House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, MARCH 29, 2023

COMMITTEE OF THE WHOLE ON SUPPLY

5:40 P.M.

CHAIR
Angela Simmonds

THE CHAIR: Call to order. The Committee of the Whole on Supply will come to order.

The honourable Government House Leader.

HON. KIM MASLAND: Thank you Madam Chair. We will continue with the Estimates of the Department of Health and Wellness.

THE CHAIR: The honourable member for Dartmouth North.

SUSAN LEBLANC: Thank you, Madam Chair. I'm going to back to - I know the minister is going to be really excited to hear this - midwives.

Yesterday we had a little exchange, the minister may recall, about midwifery services in the province. One midwife in the province - who does not want to be named - had been tuning in to the exchanges, and they shared this response:

> Number one, services aren't stabilized - or can't be stabilized because they're not supported. There are three open positions in the province, all parental leaves. No, we cannot get a midwife from Ontario to move across the country to work for 12 months without any guarantee of a job at the end of that time. We have repeatedly asked for these positions to be made permanent, and then they would be filled.

So that makes sense to me. It's kind of what I was suggesting last night, but it's good to hear it from someone who is actually working in the profession. When we have vacancies in the current midwife program, it's difficult to fill them because they're not permanent jobs - they're parental leaves.

[5:45 p.m.]

So if you're going to ask midwives, who often get trained - well, always get trained outside of Nova Scotia, because we don't have a training program here - it's really tough to ask people to pick up their lives, their children, everything. The odd person will want the adventure of coming to Nova Scotia for a year, but when those positions aren't permanent, it's really tricky. It's a chicken and egg thing: make them permanent, but that means you are de facto adding to the program, but the professionals say that those positions will be filled.

The other thing this midwife says is that if one person gets injured or has a baby and there is no one to cover that leave of absence, the program is labelled "unstable." But if it's supported properly, it can be stabilized. I guess I'll just start with that and ask the minister if she has a response to those things.

HON. MICHELLE THOMPSON: To the member opposite's point, you're right. When there are temporary positions, we are not in a position to create a brand-new, permanent, full-time position for every time someone goes away on a temporary leave. It's unfortunately not feasible to do that.

Currently, there is no plan to expand that program. We can continue to work with our partners at Nova Scotia Health Authority, where there are some existing programs outside of the IWK. But currently we are not planning to expand the program.

SUSAN LEBLANC: That is a refreshingly honest answer. I guess what I'd like to ask the minister is: Why? What are the barriers to expanding midwifery in Nova Scotia? I can't see that it's financial because the government is willing to spend money on all kinds of other things for primary health care.

Is there opposition from other allied health professionals? What is the barrier to expanding midwifery?

MICHELLE THOMPSON: I have just a couple of points to make. One is that the education feasibility study is under way to understand what the program could look like here in terms of education.

To add more or expand, would really be a complete change in the model of care. We would have to look at how and where we integrate folks. To be honest, right now we are not looking at that model. There are other things in front of us. I'm not saying that it's

not going to happen. We're undertaking transformation of the system. Right now, we are looking at primary care, surgical access, and things like that.

I don't think there's a barrier. It's just simply that we can't do everything at once. The education feasibility study will inform some of our decisions. We want to maximize the midwives that we have and understand where they could work in our system. We need to make sure that we have a sustainable workforce if we are going to change a model of care.

SUSAN LEBLANC: Again, I don't know that we're going to get anywhere with this. I will once again say that I believe midwifery care is primary care. Think about all the primary care physicians who follow pregnancies who would then be freed up to see other patients.

Think about the amount of money we spend at the IWK for people like me, and lots of my contemporaries, who didn't have family doctors when they were pregnant - who wanted to, or did, follow pregnancies - so were referred automatically to OB/GYNs at the perinatal centre. I had two very healthy pregnancies, thank goodness, followed by very expensive doctors - and for no other reason except my family provider was planning to retire and didn't want to get up in the middle of the night anymore which, God love her, I totally respect it. There is a huge amount of cost savings to be had by implementing a robust midwifery program.

The other thing is C-sections. The minister has literally just referred to surgical wait times. C-sections are the most common surgery. In Cape Breton, a huge percentage of low-risk pregnancies end in C-sections. We know there are buckets of data around midwifery care, and its negative correlation to C-sections or to surgeries. We could be saving all kinds of operating room time. Not to mention the pain of having to care for a newborn baby with an abdominal wound or whatever, major surgery.

It just seems to me that if we are looking at how to alleviate pressures on the health care system and we have lots of money to spend - which we do, because we've seen it in this budget - midwifery care makes a ton of sense, and it doesn't make sense to not pursue it.

The midwives we have heard from who watched the minister's responses yesterday were upset. I am wondering if the minister can respond to that sentiment that midwives feel like they are not being used or not being valued as much as they feel they should be.

MICHELLE THOMPSON: I thank the member for the questions. Again, we've been working very much in the last 19 months in a test and try environment, and looking for innovations from folks who are working in the field and frontline health care workers. If there is an innovative approach or an idea that the midwives want to bring forward, they should do that with their managers. I appreciate their care. I had midwifery care when I was

in Scotland. There is a massive transformation project ahead of us, and I am not saying no - I am just saying not now.

[6:00 p.m.]

SUSAN LEBLANC: Okay, I'm going to move on. We have heard from some RNs who are frustrated by barriers to the Nurse Practitioner Program, especially that seats are saved for NPs who are going to practice in rural areas. What is being done to expand the number of NPs that we can train in Nova Scotia?

MICHELLE THOMPSON: I will get back to you about that question. I know that through the Provincial Nursing Network there is some funding available to support people in areas where it's hard to recruit. We recently made permanent 20 temporary seats for the nurse practitioner program, but I'll find out a bit about enrolment rates and things like that. I think there's more to say about it and so we'll just check in, in terms of what the enrolment is and what the demand is for the program, if there are any vacant seats.

SUSAN LEBLANC: The Heart and Stroke Foundation has advocated for a centralized registry of AEDs to be made available so that when someone is in cardiac arrest, they can be directed to the closest AED by calling 911. Of course, this would save lives because we know that the time before CPR is a major factor.

Is the government working on this AED registry? Why not, if not?

MICHELLE THOMPSON: We do have a registry in the province. There's a map online. In the past number of months, $300,000 has been spent on new AEDs. Through the EHS program, Medical Director Andrew Travers does a lot of work on this registry and supporting this program through his work as medical director of EHS.

SUSAN LEBLANC: I don't think it's true that I can call 911 and be directed to the closest AED if someone is in cardiac arrest. I just want to confirm that. Maybe this is something new that I didn't know about. In any case, I'd love clarification on that - and if that is the case, are there any plans for it to be expanded?

MICHELLE THOMPSON: According to our sources, if the AED is registered, then you will be directed by 911 if you are near it. The registry is online as well.

SUSAN LEBLANC: I have introduced legislation about this, and I think what we're talking about is making registration mandatory or something. We'll leave that for now. I might have some follow-up questions later.

Is there funding in this budget to expand the use of physiotherapists in the public system? For example, are they able to provide care in an ER? How much money is available for physiotherapists to be expanded in the public system?

MICHELLE THOMPSON: There are a couple of items. There are those mobility teams - maybe not entirely all just physios but also physio assistants and rehab folks. They would be responsible to support people in maintaining or maybe even improving their mobility while in hospital, so trying to prevent deconditioning. There's $2 million for that. The expansion of inter-professional teams to support seven-day-a-week coverage in hospital - there's an additional $6 million being used to support those inter-professional teams, which would be rehab services, as an example, over the weekends, which typically doesn't happen in all spaces.

SUSAN LEBLANC: That's helpful, but specifically physios in ER. When we did Law Amendments Committee on Bill No. 256 the other day, the guy from the physiotherapy college was asked this question about expansion of scope. That was one of the things he said - that physios would be very effective in ERs to diagnosis fractures or whatever and in certain cases treat fractures or sprains, injury kinds of things.

The other thing that we've heard from physios is that they would love to expand into long-term care facilities. I know that our honourable minister worked in long-term care, but I'm quite sure that there's some space where physios aren't able to work in long-term care. Maybe I'm wrong about that? Okay, I'm getting nods. There are lots of health experts over on the other side of the room tonight, folks. Okay, I'll just ask about the ERs then. I think what the minister has just described is mobility teams for folks who are already admitted into the hospital. I'm wondering if there are any ideas for the ER to lessen pressure on other ER health care professionals.

MICHELLE THOMPSON: I can't commit that there will be designated physio positions in this budget. Currently, in a number of facilities across the province that do have physio coverage over the weekend, they would be responsible for doing some in-patient work, but also responding to needs in the emergency room. That role will be expanding through that $6-million investment, so there will be more access.

I think if we were going to look at physios designated to hospitals, emergency rooms, we would probably want to do a test and try. We would need to understand what their responsibilities would be, who they would see, the amount of flow. It may not be appropriate for every hospital because we want to use folks to the highest scope, but we also want to make sure that when they're at work, they're being utilized on a regular basis. I think there's a possibility for test and try, but certainly that $6 million is an expansion of the services that some hospitals would not have - physio coverage over the weekend. So, that would be an improvement.

SUSAN LEBLANC: Great. Thank you for that. A similar question is for physician assistants. We've been talking about physician assistants for a long time. What is the budget line to add physician assistants to ERs? How many will be added across the province? Also, is there money to add physician assistants in other parts of care, like primary care, for instance?

MICHELLE THOMPSON: In terms of physio assistants working in the emergency, there's $5 million allocated to that expansion. Ideally, pending recruitment - our ability to recruit - we would be looking around the end of the second quarter. But again, it will depend on availability of resources. Then also, there's an additional $1.7 million being invested in physician assistants in primary care.

SUSAN LEBLANC: Great. The physician assistants in primary care, are they placed? Are there physician assistants on the ground working in primary care now in the province? What is the plan for that?

MICHELLE THOMPSON: No, those currently are not in place. This is something that we want to implement. Again, looking at where the sites are that are ready to accept them. I think we have to continue to recruit to those positions. It is something that would be a new kind of sprint initiative - something that we're trying to roll out this upcoming budget year.

SUSAN LEBLANC: My time is almost up for this hour, so I'll just start and recognize that I'll pick this up when we start again.

Part of the recent funding announcements lately was the medical school in Cape Breton. While many see this as a good move, there has been concern expressed by local doctors who find the proposed school would rely too much on doctors in clinical instruction - doctors who are already overworked and in short supply. How will the government ensure that the medical school project does not syphon valuable resources from our health care system? Was it a consideration when the funding was figured out?

THE SPEAKER: Order. The time allotted for the NDP has expired.

The honourable member for Clayton Park West.

RAFAH DICOSTANZO: Thank you, Madam Chair. Good evening. I'm really glad that I've got a few questions for you here tonight.

I'm going to start with the one with regard to nurse practitioners in different practices. Can you tell me, since you took over as the minister, how many nurse practitioners have been given to family practices?

