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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, September 11, 2024

COMMITTEE ROOM

Progress Update on Actions to Improve Emergency Care

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Public Accounts Committee

Lorelei Nicoll (Chair)
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John A. MacDonald
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Susan Leblanc
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[Lorelei Nicoll was replaced by Hon. Kelly Regan.]

In Attendance:

Kim Langille
Committee Clerk

James de Salis
Administrative Support Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dana MacKenzie - Deputy Minister

Colin Stevenson - Chief, System Integration

Jeff Fraser - Senior Executive Director, EHS

Emergency Medical Care Inc.

Matthrew Crossman - President and COO

Nova Scotia Health Authority

Karen Oldfield - Interim President and CEO

Dr. Nicole Boutilier - Executive Vice President, Medicine & Clinical Operations

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, SEPTEMBER 11, 2024

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:05 A.M.

CHAIR
Lorelei Nicoll

VICE CHAIR
Nolan Young

THE CHAIR (Nolan Young): Order. We'll call our meeting to order now. This is the Standing Committee on Public Accounts. My name is Nolan Young. I'm the Vice Chair of this committee. I'll just remind members before we start to please check your phones and put them on silent. If there's an emergency here, we will exit out through the doors on Granville Street and gather at Grand Parade.

I'm going to ask the members to introduce themselves, starting with our newest member of the Public Accounts Committee. Welcome, Marco MacLeod.

[The committee members introduced themselves.]

THE CHAIR: Just a note that we have officials from the Auditor General's Office here in attendance. Also in attendance are officials from the Legislative Counsel Office and the Legislative Committees Office.

On today's agenda we have officials from the Department of Health and Wellness, Nova Scotia Health Authority, and Emergency Medical Care Inc. with respect to a Progress Update on Actions to Improve Emergency Care. I'll ask the witnesses to introduce themselves. Perhaps I'll start on my left.

[The witnesses introduced themselves.]

THE CHAIR: Welcome. We'll invite opening remarks, and we'll start with Deputy Minister MacKenzie.

DANA MACKENZIE: Thank you for the opportunity this morning. We have made great progress in acting on what was outlined in the emergency department improvement plan. We have brought in patient advocates, waiting room care providers, flow and off-load teams, and virtual care in EDs.

I'm going to start again here. I'm in my wrong notes. I'll have to reorient myself here. Let me begin again. Thank you for your patience.

Our health care system is complex. It's interconnected. There are barriers that need to be overcome, and we are overcoming them. Despite the challenges, there are opportunities. Each opportunity, solution, and innovation have one thing in common: The patient is always at the centre of what we do.

We've made significant progress to stabilize health care for Nova Scotians by creating and enhancing more options for primary, urgent, and emergency care closer to home. Mobile primary care clinics, after-hours clinics, urgent care centres, urgent treatment centres, community pharmacy primary care clinics, 811, VirtualCareNS, and YourHealthNS: These are just some examples. These services support what we're here to talk about today - to improve emergency care in the province. These services are aimed at helping people get the care they need in a more appropriate setting so they don't need to go to an emergency department.

We have made direct investments in emergency care by way of new infrastructure, digital health care, and people. We are modernizing or replacing outdated facilities to meet our current and future needs, like a new emergency department in Yarmouth or the redevelopment of the QEII Health Sciences Centre.

We are helping patients in hospital to return to where they call home sooner by helping them mobilize sooner using data and health information to fix problems in real time and expanding evening and weekend access to interprofessional teams. In doing so, we are reducing wait times, ambulance off-load times, overcrowding, and other system pressures often faced in our emergency care system.

For people who must visit an emergency department, we've made changes there, too. Thirteen emergency departments have added licensed practical nurses and patient advocates. They provide support, comfort, and information to those who are waiting. More than 100 team members are currently working in this role.

Seven emergency departments have emergency physicians care for patients in rapid-assessment zones. We've integrated virtual care in two emergency departments and 15 urgent treatment centres to offer some patients the opportunity to see a physician virtually. This helps get them the care they need sooner and allows physicians to see more in-person emergency and urgent cases.

We've invested in people like paramedics and others who respond to emergencies because care begins the moment you call 911 - improvements like increased staffing at the medical communications centre; recruiting 30 paramedics from Australia, who will start work this year; enhancing the role of some advanced-care paramedics to work as single-paramedic response units that respond to lower-acuity calls and discharge patients at the scene; introducing a new role, emergency medical responders, who are working alongside paramedics, providing basic care and expanding the number of teams in communities that can respond to an emergency; creating more opportunities for new and existing paramedics to stay and work in Nova Scotia with tuition-rebate programs; and of course, strengthening our fleet of ambulances, patient-transfer units, medical transport service, and air ambulance service.

As I mentioned at the outset of my remarks, our health care system is interconnected. That is why we will continue to take a system-wide, patient-centred approach to improve primary, urgent, and emergency care for Nova Scotians.

Thank you again for the opportunity to provide an update on our progress to date.

THE CHAIR: Ms. Oldfield, I think you had some opening remarks as well. Ms. Oldfield.

KAREN OLDFIELD: Today, with my colleague Dr. Nicole Boutilier, we'd like to highlight our ongoing efforts to improve emergency care across Nova Scotia.

In February of this year, the Nova Scotia Health Authority launched a system-accountability framework to provide and improve timely assessment and care, queue-management strategies, and surge-contingency plans. This initiative alone has saved nearly 7,000 hours of ambulance time, and that means that EHS can respond to 911 calls much faster. The longest off-load times have dropped by 110 minutes, and the number of ambulances waiting beyond target times has decreased by about 50 per cent. For example, the QEII Halifax Infirmary is down 128 minutes, South Shore Regional Hospital is down by 122, and Cape Breton Regional Hospital is down by 92. In emergency departments, the time to transfer patients to in-patient care has been reduced by 21 hours, and the length of stay for admitted patients in the ED has decreased by 17 hours.

The C3: Care Coordination Centre is a key resource enhancing patient flow across the entire province. By providing real-time data on bed availability and care needs, C3 has streamlined a previously cumbersome, resource-intensive process. Now we know our

system-wide bed capacity at any given time, and that makes patient admissions simpler and faster.

[9:15 a.m.]

There are several other new initiatives that support a faster, more efficient, and improved patient experience - initiatives like the rapid assessment zone. Now, in six emergency departments across the province, rapid assessment zones treat patients with mid- to high-acuity conditions who can remain ambulatory.

These areas are designed to see a higher volume of patients who do not require a bed for the whole visit and can use a chair or a recliner to wait for X-rays, tests, or even receive an IV. They use two to three bed spaces to see people in private and then move them to chairs and recliners. This allows for higher volume, and it saves dedicated beds and stretchers for patients who require dedicated bed space like our frail, elderly population. This model handles up to 30 per cent of emergency department patient visits. It reduces wait times and decreases the number of patients leaving without being seen, and since the start of the fiscal year, rapid assessment zones have managed over 6,000 visits.

New roles in the emergency department are also making direct, positive improvements in patient care, roles like waiting-room providers, patient advocates, physician assistants, nurse practitioners, and others are significantly decreasing the time patients spend in the department and improving their care experience. A waiting-room provider checks vital signs, inquires about pain levels, and escalates any changes in the patient's condition to the physician or clinical lead nurse, reducing the patient's stress level and supporting them to get the care they need faster. Patient advocates make the experience of waiting for care less overwhelming by providing additional comfort to the patient during their wait, whether bringing in a warm blanket, food - whatever will make the patient more comfortable.

Seven regional sites have introduced physician flow leads, a dedicated physician role to accelerate patient care and reduce delays in diagnostics and treatment. Part of providing emergency care is providing Nova Scotians with more access to primary and urgent care and knowing what level of care fits their needs and how to access it.

Since its launch this time last year, the YourHealthNS app has been downloaded more than 400,000 times. Our website and the YourHealthNS app share approximate wait times for 14 different emergency departments in the province, and these are key resources in navigating care. VirtualCareNS and pharmacies also play a significant role in diverting unnecessary visits to the emergency department. Never before have Nova Scotians had access to more effective tools, resources, and sources of care.

Despite significant challenges like high occupancy, high acuity, and high demand in emergency departments, we have made progress in reducing ambulance off-load times

and have improved many facets of emergency care. We are committed to finding new and better ways of providing care and adopting those innovative approaches to deliver to meet the demand.

Before I conclude, I would like to thank our health care providers and our staff across the system for their continued support and dedication to emergency health care in Nova Scotia.

THE CHAIR: Mr. Crossman, I think you had some as well.

MATTHEW CROSSMAN: On behalf of Emergency Medical Care Inc., I wanted to thank the committee and its members for inviting us here today to discuss the progress and future of emergency health services in Nova Scotia.

