systems for emergency departments to do the actual appointments? Have emergency departments been renovated throughout the province to allow for increased virtual appointments? When you walk into an emergency department in Bridgewater, is there a place where you can go to do a virtual appointment, as a patient? What have the costs been? What are we looking at for all that stuff?

[9:45 a.m.]

DEREK SPINNEY: We're learning as we go through that process. The renovations would be site-dependent. The very first site that was doing this, even before Think Research - and perhaps that's the physician that you're mentioning; I can't remember her name myself, which is embarrassing - our lead physician in the emergency room at Colchester has been doing this for some time. She's actually helping us now roll out this virtual urgent care to the other rural sites across the province, so she continues to be a wealth of knowledge and inspiration for us as we're doing this.

When you go into an emergency room, the idea is that if you're a good candidate for this, you go off into a different room - literally, at times. Sometimes there's infrastructure in the site that it's easy, I'll say, and that you can go do that. In other sites, we have to make some accommodations, but they're not large renovations. They may be converting an office space into something different.

SUSAN LEBLANC: If possible, it would be great to follow up with the committee on the cost. If you have a line somewhere that is like "virtual emergency care," it would be great to get that.

We've heard that the measure to address the problem that those without a family doctor are seeking non-urgent care in emergency departments - that this is part of that. Is there an estimated timeline for how long the service will be provided in emergency departments or is the measure here to stay?

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: I'm having a bit of fun. I think we heard last time that virtual care is here to stay, and in this particular case, I suspect it is as well. We're doing evaluations through it, so everything is dependent on the evaluations. If it works, we keep it - if it doesn't work, we fail fast and move on. The responses on this one have been fantastic. Based on that, I'd say it's here to stay.

SUSAN LEBLANC: More generally, we've had concerns about the value that we're getting from the $50 million sole-source contract with Think Research. Can someone speak to what metrics were used to determine that this was a good deal for Nova Scotians, besides value for people? And can we speak to what metrics are being used to measure the effectiveness? What you've just mentioned, Mr. Spinney - what exactly are the metrics to measure the effectiveness of the app?

DEREK SPINNEY: Think Research is only one part of the app, and a relatively small part as well. An important part, because it's the chatbot functionality. Just to clarify, that is the piece that they contribute. They also contribute virtual urgent care service through UHN that we're using in the rural sites. Also, when we quote the $50 million,

that's assuming that we continue through five years with them. We have the contract ability not to follow up with five years. The $50 million is a big number but it's not necessarily what we're spending or what we're going to spend. It's what we could conceivably spend, and that's why you put the bigger number and then you work down from there.

The metrics that we use with the chatbot are, Is it being used? I mentioned last time, for instance, that the stats - again, a few weeks ago, when I last looked at it - were 100 interactions a day. From there, we also surveyed folks to say if you didn't have this service, what would you have done? Where would you have gone? That's where we can do some surveying to figure out how many ED diversions are we actually achieving through this or not.

Then in the case of the urgent care that's being provided virtually in the emergency rooms, that's the evaluation of working with both the sites and the patients to ask, Is this useful for your area? In some cases, it can be. I won't quote particular sites in case I get this wrong, but it can be that there wouldn't be care if this wasn't an option. Those are the evaluations that we do to make sure that this is actually useful and practical and is providing better access for Nova Scotians.

SUSAN LEBLANC: Before apps, we had the 811 system where you call and talk to a nurse, which I love as a parent. Is that program still going to be fully funded or is that going to kind of phase out as the use of the app and the virtual care phases in or becomes more popular?

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: It's not our intention to phase out 811. We recognize that there still is the need for some individuals to be able to actually phone and talk to somebody versus use the app. There are different levels of comfort. The effort and the focus really has been working with the leadership within the Nova Scotia Health Authority around the YourHealthNS project to actually have our 811 service providers mimic the application.

Similar types of processes and patient flows would be replicated within our 811 service so that people have a seamless and similar experience whether you're actually using the app or whether you're actually using the phone service. The availability of service and service locations and hours of work - a lot of effort put in to ensure that those are accurate through the YourHealthNS app. A similar tool is now being used by 811 to make sure, again, that they are giving the same answer, same access to service within the 811 side.

We're always interested in learning what the 811 experience is through this. So through that contract, we're working with them around what's working and how we can actually tweak and shift what their service is. It is our intention to continue to maintain some form of a call-in service, which people across Nova Scotia continue to access to have a similar experience to the application.

SUSAN LEBLANC: Just a quick clarification: In all this conversation about Think Research, can you clarify: Does Think Research still exist as a subsidiary of a company that bought it out or took it over? Can you explain what that relationship is now and who we're actually contacted with?

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: What happened was that Think Research was a publicly traded company, and one of their lenders acquired all of the shares. Beedie Capital is the name of that third party, the lending party that bought out all the shares.

THE CHAIR: Time has ended for the NDP caucus. We'll now go to the PC caucus with MLA MacDonald.

JOHN A. MACDONALD: Interesting discussions. I come from an IT background and I would agree that you definitely don't do a project and keep adding on and adding on. I've been on projects that took four to five years that should have taken eight months. I applaud your changes for it. As this is a generational health infrastructure build that's occurring - and I believe this will be to Mr. Benoit - did you talk about the overall vision?

THE CHAIR: Mr. Benoit.