MICHELLE THOMPSON: We've had a net gain in the past year of 47 new nurse practitioners. There is a total of 247 in the province. I just have the breakdown of where they work. Seventy-eight of those 247 work in physicians' offices or family practices. Another 45 work in community health centres, and there would be some assigned to long-term care as well.

RAFAH DICONSTANZO: Sorry, I didn't get the number for the ones in family practice where there are doctors. If you could also add - in those family practices, how many doctors are in these? There is a reason why I am asking. My own family doctor - there were three doctors and now we are down to one, and he will be retiring soon as well. He is in his 60s. They have been begging for a nurse practitioner. They were told that because you are not five, you don't get one. Is that accurate, and what are the rules? Who gets a nurse practitioner? Which practices are allowed to have that?

MICHELLE THOMPSON: We will get that information, if you want to ask the next question and then we can come back to that - because we have to ask.

RAFAH DICONSTANZO: I thank the minister. I am also looking to see about collaborative practice. What is collaborative and how do you define collaborative? How many new collaborative practices since you have taken office? Have we opened any new collaborative practices and how do you define them? Is it just one nurse? Do we need physiotherapy? Is there a rule of what is a collaborative practice?

MICHELLE THOMPSON: There are 95 collaborative care practices across this province. There are no new. This budget has roughly about $15 million where we will be introducing 11 new collaborative practices this budget year, and we will be stabilizing another 21 with that investment.

There is no set model for a collaborative practice. You work with the team that's in front of you. You work with the group that you have. Physicians, nurse practitioners, and family practice nurses generally are the core, but there may be other allied health care professionals. We heard a physician say the other day that they'd love to have a pharmacist. We heard another one say that they'd love to have a physio. We do really look at the assets in the community. We want to work with practices to understand what the skill set is - perhaps a social worker, as an example, but there may be a mental health clinician.

I think we are very open to looking at the collaborative practice model. Of course, we need primary care providers generally augmented with a family practice nurse. Then the allied health care professionals around that team really are kind of based on availability in community, and what that team feels that they would like to recruit to the team.

RAFAH DICONSTANZO: I thank the minister for this. I am trying to understand. The government is paying salaries for a physiotherapist, for a pharmacist, for any of those. To me, a nurse or a nurse practitioner is normally what you are getting to most family practices when, as you said, they asked for a pharmacist or they asked for this. Is the government paying the salaries of those professionals?

MICHELLE THOMPSON: The collaborative practice - the allied health care professionals positions - would be paid by the government. But the staff - maybe not the physician but the other staff - would NSHA employees in the primary care program.

[6:15 p.m.]

RAFAH DICOSTANZO: Again, there must be some parameters to which practice deserves what. Do you just sit down with every request, or do you have some kind of standards that say, we need so many doctors, you need so many patients before we give to you. There must be some standards. What are the standards - if you don't mind?

MICHELLE THOMPSON: I guess what I would say is per physician there's an expectation if they're an APP, as an example, we would want them to have panel size. We would have an expectation that a full-time equivalent position or nurse practitioner would have a panel size first of all. Then as we add resources, we do expect that the care assignment would be shared over all the different allied health care professionals.

So we would expect that if we're going to add resources to a practice, that there would be more access and attachment for the patients. It would really depend on how many practitioners that you have. If you have three physicians, two nurse practitioners, it really is around the complement, and we do try to work with practices.

I visit a lot of these primary these collaborative clinics, there are never the same. They are never the same. We work with the assets. There may be three or four physicians in a small community, and we add a nurse practitioner. They may have a physio. So we really do work with them, but we do look at minimum panel sizes for our primary care providers - like physicians and nurse practitioners - in order to look. Then we will scale that based on the allied health professionals who work with them.

RAFAH DICOSTANZO: From what I understand, depending on who you like and whatever family practice, some people may get more than others. There are no specific standards that we follow in order to make it fair for all practices. There may be family doctors who have been asking for years. They need the collaborative or the support, and they received very little. Is that normal? Is that the case?

MICHELLE THOMPSON: I can't speak to that specific practice. There's a hotline that's available now and that physician would have received that letter from NSHA, Dr. Nicole Boutilier. That physician should call the hotline if there are more supports that they would like. We don't give money to practices to hire their own staff, right? So if they have a business model as a private business, and they want to hire their own nurse or nurse practitioner or whatever, that's their business.

But if they want to work with NSHA - because I have also talked to physicians who only want the money for their practice, they don't actually want the position. So I don't really know what the situation is of that position, but I have heard from practices around overhead. They want to have their own independent business, but they don't actually want to work with NSHA. So it really does depend on the business model of the clinicians in

terms of how they want to run their practice. So if that physician is having issues he should call the hotline, and then someone will get back to him.

RAFAH DICOSTANZO: No, I'm not saying that one - I'm talking in general. I'm not talking about just that one. I'm trying to figure out who is getting the help, and if they are getting it when they need it, and what the standard is, so that we know if there's a practice with five doctors as the minimum, then this is what is happening. This is one case that I talked about.

What I'm hearing is that there are a few doctors that are honestly just desperate. They're saying that they are been bombarded and they're almost feeling like you're punishing them. One of them said to me: Well, they're giving money to pharmacists, $8,000, but zero to us.

Another doctor said to me as well, we're working so hard, and now with all this expansion of access points - virtual care, pharmacists, walk-in clinics, emergency - which is absolutely wonderful. However, if you have a family doctor and you access any of those, guess what? All your information is being faxed to the family doctor. The family doctor has to hire a staff member just to enter the data, but the family doctor also has to read all that information - the decision whether he agrees or not - and now he's liable for it, and they get zero for all that work. The amount of work that has been loaded to the family doctor right now because of these extra access points - where their own patients are accessing them - and now they're responsible to hire staff and to read all this information, and to be liable for the information.

If they disagree with something, then it's more work for them. So what are we doing to protect or to help the doctors? They're feeling overwhelmed with what is happening with all these access points.

MICHELLE THOMPSON: One of the things that we've implemented is an optimization team for just that reason. These are industrial engineers who go into practices free of charge to work with family physicians, to look at their practices, which is the work that happened with Dal Family Medicine.

So they went into Dal Family Medicine. The practice was very, very busy. They felt overwhelmed - this group of industrial engineers. I think some very experienced administrative assistants went in and worked with them, looked at what the practice needed, and how they could most benefit their work environment, as well as support their patients.

As a result of that work, this team that's free were able to take 3,500 more patients by adding and tweaking their processes and adding - I'm not sure, I can't remember what the exact clinical set was - and then a supportive administrative person.

This is the thing. That optimization team is available to all practices to support them. Ideally, we want same day/next day access. We met a physician who had same day/next day access fee for service. He talked about how worrisome that is, but by changing his practice from booked, booked, booked, booked for six to eight weeks to same day/next day, it absolutely revolutionized his practice.

That might not be for everybody, but it worked well for him. It allowed some of those things, so patients weren't accessing care in other ways. If patients are attached - we want to optimize practices so that they have really easy access to those primary care providers. That optimization team is available to those physicians to support them.

RAFAH DICOSTANZO: I actually didn't get the answer. Is there any support for those family doctors now that we've allowed patients to go? Are you doing anything to help family doctors? That is the question.

You don't need to optimize when the faxes are coming, and somebody has to put in the data, and somebody has to read them. That is extra work - and he hasn't been paid for that visit. Zero. That doesn't need an engineer to figure out that this is extra work on the doctor.

Are you doing anything to help those doctors who are already overwhelmed?

MICHELLE THOMPSON: We're in negotiations now with physicians and getting feedback from them around practice supports that would help, but to my earlier point, that is the work of the optimization team. We look at what is coming into the practices. We need to understand what the practice needs in order to be maximized.

If there is excessive workload, maybe it isn't the doctor who has to look at that. Maybe it could be a family practice nurse, as an example. That's what the optimization team does. It looks at the practice. It looks at the inflow, it looks at what's happening, the wait-list, to help identify what resources a practice would need in order to be more functional.

That's the work of the optimization team, and that's the work that was done at Dal Family Medicine.

RAFAH DICOSTANZO: So, every practice can have this optimization team for free? How soon can that happen?

MICHELLE THOMPSON: The entry point would be through the hotline. They'll get a callback within 24 hours, and they can make arrangements to understand what it is - the services that they need.

RAFAH DICOSTANZO: I think there is a lot of what we're offering right now, which is amazing - the access points - but we are not thinking of what that is doing to the family doctor. Truly, they are at their wit's end with the amount of work that we have increased because of these access points that we are offering, and putting the responsibility on the family doctor to be liable.

To me, that is a huge issue for the liability that they are absorbing from everybody, from all these access points. I think that's a point that we really need to think about. Two different practices have said that to me. Please, I hope you'll listen to that because it's causing a lot of harm in the offices, and a lot of extra work for the doctor who is not being paid for it.

One of the nurses who wrote about the thank you bonus is a constituent. She tried to get the information because she wanted to sign in. She was told that the deadline was Monday, that she had already missed the deadline to sign her to this $10,000 bonus.

I had the case, and I was going to bring it to you just to see if you can look into it. Then apparently the deadline was Monday. Is that accurate?

MICHELLE THOMPSON: The deadline for the incentives is March 31st, so that's this coming Friday.

RAFAH DICOSTANZO: I'll get the exact details, but she was told Monday and she was already too late. I have it with me, and I was going to give it to you.

Last but not least, you met my constituent who was at the community consults that you had in Halifax, and she asked that specific question. I have it on my Facebook - the 24-hour urgent care at Bayers Lake outpatient centre. I understand that we're having a family practice at the outpatient centre and CEO Karen Oldfield said that it sounds like a great idea because she knows, and you know, the incredible increase in population in the Halifax West area and beyond.

Here we are, the government is handing you on a platter a brand-new facility. The old government announced this in 2017. You haven't added anything, despite the increase in population is probably three times as much as when they started planning for this. The people need access. To me, this facility can offer urgent care. What is the difference between urgent care and family practice? The only thing we are asking for is 24 hours - staffing it longer hours to serve the people.

Literally, in Clayton Park if you come - I would love for you to drive one day - you will see 30 people at most of the walk-in clinics in the morning, in the Winter. We have never had that many people without family doctors and the need. Just imagine this urgent care if it has 24 hours, it could relieve so many of those patients who are showing up at the

Halifax Infirmary and waiting 13 and 14 hours. We definitely need this and it's there. The facility is there. It's brand new. All we need is to staff it for longer hours.

[6:30 p.m.]

I have almost 2,000 signatures. The CEO asked to hear from the people, and the people have responded with almost 2,000 signatures. The last time I checked was 1,985. It needed another 60 signatures to make the 2,000.

She said if people advocate for it, it will most likely get done. People have advocated. Are we going to get something in that area to help us with the increased number of people without family doctors?

MICHELLE THOMPSON: The Bayers Lake Community Outpatient Centre will have a variety of services, as you said. Primary care. There will be clinics there. Procedure rooms and some chronic disease management, as examples, which are very, very important. It is primary care. When you have chronic disease management at a clinic that follows you, it's very important.