First, I'd like to extend our heartfelt gratitude to our employees and our teams. Their unwavering dedication, working day and night in difficult conditions, ensures that not only our communities receive the care for them when they're needed, but it also goes above their duties. It means they're caring for their friends, their families, and members within the community. For them, it's personal. Last year we responded to almost 200,000 calls. It was one of our busiest years, yet we've made some significant improvements in our system.

I'd also like to take a moment to honour not only just frontline paramedics and health staff, but all those first responders. Today's date is a constant reminder, being September 11th, of the sacrifice and ultimate sacrifice some of those folks make. I wanted to thank them and their families.

Our partnership with the Nova Scotia Health Authority and the Emergency Health Services team has never been stronger. Together, we are transforming emergency care as it's delivered, not only in ground, air, but also through digital innovations. For instance, we've added a new air medical transport service which has been able to enhance the patient experience, transporting patients from Yarmouth and Sydney, and different areas across the province, bringing them better care - faster care - to the centre. It's also added 11,500 hours back to the Emergency Health Services system where we've been able to respond to those communities.

As Ms. Oldfield has mentioned, off-load delays are actively being addressed with our partner. We're working closely with the Nova Scotia Health Authority, and we're looking to implement strategies to reduce these delays and improve overall patient experience even further. These collaborative efforts are essential for us to make differences, not only on the Emergency Health Services side but all patient care across Nova Scotia.

Our workforce remains our most valuable asset. With over 1,500 employees - 900 being paramedics - recruitment and retention are key priorities. Since I've joined the

organization in January, we have seen a 41 per cent increase in the recruitment of paramedics - both locally and internationally - and we've also looked at different initiatives and how to increase those numbers.

I'm proud to say that for the first time, our vacancies are down to about 67 across the entire province. It's one thing to be able to get employees, but it's another to also make sure we maintain them. I'm proud to say that, since January, we've had a 51 per cent reduction in the amount of attrition for paramedics across the province.

New roles are being introduced, as Emergency Health Services have just announced with the EMR program, and we're very excited. Not only is this a new tool in our toolbelt to be able to utilize, but it's also a stepping stone where individuals can enter a career and progress throughout into paramedics and other types of roles.

We're also working with the union: In December of 2023, with the Nova Scotia Paramedics Union, we were able to reach one of the best agreements that we've been able to make. It's made an increase in pay for employees, it's had a huge impact on the employee morale, and it's allowed for us to create more permanent and casual positions. This new role has allowed us to stay competitive not only here in Atlantic Canada but across the country.

We're committed to supporting our employees and improving health and safety through proactive improvements. We've added a lot of mental health supports, and we're going to continue to increase those efforts. I'm proud to say that we're looking to add in a psychologist through our Medavie Blue Cross organization who's going to be able to provide direct support to our frontline staff. This is important so that we can get them back out in the communities after they experience very difficult situations and make sure that they have the support that they need.

As a paramedic myself, I find it crucial to stay connected to the frontline staff. I try and get out as much as I can, and I think this allows me to see how things are actually operating in the front lines and be able to make adjustments through our senior teams as the system evolves and changes.

Looking ahead, we're committed to addressing several challenges, including human resources shortages, increased call volumes and off-load delays, just to name a few. Our system innovations - such as direct transfer of care - has allowed us to put units back out onto the road. About 13 per cent of all calls now, patients are being transferred to the waiting room when we arrive at a facility. With some of our other programs, like our clinical teams and our Medical Communications Centre, care starts the second that somebody answers the phone. We're able to utilize the physicians, nurses, and paramedics in that centre, and I'm proud to say about a third of our calls result in non-transport, which allows us to be able to get to people quicker.

We've seen a 36 per cent reduction in response time across the province - not just urban but rural - and we're continuing to look at innovative ways to be able to do more with our resources. We're committed to the ongoing collaboration, innovation, and responsiveness to meeting the needs of Nova Scotians. This includes continual feedback from our front line. We've created employee advisory committees. We're looking at all kinds of different ways to get feedback from the frontline staff and make sure that they're involved in the decision-making.

In conclusion, I just wanted to say thank you for the opportunity to be here today. I wanted Nova Scotians to know that our team is continuing to push forward and strengthen the work environment to ensure that not only our employees are supported but all of the individuals in the communities are as well.

THE CHAIR: Just quickly a housekeeping item. Originally, the clerk recommended that we stop at 10:35 to do committee business. I'll bump that up five minutes to 10:40 because we started five minutes late.

Without further ado: this committee is 20/20/20. If you're in the middle of an answer and I cut you off, I don't make the rules - I just follow them - so my apologies. We'll start with our Liberal colleagues.

MLA Clark.

BRAEDON CLARK: Thank you, everybody, for being here this morning. Deputy Minister MacKenzie, you touched on a word in your opening comments that I wanted to home in on a bit, and that's the fact that the health care system is interconnected. I wanted to start by talking about the interplay between primary care and emergency care.

As we all know, the number of people without a family doctor in Nova Scotia has gone up tremendously over the last few years. It's up over 160,000 people now, just over 16 per cent of the population of the province. That growth is not distributed equally either. For example, in the area I represent, that number has gone up between three and four times over the last three years. Talking to people over the Summertime, knocking on doors, I would say it remains the Number 1 issue for a lot of people.

A lot of the programs and policies that have been put in place, I see - and I think a lot of people would see them - as supplements to attachment to primary care, not substitutes. I think that's a distinction that I think most people would agree with. They want, as a foundational piece - a fundamental piece to their health care - to have a family doctor.

Deputy Minister MacKenzie, I'll direct this to you. If you want to direct it to others as well, feel free. I just wanted to start and say: What impact does that massive increase in people without a family doctor have on the emergency care system?

DANA MACKENZIE: You're absolutely correct - the system is interconnected. Your question highlights the impact of the NFPR, or the unattached list, on the emergency care system. With respect to a complete answer, I'm going to signal that I'll eventually ask Colin Stevenson and Dr. Boutilier to weigh in on efforts undertaken to deal with some of the ED impacts and some of the things we're seeing there.

In terms of the interconnectedness, I think that one of the important things is to realize that there is real progress being shown on people accessing care at different points in the system through virtual care. The people on the NFPR list are entitled to unlimited virtual care, and there has been a great deal of uptake with respect to that service. Many Nova Scotians are availing themselves of that particular option. I think the number - and I'll stand to be corrected by my colleagues - of the addition of 70,000 additional appointments each month in the system, we are seeing that lower-acuity patients are not showing up in the EDs as a result of those access points being created. I'll defer to my colleagues Colin Stevenson and Dr. Boutilier to elaborate on that if they feel that that would be helpful.

In terms of the impact, because of the challenges associated with access to care in terms of the NFPR, our efforts remain relentless on things like trying to recruit and ensure that we're doing all of those things from a health human resource perspective that we can to compete globally with respect to ensuring that we continue to be relentless in our commitment to improving access to care for Nova Scotians.

With that, I will actually hand the microphone - if it's okay with the Chair - to Mr. Stevenson, our chief, and to Dr. Boutilier.

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: I can't quite make eye contact with Nicole, so I'll talk a little bit from a strategy perspective, and then she may want to talk about some of the specifics, if it is helpful for the answer.

As the Deputy Minister has indicated, the intention around emergency care as one piece of it really is tied to all the pieces of work that we're doing within the health strategic plan - Action for Health - and the ability to create access to care from a primary care perspective but also access overall, if you think about it holistically.

I'm sure, through the course of today, we'll get an opportunity to talk about improvements in in-patient care, as well as improvements in pre-hospital care through the EHS/EMCI side. The question specific to primary care and the impact on emergency - really, the opportunity that we have had is not just for those who are unattached but for all Nova Scotians to understand that there are different places and ways to access care when you need it.

[9:30 a.m.]

Historically, I think everybody went to an emergency department because the emergency department is what they've known. We're seeing more and more uptake for things such as urgent care to other alternative primary care access points, such as virtual care - as talked about - or mobile clinics, or primary care clinics for those who are attached.

As the pharmacy uptake has grown, we see a lot of that with folks - higher utilization of, say, the pharmacy walk-in clinics for folks who are unattached. We are seeing that coinciding with reduction in the use of emergency departments to the point where the number of emergency departments that are being utilized by individuals who are unattached is starting to approach the same as what it is for somebody who is attached. It's starting to normalize. We're seeing over time that it's moving in that direction, so that unattached population is starting to have a reduced amount of impact on the emergency departments.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Great start to the question about talking about our connectedness, because I think the most important thing we can highlight today is that the system accountability approach that we're taking to improve care is across the system. You don't fix one section without fixing everything. Our steady, incremental progress over all the ways of care is really what we need to highlight. As we make improvements in the emergency system, as we make improvements in the in-patient hospital zone, as we make improvements in the community, all of those things work together to get us to a better place.