DAVID BENOIT: I think the vision starts, as I had mentioned earlier, that we've got a number of services that we want to provide in the Central Zone area. The ones that were most acute and the ones that we were looking at most critical, I guess I'll say, are the ones that fit into Wave 1. Within that, you've got new operating rooms, inpatient beds, new emergency department. That's really important because the population is growing for the province, as everyone knows, but what was not known at the time when we relooked at the numbers in 2022, the data became a little more specific for HRM.

We found that that population was actually growing much more quickly than the population for the rest of the province. Not only was it growing, but it was growing in a sector or an age bracket that uses those services more frequently. We realized that the emergency department as it stood would not be sufficient to meet the need, so we needed to make a new emergency department, which is part of the reason why that's part of Phase 1.

The vision then, as I'd mentioned - the other parts of that agreement or of that commitment then moved into the planning group, which we've already talked about. The planning group is actively putting that together. The dates were already provided by my colleague, so I won't repeat those, but we're looking forward to that work being finished, because then we'll be able to see what the plan looks like and how it gets phased, more importantly. We know what it looks like. We've all done constituent parts, but how does it

get phased, how does it get delivered? That's the next phase after the planning work is done.

JOHN A. MACDONALD: Mr. Benoit, if you could also explain how the infrastructure's going to actually connect to improve access to health care to lead to better care.

DAVID BENOIT: I think it may be a colleague of mine who may want to add in, but what I'd start out by saying is that the infrastructure provides the baseline support that delivers the care that is envisioned and needed by the Province and by Nova Scotians. We take the time to get all the details right to make sure the people who work in the facility have easy access to what they have to do so they can deliver that care first-rate - as people would expect - which they do day in and day out today, but we're going to give them better tools for the future.

That's probably the key element there. It isn't just about today. It's about what's coming in the future, and how we make sure we can adapt and respond and be able to continue to support their efforts in delivering care to Nova Scotians.

JOHN A. MACDONALD: I'm just looking to see if the other side wanted to comment on it. Looks like not.

THE CHAIR: I was looking too.

COLIN STEVENSON: Just to build on that, I think Mr. Benoit referenced the planning process within the Central Zone. I think the other component to this really is understanding the planning work and the design work that's been done. The investments that are currently being made around the construction of that site within this phase are driving increased bed capacity and increased availability of ORs, as being sort of two of the main areas. Within the bed capacity, it's both an acute care - so general-medicine bed, surgical bed - as well as intensive care. I think everybody around the table would recognize or understand or have heard about high occupancy rates within hospitals. Within the Central Zone it's been in excess of 100 per cent within our acute-care facilities, so having this structure complete, having this new in-patient tower and this phase of the project done helps to alleviate some of that pressure.

As the deputy minister indicated in her opening remarks, everything within the health system is connected. Increased capacity means better flow of people from emergency departments into acute-care beds. It means shorter wait times for surgery. It means more ambulances back out on the roads to respond to calls. I did want to stress the importance of this project and how it will drive improvements within the system.

JOHN A. MACDONALD: Mr. Benoit, you mentioned the significant consultation that's been going on with the health care providers or professionals and communities to

ensure that the facilities are going to meet their needs. Could you please talk about these conversations and how they're affecting the build?

DAVID BENOIT: Consultation is really a key element of all of being able to deliver the right project with the right stuff at the right time. It all starts right at the beginning with a conversation - somebody identifying the need, go back to the planning thing that I had mentioned earlier.

The specifics around the consultation with health care professionals - it happens throughout the project. Build Nova Scotia is fortunate in that we have an integrated infrastructure clinical team that provides that support and then makes sure that they do the reach-out to individual specialized teams within the Nova Scotia Health Authority.

These discussions started at the beginning. They are ongoing. We continue to provide updates to them pretty much weekly, if not even more frequently than that. We get their input on different products. As we get - as you can imagine, on a project of this size and complexity, you don't wait until the end to find out what you're getting. You get interim reports, but interim reports are still work in progress. But those interim reports allow us to engage those clinical groups, to bring them to the table to say, Okay, here's kind of what we're thinking. Here's where we're at with the design. Does that work for you? They'll provide input in terms of - I mean, it could be yes, no. It could be more complicated than that, and usually it is, to provide more certainty as the design continues to progress.

We have - it would be too - it would be dangerous for me to try to list all of them, because I'd probably end up missing one. But the reality is that these groups are engaged fully with the Build team and with the NSHA-integrated Build team within the Build structure. We get that feedback on a very frequent basis in order to make sure that we remain on target in terms of what we need to deliver.

JOHN A. MACDONALD: My last question is going to be: We've had a lot of talk about emergency health care. I believe there are seven emergency departments that are doing enhancements, refits. I'm just wondering if anybody would speak on how - what those are, and how they're going to help out the health care? I'm assuming it's going to go down there.

THE CHAIR: I'm looking for a nod. Mr. Spinney.

DEREK SPINNEY: Without getting into the details of all seven, one of the general approaches that we're using is trying to create RAZ zones - that acronym is Rapid Assessment Zones. By that, what we mean is when you present at the emergency department, if we believe that you're a candidate who could be in a shared location and be seen in an upright position, I'll say, and with others in the room at the same time, we can put you into a rapid assessment area.

[10:00 a.m.]

If you were to present at the emergency department and you were selected for that through the triage process, you would find yourself in a different room with maybe four other people. You're all in an upright position, you've got some sort of ailment that you're able to go through in that space. That creates more efficiency because now you're streamlined, more like a speedier checkout, if you will. Also, the physicians who are seeing you are able to stay in one physical space of the building and get through a few cases that are more similar more quickly, as opposed to seeing one at one end of the building and then back and forth. There are actually a lot of wasted steps that our industrial engineers would point out.