Diagnostic imaging and a number of things. There will be care there. I think we need to staff it initially to the purpose that it was built for. We know that staffing is very, very tight. I think the first part is to staff it to the scope that it was developed. If there's opportunity to expand, we'll review that. The priority first would be to staff it to the scope of which it was intended, and then we'll continue to reassess from there.

RAFAH DICOSTANZO: This government said that they're going to fix health care. In our area, people are seeing the opposite. This is your opportunity to show them that you care about the people in the Halifax West area and what is happening there.

It is truly a sad thing, what is going on. I think what we feel is that the people in Halifax have been ignored. You removed the incentive - four times the number of people without doctors. I literally never heard of that in my first four years as an MLA - that somebody didn't have a doctor.

We were blessed. We had a lot of doctors. We've got an exodus right now because of the load and the removal of the incentive. We have an opportunity to help these people and these doctors.

The people have spoken. They're desperate and nobody's listening to them. That was a promise made by the CEO of the Nova Scotia Health Authority that this will happen if people advocate it. I've made sure that people's voices are heard. I hope you will hear it.

When is the opening date for that facility at the latest, if you don't mind?

MICHELLE THOMPSON: It is on schedule as it was intended. Substantial completion is this Summer with an open date of February 2024.

RAFAH DICOSTANZO: We have six or seven months to find the staff and to staff it 24 hours. You have the facility. You have the capability, and you've said that there is no issue with money. Please put it in this area.

People need it and you will be glad to lessen the number of people showing up at the Halifax Infirmary. This is how we can help to solve some of our issues. I beg you and I will not stop nagging on behalf of my constituents. It's desperately needed in that area. The whole idea of the out-patient centre was to put the centre where people live.

I remember when I was first elected that we're going to take all the services from the Dixon Centre and VG because they're such old buildings, and we're going to move them to where people live. Expanding the Halifax Infirmary for the people in the south end and downtown Halifax; expanding the Dartmouth General for people to access closer to them; and Bayers Lake is for the Halifax West area. That was the whole point.

Give them what they need and increase the 24-hour service, please. I don't know how else I can beg on their behalf. Thank you.

THE CHAIR: The honourable member for Bedford Basin.

HON. KELLY REGAN: I have a couple of really quick ones here, just to follow up on the conversation that we had yesterday. We were talking about the doctor wait-list registry, which in February 2023 - the most recent numbers - showed that 6,461 people in February added their names to the list, but 2,469 took their names off the list. I just wanted to make sure that I understood what the minister was saying about needing to do some work on the list so that people could come off the list, because it did seem to me that people are coming off the list. If you could clarify how they come off the list, and what it is that we're trying to do with the list.

MICHELLE THOMPSON: The investments that we have in the list will actually assist us. In order to come off the list, you have to take yourself off. You need to notify. There's no automatic way that you would come off the list. This new functionality will help us do that - really understand who's coming on and off the list and in different ways. Right now, it's all manual. If you don't take yourself off the list, we don't know that you're off the list. The functionality helps people manoeuvre the list and see what's happening - update their health status - but also, when they are attached, there's a way for us to automatically remove them.

KELLY REGAN: I have to say, I'm pretty impressed that 2,469 people in one month, when they got their doctor, took themselves off the list. I think that's pretty

impressive that people would actually bother to do that. Similarly, coming on, you also have to call, correct? Yes, okay.

When we were talking about the list yesterday, you referenced perhaps grouping people, categorizing people, et cetera. I was wondering if you could speak a little bit more about who's going to be higher priority and that kind of thing.

MICHELLE THOMPSON: We are looking at people who have more complex care needs. There are people who need ongoing treatment, and we would be looking at those folks. I don't want to say triage, but essentially that's what it is. It's not a CTAS score that we would use or what have you, but really looking at those folks who don't have any ongoing health care issues at a lower acuity, and then looking at folks who may be expecting or have complex care needs - just trying to be a little bit more interactive. The other piece would be that as new places open or as we add additional resources, we would take directly off of the list, so that instead of Facebook and saying, I'm taking patients, we would be very deliberate in terms of taking people off of the list.

KELLY REGAN: Further to our conversation yesterday about the Cobequid Health Centre - I believe the minister talked about 24-hour service. I just want to make sure that I have everything correct - 24-hr service, adding in-patient beds that would actually be like hospital beds, not just in emergency but, in fact, where people could be there. I just want to make sure that I understood that correctly, because I wouldn't want to misrepresent anything that's going to happen, and if there is a date, when we think this is going to happen.

MICHELLE THOMPSON: Yes, it will go to 24-hour care, emergency room, and there will be inpatient beds. The service planning details are being worked out just as we speak. That is one of the initiatives they are undertaking so there will be more about timelines soon, but I don't have them right now. We want to go as fast as we can.

THE CHAIR: The honourable member for Annapolis.

CARMAN KERR: Thank you to the minister and everyone for being here tonight. As the minister knows, the Annapolis Collaborative health centre in Annapolis Royal has switched to an urgent treatment centre. I think it is identified in the Nova Scotia Health services plan.

My question is: What sites in that plan were identified as a UTC model throughout the province?

MICHELLE THOMPSON: There are currently urgent treatment centres in Annapolis Royal, Baddeck - which is temporary - at Tatamagouche and Parrsboro. There is exploration looking at the model that is under way now around other sites across the province. Also, there is one in North Sydney.

CARMAN KERR: Could the minister explain what the criteria are for identifying those sites as UTC models?

[6:45 p.m.]

MICHELLE THOMPSON: The urgent treatment model is explored in areas where there are inconsistent openings in the emergency departments. It is also informed, if we look at the CTAS data, in terms of why and when people are coming - like what they are coming to their hospitals for - usually you can see the time of day when you are the busiest.

The urgent treatment centres are generally done when there is a need within the community with the available providers to have a different model. Certainly, in those urgent treatment centres, that's really been the catalyst. It's been the availability and because the availability, when we're trying to staff 24 hours, it was leading to unpredictable hours.

This Urgent Treatment Centre model has proven itself to be a model in which people can go for unexpected illnesses or issues that arise, and get the care that they require. It's a predictable, sustainable model, particularly for the clinicians, and it also provides predictability in the community.

We work with the clinicians. We want to make sure that they're on board and that they want to staff it. There are a variety of reasons that communities may move to that model, but generally, it is fully based on the predictability - providing urgent treatment so that people can go, and know that they can access care there on a regular basis.

CARMAN KERR: I'm certainly aware of the sites that have already been identified as either temporary in Baddeck or permanent sites for UTC models. What I'm interested in is - given what the minister just said, you're using CTAS data, I imagine. I know the scale, 1 to 5. Assuming you have that data and you're making those decisions to put those potential UTCs on the list, could the minister give me a list of those potential sites being looked at?

MICHELLE THOMPSON: The service teams are working on that. It's not something that I can offer just now. There's some work happening in terms of what each - not necessarily zone but almost cluster - in each kind of community is needed. That work is under way.

Then also sometimes when things come up, we need to move to that model temporarily in order to support access for patients in the community. There will be some that will be longstanding but there are times when we need to revert to that model because of the availability of health care workers - be it physicians or be it nurses - in the community. You may see that there are some that convert for a period of time, with the hope that we are able to restore the emergency room.

CARMAN KERR: To the minister, where is the decision made between assigning a potential or current urgent treatment centre as temporary, as in Baddeck? When is it assigned as a permanent decision?

MICHELLE THOMPSON: We keep the decision-making as local as we can. I would say it's really important that communities can identify the assets and the needs that they have. There's one in Lillian Fraser Memorial Hospital. That's another one I forgot to tell you about.

The most recent one in Tatamagouche is an example. There was community consultation. We talked about the model, talked about the concerns in the community, worked with the providers there, and we were able to come up with that model.

It does really sit in community with the VP Operations, Nova Scotia Health Authority, to make sure that we are meeting the needs as best we can. It isn't a top-down. We try to have a grassroots approach to it to make sure that we're meeting the needs of the community to the best of our ability with the resources that are available.

CARMAN KERR: Appreciating that it's grassroots decision-making coming to the minister, can you say today if Middleton - or Soldiers Memorial Hospital - has been identified as an urgent treatment centre for a potential site?

MICHELLE THOMPSON: I'm not aware today that either of those facilities have been identified as an urgent treatment centre model, no.

CARMAN KERR: To the minister, there is a potential that it could've been, or can be, identified as a UTC site, yet the minister and her office may not be aware of it today. Is that correct?

MICHELLE THOMPSON: I can say that specific to Soldiers Memorial Hospital, there is an attempt for restoration of services, so it will return to four days a week, if they will be with mobile clinic support. But I don't see anywhere that they're going to move that to an urgent treatment centre.

CARMAN KERR: I appreciate the minister confirming that. So to what the minister just spoke about, I would argue we're not working towards four days a week - we're trying to towards seven days a week, and seven nights a week. Anything less would not be what the public is looking for. Is there a strategic plan to increase the opening hours of Soldiers Memorial Hospital? So far with leadership at the Western Zone, I'm not getting any detail on what specifics are being worked on to increase that capacity. Could the minister elaborate on that?

MICHELLE THOMPSON: It really does revolve around provider availability. The recruitment efforts continue, Certainly, you know through the Office of Health Care Professional Recruitment, and now having nine position recruiters at Nova Scotia Health Authority, it is very important. We continue to look at what the things are to bring physicians here, and the pool of physicians that we can. I am very encouraged by the fact that the College of Physicians and Surgeons has recently allowed U.S.-trained physicians to consider Nova Scotia as an option with regard to their licensing, I think that will be very helpful for us.

We are looking at incentives. We're looking at recruitment. Certainly, the money that was awarded to communities in your area to support the recruitment efforts in order to look at how best to sell the community, I would say - and we need to work with municipalities and community-based groups to do that. There are a number of recruitment efforts. Also, trying to get a good match, and Office Of Health Care Professionals Recruitment have a number of missions that have been quite valuable in relation to finding contacts. We want those spaces opened again as well. There's a great effort in terms of recruitment in order to support bringing physicians to our communities.

CARMAN KERR: I'm certainly aware, in a general sense, of the community groups that are active in recruitment. I wrote support letters for our recruitment teams in the community, so I'm certainly aware of that work. What I'm trying to get is: Is there a document, or is there a specific plan to work on increasing capacity? I was a business owner for many years. We always had marketing plans, and operating plans. I just see the bigger document - the 28-page document - but I don't a lot of reference locally to increasing capacity at Soldiers Memorial through that document. Could the minister talk about specifics on a plan that will increase capacity at Soldiers Memorial beyond the dwindling down to four days a week?

MICHELLE THOMPSON: We will look at recruitment efforts per zone, looking at new, different community clusters, looking at attachment, the highest need, those types of things, and recruiting there. Then also the candidates that we have, recognizing when candidates come in where they might be best suited to work. Also, in each of the zones, looking at residency programs so that we have opportunities. I mean, Clare is a great example of what a residency program can really do when it gets moving. We need to look at some of those things, but we would do it as a zone.