As Colin just mentioned, we have lower-acuity options. The triage Levels 4 to 5 - you've heard us speak about that before. They've been decreasing in our emergency rooms as there's more access in the community for people to find other ways. We also know that emergency rooms are becoming increasingly complex. With more and more aging of the population, we get more complexity.

When we look at primary care, we really had a historic master agreement where for physicians we now have an agreement where we are being lauded in Canada from the CFPC to actually bring people here. We've seen . . .

THE CHAIR: Order. Mr. Clark is signalling that he'd like to ask another question. Mr. Clark.

BRAEDON CLARK: I apologize, Dr. Boutilier. I don't mean to interrupt you. We have 20 minutes, and I'd like to get through as much as I could. I also wanted to ask a bit about accountability and some targets in terms of the metrics of how we're doing. The Province's goal is 90 per cent of ambulance off-loads in 30 minutes or less. What are we

actually achieving on that metric at this point in time? I'm not sure precisely whom I should address that to. Mr. Fraser, maybe?

THE CHAIR: We'll start with Mr. Fraser. If you want to pass it off, you can.

Mr. Fraser.

JEFF FRASER: I'll pass it off to the Nova Scotia Health Authority.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: As I spoke to a few minutes ago, this incremental progress, we've given teams and targets of 10 per cent reduction every month, month over month. We've seen a 50 per cent reduction at the 90th percentile for all off-loads, returning 7,000 hours to the community for EHS.

As we do that, it's a very systematic approach. We're not just looking at that one target. We're looking at multiple targets right across the system so that all the teams are working together towards the same goal. As we challenge the teams, on top of this we've had this increasing complexity. We have 400 more people being admitted to our hospitals every year, and we also have just growing people who are coming in needing different levels of services. So the teams have been able to get together and do that. We've had workshops, they have toolkits, we've added many things, like the RAZ. We heard talk about the Rapid Assessment Zone and how we can look at different acuity levels differently in real time in the emergency room.

We've added float teams, we've added care providers, we've added different professions to the emergency room. Nurse practitioners . . .

BRAEDON CLARK: Again, apologies, Dr. Boutilier. I know it's a complicated issue. I'm not trying to cut you off, but I want to make sure I understand the metric here. You started talking about that at the beginning there. The goal is 90 per cent off-load and under 30 minutes. I know that your goal is 10 per cent improvement month over month, but right now, today, what percentage of off-loads are happening in 30 minutes or less? Do we have that?

DR. NICOLE BOUTILIER: Over 30 per cent now are happening at that 30-minute mark. I will say that the 30-minute mark is something that - there's not a national standard or anything. Some places are 60 minutes, some places are 45 minutes. There's nothing that's a national standard around that.

We started with that, and what we've seen is we've decreased 110 minutes all over the place on that particular metric at this point in time. It started in February. It's been the

first time Nova Scotia's taken a systematic approach. This problem is not new. It's been happening since the early 2000s, and we actually are making real-time progress.

BRAEDON CLARK: Moving to ambulance response times, kind of a similar vein of questioning here. The goal was to have 80 per cent of ambulance responses within the target. What is the percentage right now that are within the target, in terms of ambulance response times from call to arriving on scene?

THE CHAIR: Mr. Crossman.

MATTHEW CROSSMAN: Our goal is to improve response times all across the province. As I mentioned before, we've had a significant improvement since January. We've reduced the overall response times from 36 minutes to 18 minutes across the province in emergency settings, and we're continuing to push on that metric.

We're working really closely with our partners at the Department of Health and Wellness. We've implemented a bunch of different initiatives to address this. As I mentioned, a third of our calls are not being transported now - they're being cared for in the community because they're not necessarily an emergency situation that needs to go to the hospital. We're being able to treat those patients better in their homes and in the communities.

As Dr. Boutilier mentioned, when we look at off-loads, we know whatever we can do to help decant the hospitals is another big initiative, so we've implemented a program where we're doing supportive discharge through our paramedics and also through 811. Patients who are in the hospital, we're trying to get them out of the hospital quicker and support them better at home, and all this has impacts on our response times.

BRAEDON CLARK: As we all know, there was an AG report last year about ground ambulance services, which had within it 14 recommendations for improvements going forward. I'm wondering: At this point in time, how many of the 14 are complete and what is the timeline to complete the remainder, if there are some left over?

JEFF FRASER: That report obviously was tabled at the start of October last year. There were 14 recommendations. We have eight of 14 complete. Two will be done in the next 30 days, and the remaining four we'll work on throughout the rest of the year, with the goal of achieving this - as the AG has outlined - within the two-year period.

BRAEDON CLARK: The endpoint to have all 14 complete, Mr. Fraser, would be October 2025. Is that right?

JEFF FRASER: That is correct.

BRAEDON CLARK: One other question on wait-time targets, and that's with regard to emergency department wait times. The goal again is, in this case, 90 per cent within the target. Where are we at on that particular metric in terms of how long people are actually waiting in the ER rooms?

DR. NICOLE BOUTILIER: Matt can probably give us the exact number right now for that. We tend to look at it in a little bit of a different way. When we do time to triage - and that is our actual measurement of when people start to receive care. If we're accepting them from emergency, they're already receiving care. We measure time to triage as that because when you come into the emergency room, you are immediately - as you get to triage - starting your care path.

BRAEDON CLARK: Dr. Boutilier, do we know what is the time to triage right now, and how would that compare to the last number of years as well? Do we not have that at hand? I just want to make sure.

DR. NICOLE BOUTILIER: Matt Clarke, the chief data officer, is behind me, and he's getting the number for you.

THE CHAIR: MLA Clark, do you want to continue?

BRAEDON CLARK: Yes.

THE CHAIR: MLA Clark.

BRAEDON CLARK: Thank you for whenever that comes. I appreciate it.

Another issue is surgical volumes. We know that population growth in Nova Scotia over the past three or four years has been essentially off the charts compared to what we've been used to for the previous number of decades. How do surgical volumes and the ability, in some cases, to keep up with that demand - how does that also impact emergency care, to our earlier discussion of the interconnectedness of the system in general? Perhaps that's for Nova Scotia Health Authority.

THE CHAIR: Mr. Stevenson.

COLIN STEVENSON: I'm happy to start, and Nicole may want to fill in. I won't be able to give you the exact numbers associated with the surgical volumes. I don't have that information with me today. But we have been seeing a reduction in the wait-list associated with surgeries. That really is, again, tied to the strategy around focusing on increased hours of operation from the ORs themselves, and ensuring that we have protected in-patient capacity associated with beds, which is a key component to it, and utilization of the different sites and locations. Expansion of opportunities for ophthalmology and

increased use for the East Coast Surgical Centre within Dartmouth have been the big strategies associated with that in particular.

I think the big piece, as it relates from surgery to in-patient capacity to EDs, if we're thinking about that from the connectivity, really would be the increased focus around how we support patients to move through the system so that they're not staying in beds as long as they previously were - so reducing the length of stay for in-patient, which actually has a spinoff on both sides. It allows for protected beds and increasing surgery, and it allows for patients to actually have a more timely move from the emergency department into in-patient capacity.

There would be a number of strategies that can actually be spoken about when it relates to access and flow in the sense of increasing the care teams on weekends, the mobilization team, and the C3. They are all examples of key initiatives that would be increasing and supporting the movement of patients within a hospital, which actually creates the capacity within the emergency department.

THE CHAIR: MLA Clark with approximately two minutes.

BRAEDON CLARK: Two minutes. I'll get to this question, hopefully, here. Last year, as we know, the AG report came out. The department at that time indicated that there would be the possibility of fines for EMC if they did not meet targets with regard to ambulance response times.

I'd like to ask Deputy Minister MacKenzie: Has the Department of Health and Wellness had to issue any fines against EMC in that regard? If not, why not?

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: I'm going to confer with Mr. Fraser for a moment. My recollection is that we have not, but I just want to double-check on that quickly.

That particular item came up in the AG report as one of the items, so Mr. Fraser is going to actually take the answer here.

THE CHAIR: Mr. Fraser.

JEFF FRASER: That's one of the remaining items that we are working through. We have initiated the change request process with EMCI. We're in the process of negotiating around what penalties will be involved within the system. That's one of the ones we are hoping to achieve within the next month.

BRAEDON CLARK: I appreciate that. If any fines were to be issued, it would not be at least until a month or so from now, when that system is in place, is that right?

[9:45 a.m.]

JEFF FRASER: That's correct.

BRAEDON CLARK: Chair, am I out of time, more or less?