That's what we're doing through these rapid assessment zones. However, it's sometimes challenging depending on the site, because we're full, as we all know. So our capacity to find space within a hospital to actually do this is extremely challenging. When we do find space, it could be challenging because of the cost and the time needed for renovations. That's what we're doing within the EDs, and of course, we're doing a lot of work outside the EDs to have people go to the most appropriate place to begin with.

One of the things that isn't talked about much is that our emergency room visits across the province this past fiscal, in the lower-acuity visits, actually declined. There's a CTAS score that we use - 1 through 5 - that you get rated on according to your acuity when you present. The worst situation is that you're a CTAS 1, which means you've arrived and trauma care is needed. It's obviously a dire situation that's taking place. On the other end, if you're a CTAS 5, it's lower acuity, meaning that maybe you've got a cold or some other ailment that you need attention for, and perhaps you didn't know the best place to go and you show up at the emergency department.

The CTAS 4s and 5s have actually declined in Nova Scotia by 9.2 per cent, which is extraordinary and what we're trying to achieve. We're achieving that through many different ways, whether it be a chatbot, whether it be through virtual care, whether it be through urgent treatment centres that we've opened, the mobile care clinics, the expanded scope of the pharmacies. All of these things are having a total impact. How much is any one of those things having on that number, I'm not sure. I just know that the total number has actually declined to 9.2 per cent.

However, on the other end of the spectrum, those higher-trauma cases have actually increased 9.7 per cent. When you blend all those numbers together, our emergency room visits are up 7 per cent year over year. So although we're having success on the lower ends, there will never be enough success on that end, so our job isn't done, but we are seeing an increased level of those higher traumas, which then starts to explain longer wait-lists that we're experiencing in some places. How do you have longer wait-lists if you're actually deferring and deflecting visits? The visits we have are higher-acuity trauma cases.

THE CHAIR: MLA MacDonald.

JOHN A. MACDONALD: I'll defer to MLA Boudreau.

THE CHAIR: MLA Boudreau.

HON. TREVOR BOUDREAU: Thank you all for coming to enlighten us a little bit today. I only have a couple of questions to ask. The first one is a little bit about local community investment, in particular about dialysis units. I just wanted to have somebody from the department or Nova Scotia Health Authority talk a bit about - there have been several new dialysis units that have been announced or completed recently. Just talking about the importance of bringing dialysis services closer to communities, where people are at themselves.

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: I think anybody who has had to, has to, or knows somebody who is requiring dialysis knows that it is a high-volume service. It requires a lot of visits for individuals every week in order for them to receive care and service. If there are not dialysis stations close to them, it does require travel, and people across this province are travelling in order to receive service. So our focus really has been to look at and work with our partners within the Nova Scotia Health Authority, as the primary dialysis service provider through the renal program, and ensure that we're identifying hot spots - and by that we mean where there's an increase in population that requires or could require the service - and create the right plan and investment in order to support dialysis stations within those areas and/or other options for service delivery.

There have been a couple of different approaches that we've been taking within the province of Nova Scotia in order to do that. One is ensuring that there's availability of dialysis chairs within acute care locations, predominantly in a regional or tertiary site, and ensuring that we have some in proximity to where there could be an intensive care unit to ensure that the sickest patients have access to dialysis in a reasonable location.

The second would be expanding dialysis chairs across the province. We've seen a number of investments across the province within the QEII, within the Chamber of Commerce - the outpatient centre out in Bayers Lake - investments being made in the Sutherland Harris Memorial Hospital expanding from six chairs and increasing that - as well as investments on the operational side to expand the hours. Part of using dialysis could be just running extra shifts, not just daytime but days, evenings and into nighttime as well.

A lot of that will actually create the opportunity for people to have an option available to them closer to home, which is part of what our primary intention is around that. The other is actually looking at partnerships with other service locations. We've been in conversation with our colleagues at the Department of Seniors and Long-term Care

around the opportunity to partner for something called NxStage dialysis, which is where you can actually have somebody come to a long-term care facility, have a designated room, and they'd be able to dialyze a patient who is in long-term care. We're working with our long-term care partners to try to create those flexible spaces. It doesn't require a lot, but it actually does bring a necessary service to somebody who would have a challenge in being able to leave their home in that situation.

TREVOR BOUDREAU: Thank you for that explanation. The next question is for the department. In recent years, there's been an increase in the amount of money in the capital plan for medical equipment as well as repairs and renovations. Maybe someone could talk about the impact the increased budget has on the ability to maintain existing infrastructure and, in a sense, provide better care.

COLIN STEVENSON: I'll probably pass it over to Mr. Spinney partway through, just in the sense of the impact within the operational side. We have had the opportunity over the last couple of years, through increased grant funding, to be able to take on more projects within the health system. I have to check the year, I think it was 2022-23, it went from $27.5 million for capital grant allocation up to $67 million. We have seen an increase in projects. We know from 2021-22 we had active about 385 projects within the health system. Those would be repair and renewal, major equipment, replacement plus it can also cover off some operating or capital leases within that. In 2022-23, it was up to 529.