We know that there are a number of vacancies in the Western Zone across all disciplines, and so the team will be creating a recruitment plan based on that. Each profession would have a different approach in order to recruit and bring them to the community.

CARMAN KERR: I certainly understand the importance of recruitment and changing where that is going with numbers and capacity, but my concern is there hasn't been an improvement, given the recruitment efforts we are doing. I know the shows that

we've attended - I know the shows that the department has attended. I know the recruiter and the work she is doing. I know the community group doing recruitment. I know the retention work being done, but it doesn't seem to be leading to a spike in attachment or access, I would argue. We can talk about that later.

I guess I am wondering from the minister: Is there any increased funding specifically for high unattached areas like Soldiers Memorial Hospital? We are one of the largest unattached areas in the province. As the minister knows, we've lost our emergency services in Annapolis Royal, and we are down to four days a week from 24/7 at Soldiers Memorial Hospital. I am trying to get into the detail of what specifically we are doing above and beyond what we have always done to improve what we are seeing on the ground?

MICHELLE THOMPSON: Maybe not specifically, I appreciate, in your area, but there have been 20 family physicians recruited in the Western Zone from April 1, 2022 to January 31st, and so we are looking at fit. The incentives are important - trying to match folks. I am hopeful that this licensing issue will improve, particularly for U.S.-trained doctors. But to your point, we are trying to grow our own workforce in addition to immigration because there is not just a provincial shortage, but really a national shortage as well.

It is competitive. That's why it is so important to work with the community groups because they are in the best position to support kind of that local - finding a place to stay, connecting people in communities. It is really all levels of government trying to support this recruitment effort. It is helpful. I was really pleased to see that there are that many physicians in Western Zone because it does start to narrow - the spots where people are willing to go. If there is anything we can do to help, we are certainly open to that but really it is around recruitment efforts, finding a match, and wherever possible settling families.

We do have a niche program and we really want to focus on when folks come to bring their families and have a rural immigration and settlement program, working with the Minister of Labour, Skills and Immigration. It is going to require a new approach - really intentional settlement and working with municipalities. I do think the efforts are starting to pay off.

Then of course growing our own workforce and having Nova Scotians have the opportunity to train and do return-for-service work in rural communities will be very essential as well. It's not a quick fix, but certainly we know that there are a number of gaps across the province.

CARMAN KERR: I'm thankful for residents of the South Shore and other parts of the Western Zone who are seeing an increase, but we're not seeing it in my area. That's my main concern, for obvious reasons.

[7:00 p.m.]

I guess my question would lie on: There's so much investment or talk from the minister on recruitment. We've had three ER doctors working in Middleton and now they're gone. I can't get any response from leadership and the minister's staff in the Western Zone of what these physicians asked for - what was not delivered. I do know that we're missing three physicians who were in Middleton - living either in Middleton or close to Middleton - and they've disappeared or are working otherwise.

That's a real concern. I would like to know from the minister: What did those physicians ask for in support and why weren't we able to support and retain them?

MICHELLE THOMPSON: I think that's something that I'll have to look into a little bit more closely. I can certainly commit to sitting with you and talking about what those reasons are. I think it might perhaps be better as a private conversation, especially if we know the three physicians and there may be some particular things that we could address individually.

CARMAN KERR: I certainly appreciate that. I can respect that. I'll take it as a private conversation or a conversation in the House, but I hope that the minister and the senior leadership team tried everything they possibly could to retain those physicians. I know there was a pull for physicians, or there has been, to work in regional centres.

I also know that the physicians who worked there for many years were highly respected and loved by the community, and did as much as they possibly could. It just seems like a better way and more economic sense - more sense all around - to retain those who are on the ground practising than it is starting from scratch recruiting all over again. That leads to my concern that there isn't a strategic plan to improve things at Soldiers Memorial Hospital. I don't see it. I'm not hearing it. Then there are several indicators such as three physicians leaving the site with no explanation given to the MLA or the public as to why that is.

My other concern, to the minister, with Soldiers Memorial having limited hours is the pressure it puts on not only the public. We live in a remote setting. We live in a very large constituency, but my concern is for the paramedics as well. I know several paramedics I know would wish to be able to bring ambulances and patients to Soldiers Memorial.

Abruptly in January, they were told that they were not permitted to bring ambulances to Soldiers Memorial. Could the minister explain why?

MICHELLE THOMPSON: I'll get back to you. If we wait, you're going to lose the time, so we'll get back to you on that.

CARMAN KERR: I want to thank the minister for being conscious of our time and being efficient.

Another issue around the same subject is that one of the things I'm hearing anecdotally - not directly from leadership at Nova Scotia Health Authority - is that physicians across the province in community ERs are struggling to get patients in and out of beds, or in and out of the facilities. My understanding is it makes it hard on recruiting new ER doctors to these community hospitals when they can't guarantee to any new physician that they will be leaving at the time when we said they're leaving. They're staying overnight day after day, night after night. That's leading to burnout, which is leading to physicians leaving. I'm very aware of that.

What is the minister doing in her department to address this? Without ambulances and paramedics being able to come in and drop off CTAS 4 and 5, they're being sent to Valley Regional Hospital. There's a backlog at times of dozens of paramedics, and we've seen that online and otherwise. So what is the department doing, what's the minister doing, to address that issue of community ER doctors staying night after night, not being able transfer patients out?

MICHELLE THOMPSON: It is certainly easier since treatment centres have started up. We are looking at the model. We want to make sure that there are adequate resources there for people who require ambulance transfers. One of the things that we are looking at currently is also how the urgent treatment centres could potentially support long-term care, as an example - so that residents in long-term care wouldn't have to go outside of their community.

Understanding that model and how it can evolve are under way is what I would say. I think there's a recognition that there's potential there. But we want to make sure that, to your point, there's adequate number of staff, and that there's clear direction about who is able to come to urgent treatment. Then what would the priority populations be to make sure there's not extended trips and transfers. So if we had someone quite unwell, as an example, in long-term care, it would be an ideal opportunity - and then we'd go from there. So there are early conversations happening about that now.

CARMAN KERR: I don't know if that was a slip of the tongue, but the question was around Soldiers Memorial emergency not accepting ambulances and not transferring patients back out, therefore leading to emergency physicians staying longer overnight, overnight, overnight consecutively. The minister answered with urgent treatment centres, so I get a bit nervous.

We've had a few constituents in my MLA office report that when they call the main switchboard number at Soldiers in the middle of the night with a health concern, they were told that the ER is closed, come back at 7:30 a.m. when it's open. This is in the middle of a period when the emergency was scheduled to be closed for several consecutive days. Who

responds to these calls at the hospital when it's not open? Why do they not have up-to-date information? This was a few constituents, and the person on the other end of the line had no idea that the emergency was not open.

THE CHAIR: Order. The honourable member for Dartmouth North.

SUSAN LEBLANC: If the minister wants to answer that question, Madam Chair, I'm fine with that, and then I can ask my first question.

MICHELLE THOMPSON: Thank you. I don't know either person. I'm really not sure why the person wouldn't have that information. If they're looking for information around a health issue overnight and they're calling switchboard, it would be ideal if they were able to access maybe 811, as an example, in order to support them. I'm hoping that the digital front door will also give them a line of sight when that comes. I really can't speak to the operations of that level - why they wouldn't know.

SUSAN LEBLANC: When I left off, I was asking about the medical school in Cape Breton, so I'll just re-do my question. Part of the funding announcements was the Cape Breton medical school recent funding announcement. While many see this as a good move, there has been concern by local doctors who worried that the proposed school, would rely too much on doctors in clinical instruction - doctors who are already overworked and in short supply.

My first question is: How will the government ensure that the medical school project is not siphoning valuable resources from the health care system, and is that being considered in the funding for the school?

MICHELLE THOMPSON: I think it's really important that we discuss it. Dr. Kevin Orrell, as you know, is working with CBU to support the development of this program. He is doing a considerable amount of community engagement, and certainly he feels that there's a great deal of positivity around this school. We hear that, and we want to make sure it informs our practice supports discussion as well in terms of how we support physicians in practice.

I do want to share - and I'll figure out how to table this. Dr. Rex Dunn - I don't know if you saw him in the Cape Breton Post - is a very esteemed physician. Throughout this long op-ed, he talks about his experience in Cape Breton, and he talks about being engaged around CBU Medical School. He says - part of it:

> I am now certain this will be a success. Still, there are years of hard work ahead. Finding enough physician mentors and teachers remains a concern . . . It will take four years to fill the roster, at 120 students. Then two more years of residency. It will be eight years

> before we see the first licensed physician from this school. I believe this is adequate time to work through most obstacles.
>
> One final observation is in the opinion of our Cape Breton citizens. I have spoken to many, from all walks of life. There is nothing but overwhelming support for this project.

I think with that amount of community engagement - the fact that you have folks like Dr. Rex Dunn and Dr. Kevin Orrell who have been in that community doing the physician engagement. Part of this op-ed talks about 20 physicians who gathered with a lot of excitement and questions - making sure that those folks are at the table as the planning continues - that that will lead to the success of CBU. They'll identify the things we need to do in terms of investment and practice supports in order to realize that medical school campus.

SUSAN LEBLANC: How does the government plan to ensure the doctors trained here will stay to work in rural Nova Scotia? Are there going to be return-to-service sorts of systems - other plans of innovative systems? What's the plan?

MICHELLE THOMPSON: We talked a little bit about this last night as well. The medical school to offer those additional seats - we know that there are a number of folks from Nova Scotia who actually are turned down as a result of the admission requirements, and the competitive nature of the program. We're really confident that this opportunity will appeal to Nova Scotians. We do currently have - CBU has five seats at Dalhousie Medical School. They do have a return-to-service agreement associated with those. We can't make people stay. There will be stipulations about if you have a return-to-service, how you will get out of it. But our current resident retention rate is 75 per cent, which is pretty significant.

By creating an environment where they learn and train rurally, we feel it will also be very beneficial in terms of our ability for them to know what they're going into in terms of that practice environment. It's art and science. There will be things to be developed as we move along and understand what people want, but a 75 per cent retention rate - return to service - if people leave, there are always stipulations about how you exit that agreement.

SUSAN LEBLANC: I understand that maybe the minister hasn't decided exactly how this will all work, but that's on the table - return-to-service agreements?

MICHELLE THOMPSON: Return to service would be part of the conversations that are ongoing with CBU, the Department of Advanced Education, Dalhousie, us, et cetera, in order to support. This is a huge investment, and we want to make sure that we have - everything we do is around access and attachment. So yes, we would be looking at that into the future of the program.

[7:15 p.m.]

SUSAN LEBLANC: Changing topics completely, the Canada Health Act says that the province has to cover medically necessary hospital services, including drugs, biologicals, and related preparations when administered in the hospital. We're hearing from people and staff at the IWK that sometimes families are required to pay for biologics administered at the IWK. Why is that? Why are families being asked to pay for biologics administered?