THE CHAIR: You have a whopping 20 seconds.

BRAEDON CLARK: Well, I'll thank everybody. We haven't heard Dr. Boutilier.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Our goal is to have 90th percentile for the time to the physician. It's currently at 4.2, down from eight hours.

THE CHAIR: Impeccable timing. I'll recognize MLA Leblanc with the NDP for their 20 minutes.

MLA Leblanc.

SUSAN LEBLANC: Thanks to everyone for being here. Can someone tell me how many nurse practitioners are now working in ERs across the province?

THE CHAIR: Deputy Minister MacKenzie.

DANA MACKENZIE: We're just going to take a moment to go through it to get you the number, which I believe NSHA would be the best responder on that particular item. I'll defer to Ms. Oldfield and Dr. Boutilier to help us find that number.

THE CHAIR: Okay. While they are getting the data, MLA Leblanc.

SUSAN LEBLANC: I have a couple more of those. I'm looking for how many NPs are working in the ERs, how many physician assistants are working in the ERs, how many agency nurses are working in ERs and how much was spent on agency nurses and how many net new ER physicians are there?

Those are some data questions. You can let me know when those are ready and then I can ask another question. Is that okay, Chair?

THE CHAIR: Sure.

SUSAN LEBLANC: I guess the next question is maybe for the data people too. This whole action plan on emergency rooms was devised following a response, or an

increase, in ER deaths. It seems that knowing the current metrics on ER deaths is a good way to assess the success of the action plan.

How else is the department tracking and measuring the success of the action plan? Is there any other data on hallway medicine? I know you've mentioned a number of things, you don't need to repeat those things but are there any other ways that the action plan is being measured and are there any data on hallway medicine, i.e., how many patients are being treated in the hallways? How often and where?

THE CHAIR: Perhaps we'll start with Deputy Minister MacKenzie.

DANA MACKENZIE: There are a lot of data points there so we're going to scurry to find the ones that you spoke about. Your question relates to actions and measurement related to the actions to improve emergency care that was in response to the earlier report.

I'm going to go through some of those actions and the progress in terms of how we've been measuring things. You will recall that one of the responses with respect to the emergency care plan was to ensure that those with the most urgent needs get care quicker. The response in that regard was having teams led by doctors focus on getting patients out of the ambulance and into the emergency department faster.

In terms of the progress on that particular item, FLOAT positions are now in play that allow emergency physicians to focus on rapid assessment of patients and efficient flow into and through seven EDs. The off-load assessment teams made up of nurses and paramedics are at 11 EDs. They move incoming EHS patients into the ED or into an off-load zone, freeing up EHS paramedics. That's one of the measurements and actions we're taking.

The other piece is with respect to that plan that you referenced, assigning physician assistants and nurse practitioners - I know you've asked for the numbers - to provide care in emergency departments. Flipping through our materials we can see that LPNs, NPs, and physician assistants have been added at Nova Scotia Health Authority ED sites to create a more multidisciplinary approach to ED care: 21 EDs currently employ 119 LPNs; eight EDs currently employ 10 nurse practitioners; two emergency departments – Eds, so I'm careful with my acronyms - currently employ four physician assistants, with a physician assistant training program currently ongoing.

The other way we are trying to achieve that goal of ensuring that those with the most urgent care needs get care quicker is to add care providers and patient advocates to support the patients in the waiting rooms. There are approximately 100 waiting-room care providers and patient advocates. They have been added in 13 Nova Scotia Health Authority and IWK Health Centre emergency departments. They provide increased support and comfort measures for patients in EDs.

The other piece that's attached to this goal of ensuring that those with the most urgent care needs get care quicker is respect to making virtual care available to more patients with less urgent needs. VirtualEmergencyNS provides support by linking appropriate patients with emergency physicians and is available at Yarmouth Regional Hospital and All Saints Hospital; 3,358 patients have received care through that pathway.

VirtualEmergencyNS connects appropriate ED and urgent treatment centre patients to out-of-province physicians. There have been 21,065 visits via this platform to date. In addition, some callers to 811 who had previously been given direction to go to an ED have been directed to VirtualEmergencyNS, avoiding ED visits in most of those cases.

THE CHAIR: Order. I think MLA Leblanc has another question. MLA Leblanc.

SUSAN LEBLANC: I just wanted to follow up on those numbers of the staffing positions. When you just listed that eight EDs have 10 NPs, two EDs have four PAs - those are the numbers that I was requesting earlier. (Interruptions)

I just want to then ask, first of all, quick answer: How many EDs are there in the province?

DANA MACKENZIE: For a total number, I'm going to defer to the experts and Dr. Boutilier. I don't want to say the wrong number.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: We have 10 regionals, one tertiary care, seven UTCs. We have 11 community . . . (interruption).

THE CHAIR: MLA Leblanc.

SUSAN LEBLANC: Basically, for only two EDs in the province to have four physician assistants, I'm wondering: What is the plan? Is the plan to add more NPs? When can we see NPs across the spectrum of EDs? I'm assuming the training program will help with the PAs, but what is the goal for that, for PAs and NPs in particular?

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: I think the goal is we need to train more NPs. As we've indicated to the committee before, we've increased the number of seats and we are looking for ways to increase the pathways for RNs to become NPs. Nurse practitioners have become a very valuable resource in the province. From my perspective, the more we can possibly recruit, retain, grow, and educate, the better.

It's the same with PAs. The program was started. The first class will graduate, I think, at the end of 2025. That is 26 PAs. They're also highly sought after, not just in our ERs, but there would be many collaborative clinics that would also want to have a physician assistant, as well as a health home, and many of the other clinics in our province. Again, if I could triple those numbers, I'd be happy to.

SUSAN LEBLANC: I'm sure everyone is aware of the awful story out of Truro about the child whose misdiagnosis, including at an emergency department, was found to have a bacterial brain infection and then had emergency surgery at the IWK. My first question is: How does something like that happen? Obviously, I'm not a physician, but there were two physicians who saw the child, and then they were brought into the IWK. How does something like that happen, and how frequent are those near-misses? How are they tracked?

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Anytime we have something that we look into, we initiate processes through our Quality and Patient Safety Department, where we invoke a full investigation and a review called a quality review, where it looks at the instances of, was there any kind of system failure? What things can we improve on? What were the factors that contributed to the situation? A lot of that is we assign people to look into that from other places or from other hospitals, things like that. We have a full-scale review.

SUSAN LEBLANC: How many of those types of reviews, the serious patient safety incidents, have there been in the last year, and how many reports come out from those reviews?

DR. NICOLE BOUTILIER: We'd have to get that number for you.

SUSAN LEBLANC: The next question about those is: Do the reports contain recommendations? Are they specific to the actual incident itself, or are they more broad recommendations? What accountability measures are put in place to ensure that the reports lead to actual changes and improvements?

DR. NICOLE BOUTILIER: The recommendations can be both. It just depends on the quality of the review in terms of where it leads us. We fill it out. We go through it. We list the recommendations. We put time frames around all of them to implement.

SUSAN LEBLANC: I guess my next question is for the deputy minister. Although the Nova Scotia Health Authority is conducting its own internal quality review about that incident, there have been calls for a more comprehensive system-wide review of factors that led to that particular incident. I'm wondering if that's something the department is considering.

DANA MACKENZIE: The quality review and the process that's been investigated is a legislated, publicly known process that is dedicated to a fulsome, complete, in-depth review inside the facility where the event happened. We have a lot of confidence in those processes. We would be supporting that and wanting to ensure that we are as supportive of our NSHA colleagues with respect to providing whatever that process needs, but there wouldn't be a parallel process inside the Department of Health and Wellness.

SUSAN LEBLANC: For the department, and also NSHA, part of the 14-point plan included adding a second EHS LifeFlight aircraft for patient transfers. NSGEU has recently said that EHS LifeFlight service at the IWK was out of service for about 50 hours between January and March this year because of a shortage of respiratory therapists. Can anyone speak to the staffing capabilities in the province right now to operate two EHS LifeFlight aircrafts?

JEFF FRASER: You are correct. There were challenges earlier with the respiratory technicians, but the IWK is working really hard to be able to fill that gap for us. We're comfortable that we're able to provide service not only to Nova Scotians but in our sister provinces. We do provide critical care service support to those provinces as well, so our air program is exceptionally busy, and our staffing is well on the way to being as solid as it possibly can be.

SUSAN LEBLANC: Are you confident that we can operate two aircrafts right now?

JEFF FRASER: What's important to note is that we have two helicopters. One is operational. The other is used so if we have any issues with maintenance that we don't have any delays so we can get another aircraft in the air. We don't fly two helicopters at the same time.