The change in the grant allocation is allowing us as a health system and our partners, the Nova Scotia Health Authority and the IWK, as the predominant recipients of those grants, to be able to plan differently, think about the projects and be able to take on more projects within that. I should add that our foundation partners across the health system continue to also contribute to work within the health system. They often partner with some of those projects, which allows more projects to get done and/or they take on specific projects that may be of interest to their specific community. The foundation contribution and commitment to projects has actually continued to increase through the generosity of Nova Scotians over that same time period.

Mr. Spinney may have specific examples.

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: The change in our capital grants has been extraordinary: doubling in the case of repair and maintenance, capital amounts from $10 million to $20 million a year, which we're extremely grateful for and helps us do more, obviously, with that. At the same time, we continue to be challenged in our infrastructure. We've already talked about the Victoria General, for instance.

Just to throw out some more numbers, there are 39-plus sites that the Province owns and maintains across the province, which would be about 9 million square feet. Even at

$20 million, I'd say that we continue to be challenged in order to maintain a footprint that significant across the province. We're doing a lot better than we were, for sure, and the teams are extraordinary in there are creative approaches that we're doing. At the same time, we're extremely pleased that we're moving into more of a provincial master planning process so that we can better understand what's needed across the entire province. Then we'll see the outcomes of those master planning sessions.

In the case of the medical equipment, same thing. It doubled from $10 million to $20 million, which is extraordinary. We still need more. As Mr. Stevenson mentioned, we're extremely pleased with the support that the foundations provide from every community across the province. They actually contribute, depending on the year, between $10 million and $20 million a year. One of the most recent, for instance, was the announcement of the new, relocatable MRI that the QEII Foundation is placing . . .

THE CHAIR: Time is up. We have 13 minutes for the second round of questions. MLA Clark.

BRAEDON CLARK: As I said earlier, I just wanted to touch on a potential issue that's come up recently with the new medical school that's set for CBU. Some doctors in Cape Breton have raised concerns around capacity, the ability to teach, handle a course load, and do all of those things. The implication is, or some have said, that in other provinces, there have been moves to delay openings of med schools for years, so to make sure that the people are there to execute and make sure that the school functions well.

I'm just wondering: What's the department's response to that? Is there any consideration to shift timing of that project given these concerns? What's the view on what some of those doctors have been saying?

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: The short answer is there's no intention to delay the opening of the medical school, but of course, listening very carefully to the concerns and the interest in making sure that there are adequate health human resources, in that case physician instructors and preceptors, to be able to facilitate the clerkships and placements for the CBU medical students. On behalf of the department, our interest is to connect, to listen to those. We are actively supporting CBU, of course, with identifying what those issues are and supporting them and the NSHA in terms of identifying resources in a proactive way so that we can be responsive and ensure that the timelines remain in place for the opening of the medical school.

BRAEDON CLARK: Based on that, Deputy Minister MacKenzie, I assume the department is confident that when the school is scheduled to open - which I believe is next Fall, September 2025, correct? - there will be adequate resources in place to make sure that

there are enough bodies there to do all the work that's necessary. Is the department confident of that at this point?

[10:15 a.m.]

DANA MACKENZIE: We're certainly engaged in helping to achieve that goal, and that remains the goal.

BRAEDON CLARK: I wanted to transition actually, a bit of a segue here. The medical school at CBU is obviously designed with a focus on rural practice. There was an interesting article in allNovaScotia that I was reading this morning around doctor wait-lists. I know that we're talking about infrastructure, so I'll digress just briefly, but I will come back to infrastructure, I promise.

There's a slightly disproportionate number of people in the Central Zone without a family doctor - about half of the overall list. My colleague to my right mentioned Halifax Citadel, 23 per cent; Bedford-Hammonds Plains, which is part of the area I represent, 22 per cent - obviously a big issue there. I believe part of the government's goal to change some of that - although it's been moving in the wrong direction pretty consistently. Last May there was a release put out about a whole suite of different infrastructure or practices - collaborative family practice teams, urgent treatment centres, primary care clinics, after-hours clinics, urgent care centres - the whole list, based on zone.

I just wanted to go through some of those and see where we are, a little over a year - or I guess about a year - after this was put out. The first I wanted to ask about, and I believe I'll direct these to the department here: There was supposed to be one new urgent treatment centre slated for Yarmouth, I believe, in early 2024. I'm just wondering when that is expected to open.

DANA MACKENZIE: I'll just need a moment to confer with my colleagues.

Chair, my colleague Mr. Stevenson will be able to answer this question.

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: I should start with, if you have a long list, you might get a bit of the same answer from each time as: I don't know the exact date. For a lot of these, I don't know the exact date, but for Yarmouth, the work continues around the urgent treatment centre component. They were one of the sites, to kind of bring it back to an earlier conversation, which was piloting virtual emergency care, so that was kind of happening within the emergency department to support care.

The urgent treatment centre, in combination with some existing physician practices or collaborative practices, is still on track and moving forward - some movement and date based on recruitment, but still active in the plan and anticipated to be open within this year.

BRAEDON CLARK: I appreciate that obviously you may not have all the details right at hand, but I do want to go through some of these other ones.

There was also mention of collaborative family practice teams. This is something that, for a long time, we've been talking about in the province as kind of the holy grail of primary care practices - the collaborative model. I know my friend and colleague, the MLA for Clare, Ronnie LeBlanc - they have a great model that's working down there. The municipality has done a lot to make that happen. I hope that that kind of success can be replicated in other areas.

About a year ago, the goal was to have eight new collaborative family practice teams established. Do we know how many of those eight are open as of today?