MICHELLE THOMPSON: I will get back to you. I know this, but I don't trust myself to say it without checking. We'll get back to you with the answer to that.

SUSAN LEBLANC: Great. I'll put a little asterisk by that one and make sure we come back to it because I have a follow-up question, but I won't bother asking it until then.

Is there a health human resources strategy under way? If so, what is the budget line? What will the scope be? When will it be publicly available?

MICHELLE THOMPSON: Under Workforce Planning Initiatives in this budget, there has been $22 million allocated. You'll find it in the administrative parts of IWK and Nova Scotia Health Authority. There is a document being prepared, and our recruitment efforts are being led by Dr. Annette Elliot Rose, who is a Ph.D. in workforce planning. There are a number of initiatives under way, and the strategy is being developed as we speak.

SUSAN LEBLANC: Do we know when it will be available - when it will be completed, and produced publicly?

MICHELLE THOMPSON: Our target would be the end of the second quarter to have that available. (Interruption) Yes. Such clarity this year.

THE CHAIR: I'd like to get all those comments on the record that you said.

SUSAN LEBLANC: We've heard from former volunteers at the Blood and Marrow Transplant Program since the change from using volunteers to using couriers. The hard-working volunteers from that program would like to know how much the bone marrow transport program cost before the change.

MICHELLE THOMPSON: I'll have to check what the amount is, in terms of what it cost. We've got feelers out.

SUSAN LEBLANC: I'd also like to know, when you are checking that, how much is the new contract with the courier? Hopefully you can answer this right now. What is the reason for the change?

MICHELLE THOMPSON: The following factors were considered in making the decision. It was the recommendation in an August 2022 position statement from Cell Therapy Transplant Canada that: Commercial couriers should be used for stem cell transport for products coming from outside Canada. Nine centres across Canada, including Nova Scotia, are using contracted courier services for stem cell, which was considered best practice. I'm reading from a letter because we responded to someone. The safety of all volunteers and staff within the program is primary concern as the travel delays, interruptions and unrest in some regions. Contracted couriers are insured and have protocols in place to deal with these issues while keeping themselves and the cells being transported safely.

Although volunteer couriers are not paid for time and only reimbursed for expenses, there is significant additional cost of time for the CTTP coordinator to deliver annual full day training sessions, prepare travel itineraries and compile the binder of documentation to ensure the volunteer couriers have all required documentation for the retrieval and the collection at the centre and associated travel.

Those are some of the things that informed the decision. Where it was contracted to a courier, the average cost for a volunteer for return travel to - that was a specific case, sorry. Those were some of things that were involved in the decision-making.

SUSAN LEBLANC: I didn't even know this program existed until we were contacted by volunteers who were told that they wouldn't be - I mean, I understand the change started during COVID because of the travel restrictions, which made sense, but then were basically told, thank you but no thank you. Except I don't know if they were actually thanked. I'm not sure.

I'm wondering, has there been any sort of follow-up with folks who were doing that volunteering, in terms of thanking them for their service, or honouring them in any way?

MICHELLE THOMPSON: In terms of the contract, it would be a demand - like a service by demand - so we won't know until we've had the contract for X number of time beforehand.

I will follow up, because certainly I learned of this through correspondence. I believe that there was a reach-out, but I'm not sure if it was to the individuals that contacted us, or more broadly, so I'll check.

SUSAN LEBLANC: Thank you very much for that. I'm just going to turn my questions to some gender-affirming care questions. I know that my colleague asked some last night, but I'm going to ask a few more.

In 2021, 42 gender-affirming care services were approved. I just want to confirm what I think we heard last night - in 2022, 100 gender affirming care services were

approved? I want to confirm that that's correct. I also want to ask what the total cost of those 100 services was.

MICHELLE THOMPSON: In 2021-22, there were 65 individuals who received gender-affirming care outside of the province. In 2021-22, there was 65; 2022-23, 118. The budget is allowing for up to 380 individuals to access care outside of the province in this upcoming budget year.

SUSAN LEBLANC: So in 2022 there were 65; in 2022-23 there were 118. There is now a budget to allow 358? (Interruption) Okay, 380, sorry. So we see that there's $1.7 million in the budget. Is that in addition to an existing budget for gender-affirming care or is that $1.7 million total for gender-affirming care?

MICHELLE THOMPSON: That is a total. In 2022-23, the budget was $750,000, and in 2023-24, we are adding $1.7 million for a total of $2,450,000.

SUSAN LEBLANC: Is that ongoing money? Will that money stay in the budget now on a go-forward?

MICHELLE THOMPSON: Yes.

SUSAN LEBLANC: The estimate of 380 surgeries being done - according to experts in our community - seems too high based on the data currently available from Statistics Canada. Can the minister explain where this number has come from? It is a big leap from what was done this year.

MICHELLE THOMPSON: Really, I think it is based on the history of referrals, and it is an estimate, so it's up to. We may not reach that target, but it is there if we need it.

SUSAN LEBLANC: Can the minister let us know if in 2021 or 2022 was anyone approved for services not normally covered - these are gender-affirming care services not normally covered by MSI - such as female vocalization surgery?

MICHELLE THOMPSON: I would have to check. I will have to get back to you.

SUSAN LEBLANC: Just a follow up to that, has the department ever used NDAs - speaking of NDAs - when services not normally covered under MSI are provided as the result of an appeal by somebody?

MICHELLE THOMPSON: I would have to check in the department.

SUSAN LEBLANC: I want to ask a little bit about the emergency department crisis and the recommendations from the NSGEU. As the minister would be aware, the NSGEU

provided a document entitled *Recommendations from the Front Lines*, which I will eventually table, but I am going to do a lot of reading from right now, Mr. Chair.

[7:30 p.m.]

There were recommendations on staff recruitment and retention, staffing, taking the pressure off the staff, safety, facility changes, and morale. I am just going to ask a few questions about staffing first of all. The first recommendation by the NSGEU was to provide two clinical resource nurses beyond the 8:00 a.m. to 4:00 p.m., Monday to Friday time frame. I am wondering if that recommendation has been looked at, if that might be changing, and if it is reflected in the budget?

MICHELLE THOMPSON: I would have to check in terms of what site-specific things have happened with that letter. We can go through it. You probably have 10 questions on it, but it would probably be easier just to get an update.

There has been an amount of money that has been invested with the flow lead and off-load teams, adding physician assistants. There has been a packet of things that we accelerated in January that we pulled out of the budget and are implementing. So I can tell you if it's specific to one site, what parts of those have been implemented.

We continue to work with the union, certainly. The recent incentive program, as an example, is based on the feedback that we receive from the unions.

SUSAN LEBLANC: I'll just ask a couple more questions about it. In terms of triage, on any given day or night there are a minimum of 20 patients in the waiting room with two, sometimes three, nurses. This is the NSGEU, so my understanding is that's HI, right? (Interruption) It can also be the Dartmouth General? That's what I thought, yes.

That means that on average a nurse in triage, on minimum has around 10 patients who come in with a complaint, but have no reassessment and no real judge of severity of illness or injury, other than a minute-long triage note. These nurses are expected to keep them comfortable, healthy, or alive, and continue to take on more patients. So there needs to be at a minimum, another nurse at least and ensure that there are three nurses there at all times. Is that a guideline that's being worked towards? Is that a metric that is generally accepted?

Does the government accept that that makes sense? If that's not happening, what is being done to make sure that does happen?

MICHELLE THOMPSON: The addition of the waiting room care provider would be a clinical staff member. The addition of a waiting room care provider - different than an advocate. The care provider is actually a clinician who works in there to do just that - support people in the waiting room who are waiting to access treatment.

We're just checking to see if that position has been filled, where they have been filled, or when we anticipate that it will be filled. That would certainly be one of the things that - it may be a rose by another name, but it is an additional resource for busy waiting rooms. It has been implemented, yes.

SUSAN LEBLANC: Has the department responded, or NSHA responded, to the call for 24-hour, seven-days a week social work coverage or on-call hours, after hours. There are often four to five unhoused patients, for instance, sleeping in waiting rooms overnight or coming in with trauma or arrest, that kind of thing.

The NSGEU is calling for 24/7 a week social workers. Is that happening?

MICHELLE THOMPSON: I know that there has been some work. I don't think those positions are necessarily designated just yet. There is $6 million in the upcoming budget, though, to look at those allied health care professionals around the clock. I do know that there have been times when we have worked with our colleagues in the Department of Community Services to identify space, as an example, for people who would perhaps present needing to be housed. There is some work that's happening between our frontline social workers and some of our busier emergency rooms to support people who present to emergency with predominantly social issues to support them.

SUSAN LEBLANC: What does the minister say to the following statement? That's the best way to ask this question. Cobequid needs to be made a 24-hour facility. Is that something that the minister agrees with? Is that something that is happening or being looked at?

MICHELLE THOMPSON: The Cobequid Community Health Centre, we are looking at 24/7, and also in-patient beds. It's in the *More, Faster* document.

SUSAN LEBLANC: In the meantime, is there any consideration being given to the idea that the Cobequid health centre should be able to admit directly to floors at the QEII? My understanding is that there's a backlog thing where Cobequid has to send people who need to be admitted to the emergency room at the HI. Then they're sitting there. They have already been at the Cobequid waiting room, they get seen, and they're told they need to go get admitted, but then there's this whole backlog waiting to get admitted.

Is there anything being looked so the Cobequid people could admit directly to the floors in the QEII with your special awesome tablet system? Could that help?

MICHELLE THOMPSON: The C3 Care Coordination Centre will certainly help us identify capacity in terms of transferring patients. I think there will be some logistical issues that would need to be worked out in relation to admitting patients. So there would be privileges in how you kind of work through all of those things. I can't say for sure if that is happening.

[7:45 p.m.]

Certainly, there were opportunities for direct admissions years ago, but ERs have kind of become the entry point for emergency rooms across the province. I would say that perhaps there are opportunities to do that, and C3 will help us have a line of sight in capacity in terms of transferring patients. I would say that there's nothing immediately under way, but if I'm stood to be corrected, I will let you know.

SUSAN LEBLANC: I apologize if this question has been asked already, but I haven't asked it. Can the minister get us up to date on what is going on with nurse practitioners and their scope of practice? Is there any movement - and I apologize if I'm off base here - for legislation to make nurse practitioners autonomous care providers?

MICHELLE THOMPSON: Currently they are autonomous practitioners. They do not need to work under the direction of a physician. Physician assistants do, but nurse practitioners do not. In fact, our scope of practice is arguably the broadest in the country, so nurse practitioners are actually allowed to admit, discharge, do a number of different things, so our scope is very broad. I think that speaks to why we've had a net gain of 47 in the province. It is an appealing practice, but there are autonomous primary care providers.