The teams are comprised of adult teams that are based at the airport. Pediatric, neonatal and maternity teams are based at the IWK, so we mobilize those teams. Beyond the aircraft, we also have a ground critical care unit as well. It's important to note that two helicopters do not fly at the same time.

SUSAN LEBLANC: Good to know. Then why was adding a second helicopter part of the 14-point plan, or am I misinterpreting the plan?

JEFF FRASER: Potentially. The reality is that there's a lot of downtime that occurs after an aircraft is as busy as ours is, so we can reduce the mechanical downtime and have an aircraft ready to go so that we minimize delays.

SUSAN LEBLANC: Sorry, I'm going to skip over that question because I think it was answered. Can EMCI provide an update on whether EMCI has developed a staffing strategy, or what stage are you at with developing that?

[10:00 a.m.]

MATTHEW CROSSMAN: We have developed a comprehensive strategy plan. We've worked with the department and are actually reviewing it again this week. We have a five-year forecast for projections on what we're going to need for numbers, and we're holding ourselves accountable every single year to recruit and retain.

As I said, we've made a lot of progress around staffing. I don't want to take our foot off the gas. That's going to be something that's going to be paramount to our success over the number of years. We're feeling really good about the changes that have been made. When I'm out with the frontline staff, I'm hearing a lot of positive feedback that things have changed, and things feel a little different. I think that's going to be really important for us to retain staff.

It's one thing to get people through the door, but it's another to better support them and make sure that they're given all the things that they need to be successful. That's going to be our focus as well: supporting that workforce.

SUSAN LEBLANC: In July, the NSHA agreed that ER deaths are partially due to sicker patients stemming from the family physician shortage. Most of you referenced some of the steps being taken to keep people out of the ERs. Can you tell us how many Nova Scotians have been attached from the Need a Family Practice Registry to new collaborative family practices that opened in 2023 in Masstown, Amherst, and Eastern Passage?

DR. NICOLE BOUTILIER: We would have to get those numbers for you.

THE CHAIR: MLA Leblanc with about three and a half minutes.

SUSAN LEBLANC: Today? Like now, or follow-up after the meeting? Okay, that's fine.

KAREN OLDFIELD: I think it would have to be follow-up. We need to make sure it's right. I don't want to be giving any misinformation.

SUSAN LEBLANC: Great. Can you tell me if all of the new collaborative family practices have family physicians working full-time, or are some still being staffed totally by nurses and nurse practitioners?

DR. NICOLE BOUTILIER: You may be referring to our primary care clinics that have NPs and nurses only, but our collaborative practice clinics all have physicians as part of them. Depending on where you are in the province, some of the collaborative physicians do other things. They work in emergency rooms and they work in the hospitals. FTE varies from clinic to clinic.

SUSAN LEBLANC: Specifically, I'm talking about the ones at Masstown, Amherst, and Eastern Passage. I'm asking for a friend because the word on the street is that there's going to be one opening in Dartmouth North too, so I'm particularly interested in wanting to know exactly how it will be staffed.

Some are run by nurses. In the release for the Masstown clinic, it was stated that a part-time doctor would join the clinic in January 2024. Did that happen?

DR. NICOLE BOUTILIER: I would have to confirm if that happened at that exact time.

SUSAN LEBLANC: Yes, thank you. Just making sure the clerk is getting these questions down to follow up with. Did the family physicians at the new clinics transfer their roster from one location to another, meaning they had their own practice and then they came under the umbrella of the Nova Scotia Health Authority. Did they transfer their patients or are they new doctors starting new practices, onboarding an appropriate number of new patients for a family physician?

DR. NICOLE BOUTILIER: Just to put it in context, we have almost 100 clinics.

SUSAN LEBLANC: I'm talking those three specifically.

DR. NICOLE BOUTILIER: Yes, but in general, there are two ways. Sometimes we do what we call "stabilize." We stabilize to prevent unattachment. When a new physician comes in, an older physician may be slowing down. They may be giving, sharing part of their resources to start. The person may also take people off the list. It really depends on if they inherit a full list or not, but we do that to stabilize the practice and keep them there.

Sometimes people are going to newer clinics and starting with someone's roster at a new clinic because some of the newer physicians who are coming on, they want to work in a collaborative setting with a variety of health care providers. They would actually maybe replace a retired physician who was in a solo fee-for-service practice, and sometimes those getting-closer-to-retired physicians will actually join us in the new setting as well.

SUSAN LEBLANC: I totally get that. This is why I think it's really important that we know exactly where we are with the Need a Family Practice Registry wait-list. This is something that we've been talking about, but if there are 160,000 people on the list and we are adding doctors, adding nurse practitioners, and adding clinics, then it just feels like we're doing this game of moving - I don't know what the appropriate video game reference would be, but the physical moving people around . . .

THE CHAIR: Order. My apologies. That concludes time for the NDP colleagues. We'll start with MLA Taggart for their 20 minutes.

TOM TAGGART: I can answer the questions on our primary care/collaborative care centre in Masstown, and it is awesome. I can tell you that for sure. I've been very fortunate. I just have to say I love nurse practitioners because they do a wonderful job in those clinics. I just had to say that. I feel very fortunate to have that clinic in my constituency.

I want to thank you folks for being here today to discuss these very important issues. We understand just how important it is to address the challenges of emergency care across the province. Really, this is not a partisan issue. It affects every community in a multitude of ways. Certainly, there are places in our province where the impacts of these programs are happening at different speeds.

That being said, this issue did not happen overnight, and there are no simple solutions. I believe that these new initiatives will have a positive impact on the delivery of emergency care, both in the immediate future and in the years to come. I think that's very important. I would encourage every Nova Scotian who might hear of today's discussion to consider the good work that is taking place and see it as a positive step forward in a much larger process.

A lot of this has already been stated, but I think it's a really important piece. We've made great progress in acting on what was outlined in the emergency department improvement plan. We have brought in patient advocates, waiting-room care providers, flow and off-load teams, and virtual care in emergency departments. Could you please talk about these actions and what they have meant to the patient experience?

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: We do constant evaluations on many aspects of the system. We're able to talk about metrics and data because we do a lot of measuring. One of the areas would be in the waiting room of an emergency department. Let's just take the patient advocate. I'm thinking in particular of evaluations at Dartmouth General Hospital because, actually, Dartmouth General Hospital was an early adopter. Before it was even a thing across the province, Dartmouth General Hospital had such a role. The level of comfort and just knowing that there's somebody there looking out for you gives a patient a great deal of confidence. That's one.

You can extrapolate that across all of the different teams that we've talked about here today. What I hope is coming across is that no more are we operating in silos. This is a team game. It starts when a person makes a phone call to 911. What we have managed to do extremely well over the past year and a bit has been to improve that line of communication between EHS and NSHA, no matter where in the province. We are talking

all the time - what about this? What about that? That also has given, not just patients but our staff as well, such a higher level of confidence that when a call is made, it's going to get answered.

I think that what we're trying to do as a team is to create that safety net, make it as strong as possible, make the lines of communication as strong as possible. That ultimately flows right through to the patient, who hopefully has a much better experience, notwithstanding that they are in an emergency room for a reason; we want to treat them well, but they're there because they have a health concern.

TOM TAGGART: On the same theme, it's been two years since the Care Coordination Centre opened. It's really an innovative initiative. Could you talk about the differences made and what are the plans going forward? I think that ties into the emergency department thing.

KAREN OLDFIELD: You would have to talk to the frontline staff who look at that information coming out on the C3 screen every day, but when I've gone into the C3 operations room, and you talk to the frontline staff, who used to track many of these metrics with their notebook and their pen, and making phone calls: What about this? What about this? What about this? It's impossible with the phone or running to try to find somebody to seek information about a particular patient and their status. It's impossible to track all metrics: Does the bed need to be changed? Do they need bloodwork?

Our technology has greatly improved our visibility, and not just in Halifax. That's the point that needs to be emphasized. We have screens across the province that allow us to have visibility as to bed and bed capacity no matter where we are in the province.

This is work that's not complete. It's almost like an evergreen project because you're never done. However, the next parts of it are to continue to spread throughout the province to make sure that the visibility is complete, but also there will be different aspects of the information that we can glean that can be used in different ways. The C3 team is on all of the metrics determining how we best spread them, how people are best able to see them, take advantage of them, and then use them to improve patient care. It's been an excellent tool. I think it will only continue to increase our ability to improve health care for Nova Scotians.

THE CHAIR: MLA MacLeod.

MARCO MACLEOD: I'm not sure exactly who to point the question to, so I'll direct it to the entire board. I'm here on behalf of the folks of Pictou West. Right off the bat, I will ask: In terms of emergency care, what improvements have been made or will be made in my home community of Pictou County?