COLIN STEVENSON: Yes, the announcement in May 2023 was the intention around eight. To date, there have actually been 10 that have opened, would be new clinics. The intention was also to invest in an additional 26, which would be on the strengthening - so an existing practice where they were adding additional resources. It could be a physician, could be a nurse practitioner, a nurse, or administrative support. To date, there's been a focus on 49 as opposed to the announced 26.

A lot of that sort of shift or change through the course of the year came as a result of some work within Nova Scotia Health Authority and provincially around primary care to establish a physician call line, so that physicians who were within a practice who had questions, who had issues with operational efficiency, who were concerned about their practice and the volume within their practice, had a gateway into assistance. We actually took on and invested in more and provided support through a practice support program, or physician support program, to help them with their practices. So there have been 10 new opened and 49 additional that had investments to strengthen their practice. That's within the collaborative family practice side.

BRAEDON CLARK: The last group I wanted to ask about was urgent care centres. At that time, a year ago, there were five - it says five more to be established. I'm just wondering, have we had five? Or more? What's the status of those urgent care centres?

COLIN STEVENSON: There were eight, I believe, at the time of the original announcement. The target was five to six additional. So far there have been two, so we're up to 10 at this point.

BRAEDON CLARK: I appreciate that. It's good to have the magic of technology. It makes all of our lives easier. Thank you for that.

Deputy Minister MacKenzie, I wanted to ask you something that I've heard the minister and the Premier talk about a lot, and it's something that I've been thinking about - the issue between access and attachment when it comes to health care. I think that the Premier and the minister and others have talked a lot about access as a critically important point. I think they've prioritized that, if I could say that. Obviously, access is important.

I think there are lots of situations where there are innovations and changes in health care that can be really helpful. My son had strep throat recently. We went to the pharmacy clinic. That was great. That was quicker, faster, and easier for everybody. I also wonder if we are losing sight of the importance of attachment. Not to say that health care should never change or the model of having a family doctor is obsolete, going the way of horse and buggy, or whatever. I don't want to give that impression, but I just wonder if you could give the department's view on that distinction - access versus attachment. Do you think that a laser focus on access can lead to issues with attachment? We have seen attachment numbers going in the wrong direction for quite some time.

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: I will begin, and I'm going to invite my friend Mr. Stevenson to elaborate and provide more context as well. I think that perhaps focusing on access versus attachment perhaps casts it in a bit of a binary way. I think the reality of health human resources, particularly on the family physician side, requires us to talk about access in a way to ensure that Nova Scotians can access health care where they need it and when they need it. The importance of attending to that issue in real time, in terms of access, is something that I think a modern health care system must attend to. I think the minister and the Premier have been making that point as well.

I don't think the focus on attachment has been lost. I think it's a goal, but the reality of the situation is that health care and health needs happen in real time and have to be addressed. So the system has to be able to respond to those needs by providing access and being really intelligent about providing the right care at the right time to an individual who needs it at a particular point in time. Access helps us deal with those pressing needs while we're still striving - health care is always about striving - toward attachment, but recognizing that we do have, globally, a health human resource challenge in terms of the availability of family physicians in particular.

I'll turn the microphone over to my friend, Mr. Stevenson, to put him on the spot if he has any thoughts to add on this particular point.

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: I think, to build off the deputy minister's comments, it really is intended to find that balance between the two. If we pursued attachment only, then as an individual who's trying to access care, if you're attached but you can't get an

appointment for three months, then you're not necessarily in a better position as having no attachment. All the focus and the work within the health system really has been, as the deputy minister has indicated, to not think about them as being competing priorities, but really complementary.

We've certainly shifted, I would say, language in recent years to help people understand attachment to a practice or provider group or to the system as opposed to attachment to one individual. We hear that from Doctors Nova Scotia, we hear that from the Pharmacy Association of Nova Scotia and others that are in the system of delivering primary care, that the focus really needs to be on team, and that what best serves us as individuals is being able to access the right provider for the right type of care.

Attachment to teams and attachment . . .

THE CHAIR: Thank you, Mr. Stevenson. Now we will move to the NDP for the second round for their 13 minutes of questions. MLA Lachance.

LISA LACHANCE: I wanted to go back to where my colleague left off. We were asking about the current management structure of Think Research. It's been acquired by Beedie Capital. What does that mean in implementation? Is Think Research still implementing that, and what contact have you had with Think Research or with Beedie Capital about the YourHealthNS app?

THE CHAIR: Mr. Spinney.

DEREK SPINNEY: The short answer is that it doesn't mean much. Our contract is still valid. All the same services are in place. We're doing the same thing. It really didn't impact our direction one way or the other. The senior leadership team at Think Research is the same as it was before, but the structure of the organization has changed. It used to be publicly traded. It's now been delisted because a private entity bought all of the shares. There's now one shareholder, if you will - Beedie Capital.

From a day-to-day operating perspective, there's really no change to us. We talk to Think Research, if not every day, then every week. We're in constant communication with them.

LISA LACHANCE: What about data and privacy? Who owns the data that exists in the YourHealthNS app now?

DEREK SPINNEY: There is no data in the app. That's the first thing I'll say. There's no data in the app, so there's nothing to breach, per se.

From a technology point of view, to explain that statement, the app is really connecting you to different things. No data actually resides in the app or on your phones.

LISA LACHANCE: Just to clarify, in terms of medium- or long-term use of this app, the minister has said repeatedly that she wants us all to have access to our health information. Is there not an intent to actually be able to provide personal data through YourHealthNS?