SUSAN LEBLANC: These are a couple of questions about morale. Has there been any consideration for free staff parking, or at least discounted parking at hospitals? I understand that parking lots are generally run by the hospital foundations, but I'm wondering if there's been any discussion about that.

MICHELLE THOMPSON: I think that would really be a question for NSHA in terms of each facility and what the capacity is. I don't think there have been any broad sweeping things, but we've certainly looked at workplace wellness initiatives - a variety of different things through the employer and the HHR department at Nova Scotia Health Authority - to understand if there are particular wishes that would improve morale in different areas. Not one size fits all. Every hospital has its own culture, so I think those would best be answered by health and human resources at Nova Scotia Health Authority.

SUSAN LEBLANC: Another sort of thing around that is free coffee for not only staff, but waiting rooms. Any thought to that - that people who are waiting can be comfortable and also the staff can have free coffee?

MICHELLE THOMPSON: Waiting room advocates have been engaged to support people's comfort in the emergency room. Maybe people don't drink coffee. I don't know. I don't think coffee is the answer. I think what we need is people to respond to individuals - whether it be a warm blanket or water or support if someone is sick. It would probably be to support people who would be drinking coffee if they were in the emergency room versus the patients. There are just a number of things.

The patient advocates are there to provide comfort and support to the individuals. It might be a popsicle, as an example, for little people who are waiting. That is the role of that provider - to really be supportive and try to meet some of those comfort needs that people have while they are waiting in the emergency room.

SUSAN LEBLANC: You know who is good at giving popsicles out? The emergency room at the IWK. My kid broke her arm and as she was leaving - she was all done and out the door - she was like, can I have a popsicle? They gave her one. It was really nice.

I am going to pass my bit of time to my colleague from Cape Breton Centre-Whitney Pier to ask a few questions about Cape Breton while I regroup.

THE CHAIR: The honourable member for Cape Breton Centre-Whitney Pier.

KENDRA COOMBES: Thank you, Mr. Chair. The death rates at the Cape Breton hospitals, specifically Cape Breton Regional Hospital, are amongst the highest in the country. Can the minister give an update on work to improve this issue?

MICHELLE THOMPSON: Through the accreditation process, there would be quality initiatives that would be happening across all different types of directorates, as an example. One good example is Monday, March 20th there was a highlight of some of the work that is happening at Cape Breton Regional. It says, "Cape Breton's seeing widespread improvement in mortality rate amongst heart failure patients." That is under the direction of cardiologists Dr. David McFarlane and Dr. Paul Morrison, and they are working with a nurse practitioner.

So really looking at their death rates, helping the standard mortality ratio and making sure that they are changing and adapting to best practices. There has been a lot of work under way. That is an excellent example. It has actually now gone beyond Cape Breton Regional Hospital, and is expanding to some of the other sites to help primary care providers in this case, and in others.

We are also looking at expanding some chronic disease programs like INSPIRED out of HRM and throughout more rural parts. There is a lot of quality work that happens.

I just want to give Nova Scotia Health Authority a shout-out since I'm on my feet. They went through accreditation process in November and the organization was accredited with a commendation, which is a very stupendous feat for anybody who's been involved in accreditation. They would have looked at the quality initiatives, and that would have been part of the review that would have happened through that process.

KENDRA COOMBES: I know the catheterization lab is going to be a game-changer in Cape Breton with regard to fatalities. I am just wondering, in the budget is

there anything that has been allocated to that cath lab that is hopefully going to be coming very soon?

MICHELLE THOMPSON: It has been included in the redevelopment project, but that investment would happen in out years, so it's not real yet. So we would have to wait to do the investment, but it is part of the redevelopment plan. Certainly, Paul MacDonald will undoubtedly help us understand what the needs would be in that new part of the development.

KENDRA COOMBES: I'm wondering right now, how many family doctor vacancies are there in Cape Breton?

MICHELLE THOMPSON: In the Eastern Zone, there are 21 vacancies for family practice physicians.

KENDRA COOMBES: One of the questions I have is regarding the rate of infections that turn septic among patients at the Cape Breton Regional Hospital. This was from January 13th where those issues have risen over the past four years, and the rate has now just doubled the national average. I'm just wondering, what is being done to decrease that?

MICHELLE THOMPSON: Can you table the source that you have for that? It would just help me understand. That's a very broad question, so it would help me better understand. We can certainly check with the prevention and control folks.

I don't know if there's a narrower part to that. But, yes, we can look into it around any initiatives for infection prevention and control specifically. Is it all of Cape Breton, or where is it?

KENDRA COOMBES: It was from this study done by the Canadian Institute for Health Information, that said: ". . . the rate of sepsis acquired in the Cape Breton health complex is 10.5 patients per 1,000 admissions. The national rate is 4.8." That's from the Canadian Institute for Health Information. It was from a CBC article, January 13, 2023.

MICHELLE THOMPSON: We'll reach back out to the zone for infection prevention and control.

KENDRA COOMBES: Great, thank you. On that, we were talking before about the mortality rate. With everything that you've said that is going to be put in place, have we seen the death rate improve at the Cape Breton Regional Hospital?

MICHELLE THOMPSON: The mortality rate has been improving steadily, but I will get some stats for you. It's going to take a bit of time.

[8:00 p.m.]

KENDRA COOMBES: I appreciate that. I'm wondering if the minister can tell me how much of the new investment in primary care is earmarked for Cape Breton. Also, what is the target for attaching patients in Cape Breton to primary care this year?

MICHELLE THOMPSON: It's difficult to break it into one geographic region, as I mentioned yesterday. There are a number of primary care initiatives. There's a significant investment that's happening. In terms of attachment, I don't have a projected number.

KENDRA COOMBES: I'm wondering if the minister can tell me how many new primary care clinics are planned to open in Cape Breton this year, and where will they be?

MICHELLE THOMPSON: There is service planning under way, and there will be more to say. I don't have anything to tell you this evening, but I can tell you that there is service planning under way for each of the zones, and those announcements will come in due process.

KENDRA COOMBES: Well, I will take the minister at her word, and I hope that next year I'm not sitting here, where she tells me to wait again. That has happened to me with a few ministers.

I'm just wondering if the minister can tell me how many nursing vacancies there are in Cape Breton. I know yesterday, I gave for an emergency room department that we were looking at about a 63 per cent vacancy in the emergency room. I'm just wondering now, for all of Cape Breton, if we can get a vacancy rate.

MICHELLE THOMPSON: We'll check. Do you want just industrial Cape Breton? Is that what you're looking for?

KENDRA COOMBES: I will take all of Cape Breton, industrial Cape Breton, or Eastern Zone. Any ones you can give me, I'll take.

I'm just wondering if the minister could tell me as well, what is the average EHS response time in Cape Breton?

MICHELLE THOMPSON: The per cent of ambulances that arrive on the scene and meet the response times, as of January 2023, is actually 64 per cent. If you look at Action for Health - that's what I was trying to do but I can't get to it in time - but if you look at Action for Health, it will tell you what the response times are.

KENDRA COOMBES: Thank you to the minister. I'll take a look at that, or if the minister wants to table it, that would be great as well. That's what I mean, you can table it.

The other question I have is: What is the average ambulance off-load time at the Cape Breton Regional Hospital?

THE CHAIR: Order. The time allotted for this hour of NDP questioning has elapsed. We will turn to the Liberal caucus.

The honourable member for Annapolis.

CARMAN KERR: Will the minister commit to building capacity at Soldiers Memorial emergency to 24/7 like it was in September 2021?

MICHELLE THOMPSON: We certainly have no intention at this time to change the model. It's really an effort in getting staff. We aren't withholding anything. If we could have that facility open 24/7, we would, but unfortunately, with the resources we have - we'll continue to work with the community, recruitment and zone leadership in order to support that.

CARMAN KERR: I think on January 18th there was an announcement by the minister and the department: Actions to Improve Emergency Care. The minister certainly would know the list. It mentions everything from assigning physician assistants and nurse practitioners to emergency departments to patient advocates, et cetera. Could the minister let me know how the actions to improve emergency care announced in January are being applied at Soldiers Memorial in Middleton?

MICHELLE THOMPSON: In terms of support, it would really be around the need to restore the services that are there. We would also be looking at increasing virtual care options, as an example, and supporting primary care for community-based needs, obviously, but really it will be around the restoration of services and recruitment to that facility.

CARMAN KERR: Is the minister suggesting that these announcements are separate from the restoration process at Soldiers Memorial?

MICHELLE THOMPSON: I think really in terms of the care that is provided, we would have advocates, but if the emergency room isn't open, as an example, those things wouldn't be there, the folks to support. It is really around the restoration of services in getting it up and running, and then looking at what the needs are. So patient advocates - if it is open as a 24/7 emergency room, we would look at whether or not there would be a requirement for a care provider, those types of things. I think really it is around restoring the services, and then supporting the times ebb and flow, working with that department to understand the needs in that department.

CARMAN KERR: I guess my concern hearing that is that we need to restore services first before we consider anything on that new announcement. I understand not

having a patient advocate in an emergency room that is closed. However, wouldn't recruiting a physician assistant help in building that capacity to open that emergency room?

MICHELLE THOMPSON: The difficulty of physician assistants is that they need to work under the direction of a physician. As we continue to restore, we will be able to add nurse practitioners. They can currently provide primary care in an emergency room setting, but they can't staff an emergency room, as an example. It's really essential that we restore those ED services for physicians, as an example, and then look at what other resources may be applicable to that emergency room.

CARMAN KERR: I understand with physician assistants and patient navigators, that won't be part of Soldiers Memorial building that capacity at emergency. How about the announcement for nurse practitioners - are we able to recruit nurse practitioners to that site to help build that capacity?

MICHELLE THOMPSON: I really can't commit to anything right now. I would have to speak to the zone leadership to understand what the plan is there, and the FTEs and things. I don't have that level of detail, so I think it would be something that I would have to speak with and get back to the member about.

CARMAN KERR: Can the minister get back to me by tomorrow?

MICHELLE THOMPSON: No. I'll get back to you soon, but there is no way I can get back to you with all this tomorrow. I would love to, but it's a bit compressed right now - but I will be timely, I promise.

CARMAN KERR: It's a bit a of a shame because we've only got a compressed time to ask these questions. It's always the hope that the people in front of us, including the minister and others, are able to answer those.

My next question - I think the minister mentioned previously certain budget items on expansion of physician assistant care. The minister is certainly welcome to correct me if I'm wrong: $5 million for expansion, $7 million for use of physician assistants in primary care. Is that correct?

MICHELLE THOMPSON: The additional investment in physician assistants is $1.7 million in primary care and $5 million in emergency care in sites across the province. Those are - understanding now the availability of the resource - all pending recruitment, of course. It's a new skill set to our province. That is the work that's under way. We'll look at readiness to accept those positions. There will be some planning done around readiness to accept those positions.

CARMAN KERR: Speaking of physician assistants and those amounts, the minister's quote mentioned sites that are ready to accept. I would like some clarification on

which sites are ready to accept physician assistants and which sites aren't. What is that criteria?