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: I just wanted to share with MLA MacLeod that, luckily for him, Dr. Boutilier is from Pictou County, and she will be happy to share the good things that are going on at the Aberdeen Hospital.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: The Aberdeen Hospital is one of our stars in the triage and the off-load. They routinely are between 30 and 60 minutes, and most are closer to 30 all the time. They have an unbelievable culture with EHS where they work very hard. We've had many site visits from other folks there to see what the magic is that allows these teams to do that.

As you know, we have a beautiful new emergency room that allows us to see patients in many ways. The other thing we've added recently is we've begun the work on the rapid assessment zone there by adding a nurse practitioner. The numbers that have been able to go through that part of the emergency room is reducing some of the volumes that previously would have been waiting by 30 per cent.

There are a lot of staffing challenges. As people know, the Aberdeen Hospital has never closed its doors as a regional centre, as all our regional centres are always open. I think it's really to all of the emergency rooms, but they're really making good process. They have the waiting care provider positions filled. They have the patient advocate positions filled. They continue to try to implement all the different recommendations.

We have toolkits that people work on. They have come up with innovative ways to let them know when - and this can go for all the teams across the province - they're looking at ways that they can actually be always aware of what's coming in, what's on the ambulance stretchers, when they're approaching off-load times, and also really close eyes on the patients. We'll be continuing to implement those at the Aberdeen and everywhere.

MARCO MACLEOD: Again, a question for the board. I've heard of virtual care in emergency departments. Knock on wood, I haven't been to an emergency department recently, so I'm not familiar with the virtual care. I was wondering if you could explain how the virtual care and emergency departments affects the patient experience.

THE CHAIR: Dr. Boutilier, we will start there.

Ms. Oldfield.

KAREN OLDFIELD: There are really two things that should be explained: One is virtual emergency and one is virtual urgent.

Let's start with the virtual emergency. We have two departments across the province that are currently using this. It's innovative and it's a Nova Scotia innovation.

The technology we're using was created by Dr. Jan Sommers, who is an emergency physician in Colchester. During COVID she was looking for ways to treat patients and devised this methodology.

[10:15 a.m.]

How it works is that when a person presents, if it is acceptable and suitable, they can be seen virtually. It doesn't work for all cases, of course. The individual will have somebody with them - it could be an RN, it could be another health care professional - while the emergency physician is connected virtually. So the patient is seen virtually and treated virtually. We are currently using that technology in two emergency departments, as I said. As people are comfortable and we are comfortable, then it is something we would look at scaling, if it makes sense. So that's one.

The second pathway is virtual urgent, which is also very relevant to our ERs. I'll ask Dr. Boutilier to touch on that one.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: We have now expanded, I think, to 17 different sites for virtual urgent. When we have people who need to see someone sort of in an urgent way, and we may have different levels of staffing and things like that that are happening, we can actually connect them virtually. It's run by a group we've connected with out of province, so the physicians are out of province. It has allowed us to expand our ability to treat emergency patients.

I believe there have been over 20,000 visits through the virtual urgent path already.

THE CHAIR: MLA MacLeod.

MARCO MACLEOD: I will pass to MLA Sheehy-Richard.

MELISSA SHEEHY-RICHARD: I know it's the longest name in the Legislature so it's a challenging one.

How much time is there?

THE CHAIR: You have until 10:24 a.m.

MELISSA SHEEHY-RICHARD: Thank you. I just wanted to dive in while I have an opportunity to talk about and thank you for the incredible work that everyone is doing. It is appreciated and sometimes it's difficult to see the change but when you are in the change and living it, steps are being taken.

I just want to talk, if we could have the opportunity. I represent Hants Community Hospital, a beautiful little community hospital that happens to be, as I am told by the teams that I meet with quarterly, the busiest Level 3 in the province. Of course, at times the ED does have to be closed, unfortunately, and it can be a concern of the community.

I was wondering if you can talk about reasons why these closures sometimes happen, what that means for the actual ED - is the door still open? What types of things are there - and maybe just a little bit of insight on some steps that are better under way. I hope and understand in the coming months to look at some of that in the community.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Thanks for the question and thanks for the acknowledgement of the work. We are very proud of our teams and how everybody across the system is digging into these issues, helping us.

We do have shortages of different providers, as everyone knows. It's something that all of Canada struggles with. Some of the times when we have to close emergency rooms it may be due to a shortage of providers - maybe physicians, maybe nurses; it varies. We make a really big effort to keep all of them open, especially when it's really important to Hantsport or other ones, during certain times. We really try to focus on that. Our priority has to be, in those circumstances, at times, to pull staff to our regionals or our other community centres. It just depends on where you are and what level of facility we're talking about.

Ideally, we would fully staff and have open at all times, and we make really close connections with our EHS partners at those times so that they know where we are fully open. Some of the advances we've made with that are really with the urgent treatment centres. We have the urgent treatment centres that are predictable and that people know where to go and get the care. There are seven open now; one just opened in Yarmouth yesterday, I believe. Having that scheduled time when people can seek care is really important - if they need an X-ray, stitches, those kinds of things. The other thing is that sometimes when we have closures and we know that the closures will be in the month, we would schedule it rather than just announcing an unexpected closure. We try to avoid unexpected closures above all.

Some of the things that we're doing: recruitment, of course. We're all over the world looking for emergency physicians and other physicians. We have processes now due to changes in either our own college or the Royal College of Physicians and Surgeons of Canada, where we can actually recruit folks who previously wouldn't have been automatically getting a licence through a practice-ready assessment. We've recently started, for the first time in Nova Scotia, practice-ready assessments of emergency room physicians, which gives us a whole new avenue of ability to recruit. It's going very well,

and we expect to continue to bring in more people for practice-ready assessments, to be able to go to our emergency rooms and work.

MELISSA SHEEHY-RICHARD: I just want to talk about some of the implements that were discussed: the virtual urgent care as being a good option for Hants; I know for a fact that we just recently hired a new RN to start in our ED. I think that those are all key, pivotal things to know, and the reassurance there that the doors are never locked, that there is care in the community as needed, and we do have a lot of other alternative measures. It's trying to reset the mindset, sometimes, in a rural community that I represent.

If Ms. Oldfield wanted to add - I think she does - to some of the advancements that I think are being looked at for the community as a whole to reduce the need to go there in the first place. If you will, Ms. Oldfield.

THE CHAIR: Ms. Oldfield, with about a minute and a half.

KAREN OLDFIELD: I think I've said this before at this committee, but if any one of us could wave a magic wand and create teams - whether they are in surgery, whether they are in the ICU, whether they are in the ED - we would. That doesn't work, but what works is we've created the seats. Yes, that does take time. We're recruiting extensively. It doesn't matter which role, which job, which position. Our job fair, as an example, was hugely successful. I suspect we'll be doing it again.

There's no part of the province that we don't have our eye on, and there's no part of the province that we would say, Well, that doesn't matter. That is not true. It is a huge, monumental task. You acknowledge the teams. I do too, every day. Folks are really digging in, and they are working very, very hard, and that's why it's moving, because they're putting the effort to the wheel and it's moving. There's no stone unturned here. In fact, as I've also said before, the good ideas are welcome.

THE CHAIR: Order. That concludes time for the PC colleagues. Our second round of questioning will be approximately five minutes each. I'll start with the Liberal colleagues. MLA Regan.

HON. KELLY REGAN: I hope there's no approximation; it's exactly five minutes each, is that right? Thank you very much for coming today. I know that folks are very busy, and we do appreciate the work that you have been doing. I'm wondering if someone can indicate for me - I notice that in-patient surgeries, when we look at the total number of surgeries for the province, they're down pretty much every week compared to 2019. We were told that our operating rooms would be open 24/7 - this is the government's own data that I'm looking at here. Have we achieved 24/7 operating rooms in this province at this time? For whoever can answer.

KAREN OLDFIELD: The simple answer: No, we have not.

KELLY REGAN: What about surgeries at the Halifax Infirmary? I know that there was a story out some time ago saying that the reason they were down was because they were doing more of the more serious ones. I've spent more time in hospitals this past year than I've ever in my entire life, not because of my health or anything like that but because of a family member's health. I would say the takeaway that I have is: Don't get sick on a Friday. Don't get seriously ill on a Friday because you're going to sit there and wait for someone to perform surgery. Can you give me any indication as to whether we have operating rooms fully operational on weekends at the Halifax Infirmary?

DR. NICOLE BOUTILIER: First of all, I want to go back. We've actually had a 25 per cent reduction in our surgical wait-list and we operate in our operating rooms seven days a week, elective versus planned surgeries. All those emergency surgeries are available.

KELLY REGAN: I understand that there has been a reduction in the wait-list, but according to the government's own public relations people, the number of in-patient surgeries is down. Why is that happening? If you look at your own data, you can see week after week the numbers are down from 2019. That's in-patient surgeries.