DEREK SPINNEY: The key word there is "through." You said it quite well right there, where we would access health information through the app as a conduit or a pipe, if you will, but nothing's being stored there. Nothing's being stored on your phone.

The trial that's under way right now with a few primary care clinics is already allowing Nova Scotians to do this. The way that they do it is, you need to authenticate, so we worked with our partners at the Department of Cyber Security and Digital Solutions within government to make sure that the appropriate authentication takes place. Then once you're inside there, that data is being made visible on your screen through the app, but it's not stationary. The app itself really is just a pipe, if you will.

LISA LACHANCE: I'm probably going to leave this at this point, but I guess I just would say that I think Nova Scotians need to understand that even a pipe or our information passing through something that - for the analogy - that's not leaky, right? That while the information is being passed, there isn't sort of a footprint left, or that sort of thing. I think it is concerning that we're relying on this major piece of health care infrastructure that is being passed around amongst private entities. But I am just going to leave those questions there for now.

I wanted to ask some questions around unattached patients. I'm obviously very concerned that the number of unattached people in Halifax Citadel-Sable Island continues to rise. I have two questions related to that.

One is, can we tell, of the folks who are using the Maple service for unattached patients, what constituency they're from? What I'm interested in is knowing if the folks in Halifax Citadel-Sable Island - the almost quarter of the people who don't have access, or aren't attached to a practice - are they able to access Maple? Are they accessing Maple? If they're not, then the question would be: Why not?

Then in terms of the evaluation of those Maple services, you talked about the one question being: Where would you have had your needs met if you hadn't had this service? Are you doing any medium- or long-term evaluation? I think that question is different. "Where would you have gone if your needs were met?" In the short term, it's one thing - if I have a fever and somebody talked to me about my fever and maybe I got some antibiotics. But it's that follow-up piece and sort of ongoing complex - or not even complex. Just health care issues that are linked and sort of ongoing care.

Two questions. Do we know Maple use by area, and what is the more fulsome evaluation strategy around Maple use?

[10:30 a.m.]

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: When somebody goes on the registry, there are certain things they can provide. Part of that would be their postal code, so we are able to differentiate people, obviously, on the unattached registry. I think some numbers were quoted earlier. We're able to see who's there. If we cross-reference those individuals through health care usage or billing data, we'd be able to look at how they're accessing services.

Back to your privacy, we're not looking at an individual, Colin Stevenson, and how he's accessing services, but we'd be able to look from a collective perspective - were there people in certain areas, and how they're actually accessing services, whether it's virtual care or whether it's through a pharmacy clinic or whether they actually are attached to a physician, because of how a physician is billing for them.

I say that very deliberately, because everybody is often very diligent about putting themselves on the registry. People forget that if they do get attached to a physician or a nurse practitioner, you need to remove yourself from the registry. There will be some people who are on the registry who may actually be receiving care as an attached individual. So we're able to audit and understand how people are accessing care.

Mr. Spinney mentioned earlier about the change in utilization of emergency departments, and a percentage reduction in the Level 4s and 5s. Part of our intention is to be able to assess deeper how people are actually accessing care if they are on the registry. Are they actually going to pharmacy clinics? Are they going to urgent or emergency care? Are they using virtual care? If they're using those patterns of services, is it having an impact on their utilization of emergency care?

LISA LACHANCE: I'm just going to quickly interrupt. You want to be able to do that, or you are doing that - in terms of the detailed analysis that you're talking about, in terms of pulling from postal codes and who's using health care where and how they're using it?

COLIN STEVENSON: We are analyzing that. We don't have all the results available at this time, but again, as Mr. Spinney has indicated, seeing a reduction in the Level 4s and 5s of emergency department visits is driving us to ask more questions around what's driving that and how people are accessing care. We are in the process of assessing that.

LISA LACHANCE: Just to the second part of my question, which was around the medium- to long-term evaluation strategy for YourHealthNS - or for Maple, actually. Are you following up with people a month down the road? What's your evaluation strategy?

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: I think your question focuses on the idea that the app is following up with people about where they would have otherwise gone, other than the app or the use of virtual care. The evaluation of the pilot continues. I think your question gets at what we are evaluating. Your question is a good one, in respect of longer-term care, and what people are doing with response to longer-term care.

I think it's an important point to understand that when people receive virtual care, the provider of that virtual care always has the option to, if clinically indicated, refer the person into an in-person appointment.

LISA LACHANCE: I apologize. I just have a short amount of time for questions.

I might leave this alone, but my question was really: What are you evaluating, and are you following up with people at different points after they access Maple?

I want to switch gears and ask about some of the health care infrastructure projects being developed in CBRM and in Cape Breton. What I understand is that there are four projects under way, and that two of these don't have contract amounts awarded. I'm just wondering if you can bring us up to speed on what's happening with those projects.

THE CHAIR: Deputy Minister MacKenzie to advise whom she's passing it on to.

DANA MACKENZIE: I'm going to ask Mr. Benoit to take this question.

THE CHAIR: Mr. Benoit.

DAVID BENOIT: There are four projects that are under way. The first one is the Cape Breton Regional-Halifax site, which includes the cancer centre, the energy centre, the clinical care building. The second one is at New Waterford, where it includes a hub concept of a new school, which is nearing completion now and a long-term care facility and a medical centre combined together. The third one is at Northside General, which is a new clinical replacement for the hospitals that exist in that area and provide care for that region. The last one is an expansion for the Glace Bay emergency department.