[8:15 p.m.]

MICHELLE THOMPSON: The physician assistants will initially be rolled out in the regional hospital sites.

CARMAN KERR: Could the minister provide a timeline of that rollout?

MICHELLE THOMPSON: I think we're hoping to start as soon as the budget passes. It will be subject to recruitments. As soon as we move through the process, those recruitment efforts can start.

CARMAN KERR: I'm skipping around, but there have been several references to recruitment and how critical that is to move along with other plans. I certainly understand that. With our local recruiter, who's working as hard as she possibly can, is there any discussion or any funding to support her role in Western Zone? As far as I know, we have one recruiter in charge of recruitment for a large area - maybe the minister can correct me - from Windsor and Wolfville all the way to Yarmouth. Is there any look or consideration from the department and the minister to provide support - either funding or otherwise?

MICHELLE THOMPSON: In addition to the recruiter for the zone, there would also be a physician recruiter who would support - and I believe in the Western Zone it's Dr. Dow. But those folks don't work singularly on their own. There is a network behind all of those recruiters. Certainly, the Office of Healthcare Professionals Recruitment for example, there would be resources available to those individuals, and also Medical Health. There's a lot of work that happens through Medical Affairs.

The recruiter has a part to play, but there is actually a team that works behind the recruiters in order to support her or him, whoever that recruiter is. They work in concert together in order to recruit and do all the things that they need to do to bring people to the community. They would also work with the community navigators as well. A number of municipalities now have community navigators as well.

CARMAN KERR: I certainly appreciate Dr. Dow. With all due respect, I believe Dr. Dow is on for 0.5, or half a day. I would like Dr. Dow on seven days a week, given the success that she's had in recruitment. Above and beyond is what I was trying to get at. I think the current navigator does a good job working with that community group, has an assistant role, is liaising with other departments, but it just doesn't seem like we're outcompeting private recruitment companies or other recruiters. I'll take that as just a note for the minister to look into.

Going back to stopgap measures, we've talked about a transition from an emergency centre in Annapolis to an urgent treatment centre, losing our emergency room in Middleton, going from 24/7 to four days a week. It's just been highly emotional and a lot of anxiety, as I hope the minister can appreciate. Are there any stopgap measures being considered for Soldiers Memorial - such as the collaborative emergency care model that we use in Annapolis Royal - combining the expertise of RNs and advanced care paramedics? Is that model being looked at as a stopgap at Soldiers Memorial Hospital?

MICHELLE THOMPSON: Part of the issue with the CEC model, obviously, is around the recruitment. ACPs are necessary, and there are some recruitment challenges.

THE CHAIR: Order. I would like to respectfully request the whispering to drop down by about an octave.

The honourable Minister of Health and Wellness.

MICHELLE THOMPSON: It does require, and also a CEC model requires stable physician coverage as well. It isn't just predominantly a nurse and an ACP. It would also require stable physician services as well for a good portion of the day. I think the model that we have now has some stability and some predictability. I know it's not ideal, but we certainly want to continue to build on the model that we have, and restore those services to the best of our ability. I'm not sure that changing the model would be the best option at this point. I think we should really work towards the restoration of the services.

CARMAN KERR: That's the best thing I've heard all night. I agree with the minister that we shouldn't change the model, and that we should work towards the restoration of Soldiers Memorial in Middleton. Thank you.

On the same subject, what other pilot programs are being considered from around the province at Soldiers Memorial? Is the minister suggesting that in the restoration process, there is room to partner with a new pilot to build that capacity, or is the minister suggesting that the restoration process is, again, on its own without the use or working with other pilot programs?

MICHELLE THOMPSON: Some of the pilots that have been done there are around the use of the mobile clinics. I know the member opposite has submitted a proposal for a pilot project, so I will check to see if the review of that has begun.

CARMAN KERR: Thank you to the minister for that. I'm certainly going down that path. That wasn't my pilot, just to clarify. That was from highly experienced emergency room staff - physicians and nurses. When I was asked to provide solutions, rather than just critique, I spent a lot of time talking to staff. So the credit is due to those staff, but thank you to the minister for considering that pilot.

I certainly appreciate the mobile health clinic. However, I don't look at that pilot as sustainable. My understanding is that it's staffed by those staff who are on vacation, or taking vacation time or extra time. Can the minister clarify if the mobile health clinic is, indeed, staffed only with those other staff around the province on their vacation time?

MICHELLE THOMPSON: While Nova Scotia Health Authority does use some internal resources, the work of the mobile clinic actually is a public-private partnership with Praxes Medical Group. So similar to locums, it could possibly be folks who come in and are working on days off, or maybe working in a locum environment.

I don't know the terms or the conditions of the folks they employ, but you would have people who perhaps were doing similar to a locum, taking a couple of weeks off to work in a different environment. Some people just choose that to get some variety in terms of their clinical practice and approach. I suspect those are the individuals you're talking about.

CARMAN KERR: Virtual care ER - I was excited when I heard about this. I think the pilot started in Truro. I believe there are three sites now working as the pilot. Can the minister confirm if there are currently three sites or more, and is this pilot being considered for Soldiers Memorial in Middleton?

MICHELLE THOMPSON: Just to let the member know, virtual care emergency care is in Colchester and Yarmouth, and it's in progress at Strait Richmond Hospital. Once those sites are up and running, we'll be able to look at our opportunities for expansion.

CARMAN KERR: To the minister, is there any indication of how far along that pilot on those three sites is, as far as leading to a timeline of when that may be looked at expanding across the province.

MICHELLE THOMPSON: In terms of the pilot, I think we have accepted that it is a great option for folks. I think it's more around the scaling - getting the resources in place to do it. It really is around recognizing that it is a valuable resource and scaling it, in a way that it doesn't fail. Sometimes when we scale too quickly, things flop, and we really don't want to have that. We'll scale over the coming months to other areas once we have these three sites. Colchester and Yarmouth are up and running, and we're in the process with Strait Richmond Hospital.

CARMAN KERR: I appreciate that. I think the second part of my question to the minister was: Is this pilot being considered for Soldiers Memorial as part of the restoration process of building that capacity back up to 24/7?

MICHELLE THOMPSON: I would say no, imminently, but we will be looking at scaling. So no - I just would say that I can't confirm that's actually one of the sites, but that's not to say it couldn't be. I think there will be more to say around the virtual options

that we offer in the coming weeks as we scale up a few things and understand our resources. There's some work under way currently. So that would be something that hopefully I can get back to you with, but I can't confirm tonight that Soldiers Memorial is one of those sites.

[8:30 p.m.]

CARMAN KERR: Could I ask that the minister confirm that at her earliest convenience, speaking to the leadership team at Western Zone?

We're talking about pilot programs. As the MLA for Annapolis, my concern is obviously with the lack of emergency service throughout the constituency. Is there a list compiled of pilot programs that didn't make the cut? I've asked about pilot programs that we're considering that show some kind of success across the province, but is there also a list, say, for Soldiers in Middleton, that didn't pass the test, or wouldn't work, that we're currently using in other parts of the province?

MICHELLE THOMPSON: I don't know if you mean that we took the pilots and said, like: Soldiers. Not Soldiers. Soldiers. No, we haven't done that. (Laughs) We haven't taken that approach. (Interruption) Yes. I did teach nursing for a little while, so I haven't done that for a bit.

We haven't done that necessarily. Again, there is a lot happening in trying to scale the projects, but in terms of the test-and-try environment, we're very open to it. Usually, if a test and try is not going well, we kind of just adapt it until it does go well. We are really open to a variety of pilots. If there's one in particular that you had in mind - I know there is a submission, but if there's something that you're interested in, we can certainly have a discussion about it if you think it would be suitable for Soldiers Memorial.

CARMAN KERR: I think as an MLA with a business background you don't want me to come up with any pilot ideas, but I certainly will keep consulting with professionals on the ground. All these questions that I'm asking - and I've talked to the minister in private - are all around the anxiety and concern around the lack of emergent care. There's no secret about what I'm trying to get answers on.

From the petition with thousands of people signing, asking for a strategic plan - we all know this as MLAs, but spending time in living rooms, back porches and driveways, how anxious, emotional and upset people are. It's that unknowing. It's also that expectation of always having that emergent care and then not having it.

All my questions are around what I can go back to the people I represent to give them any kind of hope or any kind of specific. Where my frustration is lying is that I can't get details on a strategic plan to get to that goal. In my background in business, we'd have

that plan, and we'd get to that goal. I know the minister would have that as well in her background.

All that to say when I ask about pilots, capacity, recruitment, and specifics on steps taken, I'm just looking for a lot more detail from the minister and the department, and from the Nova Scotia Health Authority. It's so that I can report back to people and manage expectations, speak plainly and honestly to them, but also give them a bit of hope where I possibly can. I hope the minister understands that, and helps me work on building that capacity for emergent care.

My next question - sorry, I guess it's flipping a bit - is on primary care. Are there any plans to help connect patients who present at the emergency department with primary care needs? We're talking at low acuity, that low CTAS level, to connect them with VirtualCareNS.

I've heard in certain literature and certain documents there's talk of virtual care kiosks. We've done it in our own office - tried to onboard as many people as we can. We partnered with NSCC to offer sessions to onboard people onto VirtualCareNS. But we need help. Is there any plan or budget to look at building that capacity for signing people up to virtual care when you've got a captive audience in that emergency department?

MICHELLE THOMPSON: There is no allocation specifically for navigation, I guess is what I would say. To your point, MLA offices have been helping. We've also seen partnerships with libraries in a couple of communities as well for folks to support the virtual care option.

It really is the investment that we'll make in the digital front door, which is a bit hard to explain right now. Once we present it and people see how it works, it will actually allow individuals to navigate, and see what services are available to them for primary care options close by. It's a connector.

We have the primary care clinics staffed by pharmacists, as an example, so it could identify that. It could identify walk-in, urgent treatment, all of these types of things, so that folks have an ability to navigate within their geographical area of what is closest to them. We're in a hurry to get that work done, and so I expect that you'll see something within the quarter in order to support people with that.

I know there are some people who struggle with technology, but I also think that almost everybody across ages has one of these, or an iPad, and I think there is a lot of opportunity to support people. Just my brief experience with COVID and iPads, we underestimate seniors in particular in terms of their ability to navigate. I think you will see big changes in the first quarter in terms of the ability of people to navigate and support their primary care needs in terms of identifying resources.

CARMEN KERR: Thank you to the minister. I know she explained Digital Front Door may be complicated. Does the minister mind explaining that platform or that function or that tool in more detail for me?

MICHELLE THOMPSON: I haven't actually seen the demo yet, so it is still a little bit cerebral for me as well. It really is that. It would be an opportunity to help navigate and it is hard for me to - I have an idea of what it is, but I haven't actually seen a demonstration of it yet. We're building it, but I do expect that it will be - we want usability. That's the whole point of it. I do expect it to be easy to navigate and to support people, and be able to identify resources for primary care.