I will tell you because I only have a certain amount of time and I'm not going to listen to a regurgitation of the stuff that we've already heard. I'm going to say my piece. That is listening to folks here who I know are working very hard. It's a very different reality when we talk to our constituents. They are upset. They have a very different experience - diabetic patients left to sit in rooms for hours and hours, no meals.

I was in emergency repeatedly this past year with an adult child who is very ill. At no time did anyone ever identify themself as a waiting-room care provider or patient advocate. My child was extremely ill. The surgical resident said, Quite frankly, if she had been older or in less good shape, she would have died from what she had, and she would sit there for hours. You may say, "Oh, the time to triage," but I'll tell you triage is just the first part. You can get triaged in minutes and then you sit there for hours and hours in agony.

Then you wait for three and a half days to have a stent put in - a simple operation, but because it's over the weekend, you're sitting there. This is the kind of thing that still continues to happen in this province. Don't get ill. Don't get really sick in Halifax on a Friday is all I'm telling you.

These are good improvements, having patient advocates, but if they don't actually go around the room and check on people, it's no good. I've never felt so helpless in my life. Watching my child yellow because they're . . .

THE CHAIR: Order. That concludes time for the Liberal colleagues. I recognize the NDP. MLA Lachance.

[10:30 a.m.]

LISA LACHANCE: I only have a short time, so I'm going to have some rapid-fire questions, hopefully. I certainly understand the interconnectedness of the health care system and the need for everything to be working well together.

Thinking about primary care attachment, the last time we had publicly available figures, Halifax Citadel-Sable Island had one of largest amounts of unattached patients in the province. I think we were at 23 per cent in June. I would say too that the number of people on the doorstep whom I talk to who just haven't even bothered to get on the wait-list because they're like, "When will it ever happen?" People have not bothered to update the wait-list. People are just skeptical that they'll ever have a primary care provider.

One of the questions I asked the Minister of Health and Wellness in that time in a written letter - I don't think I've received a response - is: If I have a riding with 23 per cent of folks who are unattached, how do we know people are also receiving primary care from Halifax Citadel-Sable Island? How many folks are having virtual care appointments? How many folks are at a primary health clinic? Do we have that information?

I am willing to consider that there are various ways for folks to access health care, but I want to know that almost a quarter of the folks in my riding who don't have a primary care provider - those people who registered - also have access in different ways to primary care.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Yes, we know the numbers of people who access in different ways and watching that carefully - I could never say off the top of my head in your riding or anything. One of the things about the registry that people don't . . .

THE CHAIR: I think they're signalling that they have another question to follow up to that.

MLA Lachance.

LISA LACHANCE: I do apologize. I only have a few minutes.

I have asked the minister for that information. The information specifically for my riding would be excellent, and potentially for the whole Central Zone would also be helpful. I think that the Action for Health public reporting includes numbers of appointments at primary care clinics and for virtual care for Western, Northern, and Eastern Zones, but not Central. It's really essential that we know how folks in the Central Zone are able to access care.

I wanted to ask some questions along the lines of what MLA Regan was talking about. I think patient advocates, the physician flow advisors, rapid assessment centres - these all sound like excellent innovations. What I'm wondering is - particularly when I think about the physician flow advisors, nurse practitioners, others - when are they working? We have information. We know when ERs are at their busiest. It tends to be evenings and weekends. Is that when the seven patient flow advisors are working in the ERs?

DR. NICOLE BOUTILIER: We try to fill as many shifts as we can every day of the week.

LISA LACHANCE: Maybe we can get very specific. Is there a physician flow advisor at the ER at the QEII, and what hours do they work?

DR. NICOLE BOUTILIER: It depends on the facility. It depends on the way they organize their shifts. It depends on how many shifts are filled.

LISA LACHANCE: In your best estimation, or as a policy, are those shifts assigned based on demand at the ERs?

DR. NICOLE BOUTILIER: We always are - and the Department of Health and Wellness can speak to this - looking at the flow and the number of physicians and how many physicians we support for any one shift. We would try with a float physician to have it at the most appropriate times.

It's different for every facility, when they actually decide when they're going to have it. One facility may have different shifts that overlap and it's better to have it at a different time.

LISA LACHANCE: If that specific information is available, I'd be grateful to receive it.

I have another question. In terms of collaborative health care clinics, the theory around physician health homes or collaborative care clinics . . .

THE CHAIR: Order. That concludes time for the NDP. I'll pass it on to the PC colleagues.

MLA Taggart.

TOM TAGGART: My question, I think, is for Mr. Fraser or Mr. Crossman. EHS has been innovative in complementing its paramedics through introducing emergency medical responders and investing in medical first responders, such as firefighters. In a rural

area, they're pretty darn important to our communities. Could you please outline how each of these roles has helped to expand EHS's capabilities?

THE CHAIR: Mr. Fraser.

JEFF FRASER: MLA Taggart, I think the guiding principles that we began to follow a few years ago - we know that not all patients need a paramedic, not all the callers need an ambulance, and not every patient needs a hospital. We continue to transform the system.

You asked about emergency medical responders. That is the new profession that we've created over the last eight months to help augment the EHS system. We've also spent a great deal of time working with our partners across the medical first-response community, or the firefighters, which you've indicated, which is an integral part in our link of care.

As discussed earlier, care begins when you access 911. Across many of our rural communities, we have medical first responders there. I've spent a lot of time in that space over the last number of years, not only acknowledging the downstream effect of ambulance off-load challenges that have happened and what their experience has been, but really trying to refocus on what we're asking these folks to do within the community. They make a difference.

I worked as a paramedic myself many years ago, and nothing was more comforting than arriving on a scene and running into one of these folks. That is a part of our program. We've focused on training, enhancing their training, enhancing their equipment, and we've got a road map, over the next number of years, of enhancements we'll continue to make and invest in these important resources across our system.

TOM TAGGART: Time?

THE CHAIR: You have until 10:39 a.m.

TOM TAGGART: I just want to follow up on that. What I call medical first responders - Truro firefighters - are a godsend in our communities and some of them are extremely well-trained, committed volunteers. I'm thrilled to see that you folks - if I understand it right - see that value, are working with them, and maybe training them up more in certain places. I really appreciate that.

No matter what new initiatives are brought in, we need staffing. There's no question about that. I know you folks had great success with the paramedics from Australia - 30, I believe - and I believe we've made advances in growing 80 staffing members. Would somebody here like to talk about the progress being made in recruiting staff whom we need

for emergency departments and Emergency Health Services? It hasn't been said already, but I think it's one of our biggest challenges - staffing?

THE CHAIR: We'll start with Mr. Fraser.

JEFF FRASER: I can start, and I'll probably hand this off to Mr. Crossman. Going back to what I said a few moments ago, the diversification is important. Not all patients need a paramedic, and so what we've done and spent time and the space over the last two years is look at how we split our system up and make sure that we've got the right provider responding to the right patient at the right time.

That included the development of transfer operators, recognizing that almost half of our service's volume is moving patients in a facility, work that paramedics don't necessarily need to do. We're below 20 per cent of the time now that paramedics are moving patients in between facilities, and we use this number today. You've heard about the impact of our aircraft on moving transfer patients, which creates capacity in the community, the fantastic work that the Nova Scotia Health Authority has undertaken to free up capacity in the community. This is all about increasing the capacity and making sure we've got the right provider for the right patient at the right time. That's really what our focus has been.

As far as recruitment and retention go, I'm going to turn it over to Mr. Crossman.

THE CHAIR: Mr. Crossman, you have 25 seconds.

MATTHEW CROSSMAN: As I mentioned earlier, we've had great success in recruiting. You mentioned the Australia mission. We're actually doing another one right now which has yielded great success. Locally, we're really focused on getting Nova Scotians into the programs, and EMR is a great step for people to try it, see the profession, and then continue through their career. We're really confident, over the next number of years, we're going to close the gap.

THE CHAIR: Order. This concludes our questioning. I thank the witnesses. I'd invite them for some brief closing remarks if we have any. I'll start with Deputy Minister MacKenzie.

DANA MACKENZIE: Thank you to the committee for your questions and the exchange here today. I didn't want to close without addressing MLA Regan's remarks. They are compelling, and when I opened my remarks, I talked about putting patients at the centre of everything. Any negative experience is really hard, and we regret and are sorry for those types of experiences and are committed to and open to talking to you more about it so we can understand the experience and learn from it.

Patient experiences are the most important input we have, and we are collectively doing more. We are seeing improvements in flow, response time, and ambulance hours but we do need to keep hearing from the patient. Appearances like today help us with that. The system can only change when the system listens to all of its parts. Thank you for this today, thank you for the questions, and we look forward to talking more about this as time goes on.