The projects that are actively under way or that are actually in their construction phases are the ones at the Cape Breton Regional Hospital and the Northside General, as well as, as I've just mentioned, the New Waterford school. The plan was to get the school built first and then do the demolition of the current school and then carry on with the program. In Glace Bay, we're looking at the design - and that's still ongoing - of the emergency department.

Was there another part to the question?

LISA LACHANCE: I think I only have a few seconds left. I'm going to ask: The new cancer centre is supposed to open in 2025. Is it on track? Do we have a precise date for when that will be?

DAVID BENOIT: Because of time, I'll say that it is on track and things are progressing at the Cape Breton Regional site as expected.

THE CHAIR: I will now go to the PC caucus, and I believe MLA Taggart is first.

TOM TAGGART: Just a quick series of questions for the Department of Health and Wellness. Central Zone is HRM - is that correct?

THE CHAIR: Deputy Minister MacKenzie is nodding yes.

TOM TAGGART: HRM has 50 per cent of the population of Nova Scotia?

THE CHAIR: She's continuing to nod.

TOM TAGGART: So it stands to reason that 50 per cent of the people who are unattached would be fairly proportional across the province, because 50 per cent of the population is in Halifax. Anyway, I just wanted to get that out there.

This is for Nova Scotia Health Authority or the Department of Health and Wellness. Infrastructure is not always bricks and mortar. We've talked about the importance of new medical equipment, but there's also the digital infrastructure such as the Oncology Transformation Project, the YourHeathNS app, virtual care, One Person One Record, and the partnership with Varian. That's a lot of pieces in there.

I really want to go to the virtual care app first. I want to dig a little bit deeper. I personally am very impressed with that app. For someone who's old and technologically challenged like I am, you wouldn't think that it would be that appealing to me, but when I see the success there, I think it's something that we're not really getting the full benefit of. I'm wondering if you would start with giving me a solid look at understanding what that digital care app is doing. I know you touched on it a few times already about keeping people out of the emergency room and that sort of thing, but I think Mr. Spinney's the data guy there, so maybe you can give us some information on that, please.

THE CHAIR: The data guy - Mr. Spinney.

DEREK SPINNEY: Thank you, I think, Madam Chair. (Laughter) It's a great question and if we had Scott McKenna, our CIO - if he's watching out there, I'm sure he's like, Oh, I wanted that question because it's a really important question. It's a really important question. The infrastructure, like bricks and mortar, needs a lot of planning and understanding and a thoughtful approach to it.

I also agree with your comment that we haven't fully seen the potential of the app yet. We certainly haven't. I'd be disappointed if we stopped here, is the way that I would say that. An app, like a lot of apps that we have, is really just a connection to something else. It's a way to interact with people. It's a portal, it's a front door. There are many different ways that we describe it, but it becomes one single point of contact, if you will, or one place where you know you can go and you can figure out what you need to do using that tool.

That's what we have. We have an app now that Nova Scotians can use. Everybody should have it downloaded. You should be able to go to it, and then once in that app, you should be able to understand what services are available where, and you should start to understand what services you actually need. We're seeing that through the chatbot functionality, which is really some clinical workflows. What do your symptoms look like? Based on that, here's where we recommend that you should go. That in and of itself doesn't replace a person by any stretch, but there is a certain number that that is useful for. That's all that you would end up needing to want.

Even today, with the urgent treatment centre question, I was like, Oh, gosh, what are all the different locations? I'm not going to remember that. You can go to the app, and the app would tell you how many there are and where they are, and you'd be able to click a map and see them and find out their hours. That's just one of the functionalities of what this is.

As we start to expand that, as we start to say that Nova Scotians should have access to their health records, in order to access your health records, as was rightly pointed out earlier, they need to be stored someplace, first of all. Step one, they actually need to exist digitally. If you bear with me, we go on this IT journey. They need to exist digitally. Today, many of our health care records are on paper, so they can't be digital, because they're on paper, but we're going to make them digital - that's One Person One Record. That's a large part of what it's doing. There are a whole bunch of clinical benefits of that too, like closed-loop medication, patient safety, the clinician experience, a whole bunch of other stuff. Sticking to the digital, it creates a digital record.

That digital record, whether it came from One Person One Record or the oncology project or a different project, needs to be stored someplace safely. We have created that safe, secure environment using what we call FHIR standards, Fast Healthcare Interoperability Resources. That's a standard in the health industry that allows us to connect records for me and you across different systems. If I'm in the One Person One Record and I'm also in the oncology system, for instance, we need a way to join those records together, and we need to understand the information in the two systems. We use the FHIR standard to do that. That's a national standard that I believe the federal government just approved as well, FHIR Version 4, I think. The global environment is going that way. In many respects, we're ahead of a lot of people.

Once you've got that safe, secure environment and the different systems that feed into it can talk to one another using the FHIR environment, then what you can do is you can make it accessible to people. We can make it accessible for research purposes through anonymized data, so we can anonymize it and then use it for clinical research. That's one of the applications. We can also then use it for citizens. I can go in and say, What do you have about me in there, one, out of curiosity, and two, hopefully to improve my health and for me to play a larger role in my health care?

That's the authentication piece. You need that secure access or swipe card, if you will, to get into that data. What the app does is it just creates the hallway or the pipe into that to be able to bring it out. As I'm going through that hallway and I get there, I need to present my swipe card or the authentication to actually allow me into it.