THE CHAIR: Ms. Oldfield.

KAREN OLDFIELD: As the deputy minister says, this team and many more are completely committed to transforming health care in this province, from shortening the wait times in emergency departments to ensuring that Nova Scotians are aware of all their care options. These are very important things.

I do have one little, tiny point that I would like to share because I think it's important, and I don't know how I missed it. When we talk about patient advocates and waiting room providers, there is one thing that we have trialled that I think is going to be really good going forward and that is it's a wearable. It's been trialled at the Dartmouth General and it sends vital signs direct to the triage desk and to the charge nurse. This is yet another tool that gives our patients comfort that somebody's there and watching for them.

I think we are going forward to scale that across the province, so that will be coming soon.

THE CHAIR: Thank you, Ms. Oldfield. Okay, seeing no other hands here, you are free to carry on your day.

We have a significant amount of committee business here, so I'm going to just hop right into this. I think probably the most pressing thing is for topics, to have topics in the upcoming meetings. Perhaps we'll move into our agenda, a record of decision.

MLA MacDonald.

JOHN A. MACDONALD: Reviewing the Record of Decision as presented, as opposed to reading all this out, I'm just going to say that I move to accept the Record of Decision with the exception of the items of the one for population growth, the topic of government measures addressing affordability, the item of virtual care contracts, and the Nova Scotia Loyal program.

THE CHAIR: MLA Leblanc.

SUSAN LEBLANC: Sorry, can we have just a two-minute recess to digest what the member has suggested?

THE CHAIR: A two-minute recess. We'll be back at 10:45 a.m.

We are now in recess.

[The committee recessed at 10:43 a.m.]

[The committee reconvened at 10:45 a.m.]

LISA LACHANCE: I think I just want to clarify why the government is suggesting to remove the topic of virtual care contracts.

THE CHAIR: MLA MacDonald.

JOHN A. MACDONALD: I would just submit that we had 13, which is a huge number that went through, and I just went through ones that I thought could be deferred or they've been discussed at other ones, so I'd just leave it at that.

LISA LACHANCE: I think we can all agree that health care is critical. This is what this government ran on. We just heard a wealth of information, but really also too common a message that our health care system, of course, is interconnected and complex, so I think that we should retain virtual care contracts in this list.

THE CHAIR: MLA Clark.

BRAEDON CLARK: Just a quick point: I take MLA Lachance's point. I understand that the die is cast here, more or less, but I also just wanted to make the point that I think the other topic - which has been removed - that I think is important is government measures addressing affordability. Obviously, between health care and the cost of living, we all agree those are the two major issues. I would love to see those two topics retained on the list, but I will leave it to my colleagues to make that choice on the vote.

THE CHAIR: Seeing no further discussion, are we ready for the question?

All those in favour? Contrary minded? Thank you.

The motion is carried.

We have topics.

We'll hop back down to just from the top of our agenda here. We'll start with committee business. We have correspondence. I'm not going to read all the correspondence today, but I'm assuming everyone has had an opportunity to read these. The first correspondence piece was the Office of the *Auditor General Report on Performance 2023-*

24, *Business Plan 2024-25*, and 2023-24 audited financial statements. Do we have any discussion on these topics?

Seeing none, moving onto the Department of Education and Early Childhood Development, we had information requested from the June 19th meeting. Do we have discussion on that item?

Moving along, Nova Scotia Health Authority, information requested from the May 22nd meeting. Is there discussion on that piece of correspondence?

Seeing none, we have the CAAF workshop. The CAAF has been tentatively scheduled to provide the committee with a workshop on the 18th day of September and possibly the 19th. Given that the Legislature has resumed, is the committee still wanting to proceed with this workshop, and would they want to take it over one to two days?

MLA Leblanc.

SUSAN LEBLANC: I think it's pretty much impossible to do it while the House is sitting, but I do think it's really important. Those of us who have taken them before know that they're very helpful. I would suggest keeping with the two-day version of the workshop but seeing if CAAF can move it to maybe later in October, when we presumably will not be sitting. However, we may be in an election, but who knows.

THE CHAIR: How does the committee feel about the suggestion? Anybody else? MLA MacDonald.

JOHN A. MACDONALD: Just to be clear, we're confirming about moving it to October, not the point that we want to have an election. Just making sure, on the record, that I don't come back and somebody says, MLA MacDonald wanted an election in the Fall. (Laughter)

THE CHAIR: We're confirming to move this until October. Give me one second here.

Just so the committee is aware, then, if we do defer this until October - seeing how we just passed the Record of Decision today - I think it would be a lot on the clerk to try to schedule witnesses over the next seven days to get into a meeting here. We'll have nothing scheduled for next week, just so everybody is clear. Seeing lots of nods.

Let's move on. We have the endorsement of the Auditor General recommendations regarding the 2024 Report of the Auditor General. That was on, if you remember, Preventing and Addressing Violence in Nova Scotia Public Schools. The committee has a practice of endorsing Auditor General recommendations that have been accepted. I would ask that somebody put a motion forward. MLA MacDonald.

JOHN A. MACDONALD: I move that the recommendations approved by the department are moved. (Interruptions) Oh, is there? I went looking, and I couldn't find it.

I move that the Public Accounts Committee formally accept and endorse recommendations contained in the 2024 report of the Auditor General *Preventing and Addressing Violence in Nova Scotia Public Schools* that have been accepted by the audited departments or agencies and ask that those departments and agencies commit to and take responsibility for full and timely implementation of the recommendations accepted by those departments and agencies.

THE CHAIR: Seeing no hands, are we ready for the question?

All those in favour? Contrary minded? Thank you.

The motion is carried.

Are we down to the last one? MLA Clark had a motion. It was left on the floor from the 19th day of June. The motion that was left on the floor reads as follows:

> . . . that this committee request that the Department of Education and Early Childhood Development work to implement the recommendations from this report before the next school year begins, including providing clear directive to teachers regarding discipline in the classroom, committing to hiring more teaching assistants and school support staff to reduce the pressure on teachers in our schools, allowing teachers to have more monitoring time, and introducing a detailed plan to reduce overcrowding in our schools. I request that the committee hold a meeting on this topic in September, and that the Department of Education and Early Childhood Development be called as a witness to update the committee on its progress in implementing these changes.

Just before we get into discussion on this motion, this would have come late - I think it was an oversight, perhaps, by the clerk. Do we want to deal with this motion now?

MLA Leblanc.

SUSAN LEBLANC: I'll just say - part of it is probably null and void, but the part about calling back the department for a sooner meeting than what would normally be the case, I think, is important. Perhaps we can flag that for our next agenda-setting. Perhaps it would be at the top of the next round of agenda items.

THE CHAIR: I think what we would have to do is maybe have unanimous consent to retract the motion, or a motion to defer, motion to table.

MLA Clark.

BRAEDON CLARK: I have no issue with that in terms of moving to defer or table - whatever the correct terminology would be. I can't recall this off the top of my head, but I believe the Office of the Auditor General of Nova Scotia was talking about maybe updating on that report faster than normal. I think that's something, obviously, I would like to see and I hope we would all like to see. To MLA Leblanc's point, I think it's just one that we can perhaps put extra emphasis on to make sure that we get updated on it as soon as possible, which I believe was the intention of the AG's office on that report in particular.

THE CHAIR: MLA MacDonald.

JOHN A. MACDONALD: It's just a point that the only bad part of deferring and tabling is that it's going to sit on there. I'd rather vote it down and agree unanimously because the Auditor General did say they would do it quicker. It has happened for the Office of the Fire Marshal. They're doing that quicker; they're not doing the two years. If they're in confirmation that it is going to be fast-tracked, I would prefer to vote it down rather than it sitting on the thing tabled. That's just a process for me.

THE CHAIR: I think I would be more comfortable with just unanimous consent to remove it. Can we reach unanimous consent to remove this? Yes, seeing lots of nods there. That is removed.

MLA MacDonald.

JOHN A. MACDONALD: Since we have the representative for the Auditor General, did we want to get confirmation for the member that it is being fast-tracked? Do you know what I mean? Since the member's here, let's get confirmation for it.

THE CHAIR: Would you like to come up, Mr. Harding?

ADAM HARDING: I do apologize; I don't have the answer off the top of my head as to whether that's on our list. I would have to go back to the office to confirm that we are following up on that one earlier. I just can't recall off the top of my head.

THE CHAIR: Our next committee meeting will be communicated to us through the clerk. Once we have that information, we will meet again. I would just like to say that we had an awful lot of committee business here today, members. We got through it, so thank you, everybody. Have a great day. We're now adjourned.

[The committee adjourned at 10:55 a.m.]