Hopefully that's a simple way of thinking it. I know I've oversimplified it. Again, if Scott's watching, he's probably saying, He got most of it right, hopefully. That's the idea. It does take time, and it takes a lot of thoughtful attention to make sure that we're using the right standards, that the environment is safe and secure, all the privacy issues that we demand here in Nova Scotia - that's what we're up to. The app is a way to connect Nova Scotians to all of these things that we're developing.

TOM TAGGART: I appreciate that very much. It wasn't really where I was headed. I just want to say, four years ago, before I got elected, we had two doctors at a local clinic in West Colchester, and they were both leaving at the same time. They'd both been around forever, and all they had was paper records. We were told that we had to find a way to make them digital. I was shocked at the time. I couldn't believe it. I thought that if I came to Halifax and had a heart attack and went to the VG or wherever, that somebody could just pull up my records. I was shocked to find out that four years ago - even possibly today, although I know we're heading in that direction - that doesn't happen. I think that stuff is great.

When I referred to the data piece on the app, was that the number of people - like, for me, and I think for most all of us - well, I shouldn't say that. I've been very fortunate; I've had a doctor all my life. But if I'm sick today, I can't get in to that doctor tomorrow. I can't get in for two or three weeks, maybe. So I would run off to the emergency room and sit there and say, "Well, am I sick enough to be here? Or where should I be?" sort of thing.

I understand that this app tells me that I can go to the drugstore, or I can go here, go there. You had talked about some numbers earlier. That's where I wanted to go with that app, and why I believe we should all be joining that app, so that we can reduce the number of times we go to the emergency room, and sometimes the number of times or the spots that we're taking up in our own doctor's office for other patients.

That's kind of where I want to go with it. Can you talk about that a little bit?

[10:45 a.m.]

DEREK SPINNEY: I love where you're headed, with everybody taking accountability of our care, and where do we go. That's an important question for us to ask to make sure we're getting the care we need, but also so that others are getting the care that they need.

We shouldn't be taking a spot at the emergency department if we don't need to be there. If we need to be there, we absolutely should be there, and we should, and will, receive great attention by our clinicians. But if there's a better way, we need to know about that, first of all, because I may not know. Again, that brings us back to the app to help me understand where else I could go. What are my other options? Through there, you would find that through the PANS - the Pharmacy Association of Nova Scotia - many of the pharmacies actually take online appointments now, so you can click through and actually make your appointment online.

For those who are in the app and they are looking for a virtual care session, as you said, some with family physicians, it may take a little while to get in, depending. My family is no different. We're going through that right now, "Oh, when's the earliest that somebody could get in?" Through the virtual care, for those who are on the Need a Family Practice list, you'll be seen that day. That's actually faster than what I'll get through my family physician.

Now, you will end up speaking to somebody who doesn't necessarily have all of your backgrounds. That brings us back to One Person One Record, where we do need for the whole province, so that whoever the physician is, going in, can see everything about me. But you're going to receive care, and if you can't have it resolved, you will be, as the deputy minister pointed out earlier, referred and handed into and booked at one of our primary care collaboration centres.

There are between 400 and 500 Nova Scotians a day who are on the Need a Family Practice list who are using the virtual care experience. It is - I mean, you take that and times it by 365 - it's a big number of Nova Scotians who are using that service every day.

THE CHAIR: MLA Taggart with a minute and a half left.

TOM TAGGART: A minute and a half. I guess I just want to make the comment - where the heck would we be without that - as we grow our population and we struggle to grow with it, I mean, - the idea that we've got 400 or 500 people a day who we're keeping out of the emergency room and doctor's office and going to a proper place for care is a pretty huge statement.

Is there time to speak about your partnership with Varian? Who can give us a little bit of - Mr. Spinney, I guess you're the man.

THE CHAIR: I guess, Mr. Spinney, we're going down the Varian pipe now.

DEREK SPINNEY: It's a great partnership. I can't speak about it enough. We should have a session just on that and invite folks into the Innovation Hub and learn more about it. Varian is an oncology company owned by Siemens Healthineers. They've committed with us to a 10-year project where we're going to work more closely together. There are many aspects of that agreement. One of those is to allow us first access to their most modern equipment - Ethos is something I've talked about before - with their most modern software called Hypersight.

THE CHAIR: Thank you, Mr. Spinney. Our time is up for questioning. I would want to thank each of you for being here. Are there any closing remarks from any of our presenters? I thought Deputy Minister Hackett would just be wanting to say something. Deputy Minister MacKenzie.

DANA MACKENZIE: Thank you, Chair, and to the committee for having us and asking great questions.

THE CHAIR: I just wondered, is there a desire to have a break while our guests leave? We'll take a five-minute break.

[10:51 a.m. The committee recessed.]

[10:56 a.m. The committee reconvened.]

THE CHAIR: I call the meeting back to order. As the committee knows, we have some correspondence, and I just wondered if there was any discussion to be had. We have Mr. MacPhee here with the Auditor General's Office if you have any questions. I'm not seeing any, therefore, thank you, Mr. MacPhee, for being here. Did you have any opening remarks or closing remarks?

As we know, the next meeting is June 5th, and it looks like it will be in camera for topic selection and committee discussion. I'll just remind you, if you have anything that you want to submit for that, let me know. Seeing no further business, the meeting is adjourned.

[The committee adjourned at 10:57 a.m.]