CARMEN KERR: I certainly appreciate it being in the test phase. Is this new technology that's being used in other jurisdictions, or is this technology that we're building and funding from the ground up?

MICHELLE THOMPSON: No, it's actually technology that we're using in other platforms. So it does exist in other places, and tailored specifically, of course, to Nova Scotia. I think wherever there is an existing resource we can just pick off the shelf, it's really ideal to do that.

CARMEN KERR: I certainly agree with the minister. There are plenty of seniors in my life who have smart phones and iPads. There are challenges accessing wi-fi and internet along the coast, as a lot of rural MLAs would appreciate.

I'm switching gears a bit. What has been done to develop opportunities for local health professionals who aren't working due to COVID-19 vaccination status to safely contribute to health care again? I do know there's a number of those staff in the Western Zone. I just wonder, rather than say, no, they can't practise - I don't know the details - are there any options for those staff to either work in virtual ER or other ways where it may be still in a safe manner?

MICHELLE THOMPSON: I would have to double-check with NSHA. Currently, there are no options, but we continue to consider how best to use folks in the system. At this time, no, not to my knowledge - but I may stand to be corrected.

CARMEN KERR: The minister and I spoke about this when we were first elected. It was a conversation out of the Chamber, but I think she doesn't mind me bringing this up. We talked about retired health professionals. We talked about how we can get these retired health professionals back - physicians, nurses, nurse practitioners - either part-time or more flexible hours or back into the system in an environment that they want to join. Could the minister elaborate on if we've had any success bringing those retired health care workers back into the system?

MICHELLE THOMPSON: Last year we did the vaccination clinics. I think it was this time last year that we were heavy into them. It seems like much longer ago. We were able to reach out and identify a number of retired employees, and on-board them. A couple of things have been done. I know that Nova Scotia Health Authority has looked at their policies specifically around bringing back retired workers, because we heard from NSHA employees that it was a very labour-intense, frustrating experience to come back into the system. I know that the processes around that have been looked at.

[8:45 p.m.]

The bonus that we talked about, bringing people back into the profession - if you would like to come back, there are incentives there for people to do that. We're hopeful that will lure some folks back.

We're also investing in a mentorship program for just-in-time supports for nurses specifically. I think we'll see how that program goes. Our novice nurses really do need additional supports because of the complexity of the environment they work in, and because in some places they are working with reduced staffing. There's $1.4 million that's being invested in a nurse mentorship program. It doesn't always have to be in situ. It can also be on the phone, as well, for some support.

There have been a number of things. Now, because we've had that experience, there is line of sight, so there is easy communication with some of the retirees who came back to help with the immunization for NSHA, to reach out to them. There are a bunch of different things. Do you want to work in a mobile care unit? Do you want to use your skills somewhere else on a part-time basis? There has been some work happening.

CARMAN KERR: I want to switch gears again, if you don't mind. What's the average off-load time for EHS at the Valley Regional Hospital in Kentville? I'm interested in what the average off-load time for EHS is now that they can't off-load at Soldiers Memorial emergency in Middleton.

MICHELLE THOMPSON: I can see if I can get that site-specific information for you. Certainly, the average off-load interval in Western Zone is 73 minutes. That would be the entire zone. But we can see if we can drill down and get you the Valley Regional specifically.

CARMAN KERR: I appreciate that the minister will follow up with that information. What I'm trying to get to is: In the last three months, since emergency at Soldiers Memorial in Middleton has not received ambulances, how has that affected Valley Regional off-load times for paramedics? I guess the request is if the minister could follow up and find out, in the last three months, how that has affected those off-load times for paramedics at our local regional hospital.

I believe I asked the minister this previously, and I looked back quickly at the video, or tried to. Why were ambulances stopped all of a sudden in January from being able to access Soldiers Memorial emergency?

MICHELLE THOMPSON: The Valley Regional Hospital has an average off-load time of 63 minutes, so it's a bit lower than the average. We're just looking specifically for that information that you just asked about.

CARMAN KERR: I appreciate that. There are challenges for our paramedics in Annapolis and Kings West at the Valley Regional Hospital, and several issues have been cited for paramedics at the Valley Regional Hospital. There's no area for them to chart. There's no overflow area. Paramedics have been asked to go - I've heard this several times - to the back hallway with no wi-fi, to do their charting. It's just so congested.

My question is: With recent announcements through the budget for improvements at the South Shore Regional Hospital, are there any planned improvements or funding to improve emergency at Valley Regional Hospital?

MICHELLE THOMPSON: There are 53 staff who are currently off at Nova Scotia Health Authority, who are unvaccinated. I just wanted to follow up on that. There are only 53. I don't actually remember what you asked me, sorry. It's the time of night, I think, like that last question.

CARMAN KERR: No problem. Thank you to the minister for getting back to me on the other question. My question was around challenges that paramedics who are based in Annapolis and Kings West are facing at the Valley Regional Hospital. Given the new funding and new improvements at the South Shore Regional, we are all wishing there might be an announcement for improvements at the Valley Regional for those paramedics and the public. Could the minister comment on that?

MICHELLE THOMPSON: Thank you for the prompt. I actually lost my phones today as well, so you'll just have to bear with me. I'm sliding.

I would say that there will be more investigation. There are a couple of facilities that are in a similar boat. It speaks to the complexity. There are a number of places that probably need to be assessed for redevelopment. We have a current new capital plan in place now, but if there are particular issues, it would be great if the leadership at the Valley Regional would flag those, and we could maybe have a discussion around infrastructure - whether or not it is something that we would tackle.

I know that in my own community, St. Martha's Regional Hospital is in a similar boat. The department isn't able to handle the current dynamics sometimes. Yes, I think there is more to ask them of that, but if they go up through the leadership channels at NSHA, it's something that could be flagged for the department.

CARMAN KERR: I'm going to flag it - or I have flagged it - here as well, just to make sure it's noticed. EHS is testing a new model - SPEAR. The minister mentioned it earlier in Estimates, I believe. It stands for Single Paramedic Emergency Advanced Life Support and Basic Life Support. Can the minister provide an update on this program?

MICHELLE THOMPSON: It is a single paramedic response unit. It sends an advanced care paramedic to low-acuity calls. EHS is investing in six new SPEAR units across the province in 2023-24. We currently have six in the province, and this will bring them to 12. That is something that's kind of happened in more urban regions, I would say. We'll be expanding it to certain areas across the province. It's a great program.

CARMAN KERR: Six new units - 12 in total - a focus on urban Nova Scotia. I represent rural Nova Scotia, so obviously my ask is that Annapolis, Kings West, the Valley be considered for that SPEAR unit. Is the SPEAR unit one of those new six?

MICHELLE THOMPSON: They are currently for more densely populated areas, simply because help is a little bit more quickly accessible if they are there, if it's required. There are some other opportunities, potentially, with our paramedic workforce, but we need to increase it.

We're really pleased with the response that we got around the additional program in Yarmouth. We really do need to grow that workforce. Again, we're thrilled that there has been so much response, especially in the Western Zone - more so than what we saw in the Northern Zone.

I think it will evolve over time. The paramedics have talked about different ways in which they feel they can support the special patient program, and things like that. I think we're only going to see more and more expansion in terms of how we support community with our paramedic colleagues. It will take a bit of time because we need to bring the workforce up.

CARMAN KERR: It's certainly promising that there are 80 applicants, I believe, at the Yarmouth program for paramedics. My understanding is that would take at least a year for them to hit the ground running.

In the immediate term, is there a commitment from the department to have at least one SPEAR unit per zone? Is there a commitment or an idea of how many SPEAR units might be per zone, and how many might be in each county, et cetera?

MICHELLE THOMPSON: We are looking predominantly right now, as we do this first expansion, at HRM, CBRM, and a couple of regional sites. The important thing is when we have those SPEAR units that can respond to low- or moderate-acuity-level calls, it allows our rural trucks to go back home as well.

Often what happens is when the cities get busy, we have to pull - you'll hear the paramedics talk about that - and folks have to cover. The SPEAR units will actually support our rural sites in that there will be a different form of response unit.

I would also say that I can't underscore enough how important that RN, physician, and advanced care or critical care paramedic - that trifecta of clinicians - has been. If someone calls with low acuity - four out of ten calls are now being diverted away from the emergency room as a result of that skill set.

RNs specifically are doing work with people when they call around care planning, and helping to support and connect them to primary care services. Our physician folks are also calling folks and saying: You're going to go into a queue - we know you need to be seen, but we don't think you need to be seen right now. So there has been a lot of effort to support people if they can wait in order to free up trucks for that emergency response that we talked about. There is a lot happening with EHS - really incredible work to move that system along.

CARMAN KERR: I certainly appreciate the work, the working group, and Jeff being at that table. Another argument for keeping Soldiers Memorial Hospital emergency at 24/7: As the minister just suggested, that SPEAR unit would need that backup or that ability to transport those patients to a centre. The minister also highlighted that another concern is when most of our ambulances end up in Halifax, and they don't have that emergency in Annapolis, in Digby, in Middleton, the feeling is that the people I represent have nowhere to go. I have heard so many stories, dozens and dozens - what's the point of calling 911? We're either being taken to Yarmouth or Kentville. They're forgoing making that call.

Switching gears again, the minister mentioned earlier about that collaborative team optimization, including industrial engineers. It's free of charge. It's an optimization team that goes into these collaborative care teams. Could the minister let me know how many collaborative teams have accessed this service?

MICHELLE THOMPSON: We'll just check on that. I know that sometimes we hear from folks about 911, but I would really encourage everybody who's here - it is really important if people feel they need emergency services is to call 911. The reason is that they immediately get help. There are trained dispatchers on the phone. They now have access to a physician, a nurse, and a paramedic. I know you know this, but I always worry when people say they're not going to call 911. It is important that people do that - also 811. If it is a primary care need, 811 is there. It is really essential if people feel they need emergency services, because help can be on the phone immediately to support them, and it can help them navigate if it's not a critical situation. I just share that because it always worries me when I hear people say that.

We'll check on the optimization and get back to you.

[9:00 p.m.]

CARMAN KERR: I certainly don't want to cause alarm, but with one of the biggest ridings in the province, on a good day, people are travelling an hour and a half to two hours to emergency care on a road that hasn't been plowed for a day or two, on top of ambulance or paramedics making it to that home. We do as best as we can in the MLA office, with my CA and myself, trying to encourage people to call, but there is certainly a lot of hesitation to do so.

The minister just mentioned 811 alongside 911. Does the minister think that the partnership between the 911 service and the 811 service could be closer aligned?

MICHELLE THOMPSON: What I would say is that we certainly recognize that 811 was built at a different time, and I think there is opportunity to modernize it. We're under contract with a provider, and we know that 811 or a similar service is being used in a variety of different ways in other provinces and being modernized. We are looking into how that could be. Certainly, when I had the opportunity to go to Denmark, you could see that there were very clear linkages in their system, and it was very helpful.

I think that as we continue to transform and modernize our health care system, we will see eventual changes in 811, but I can't tell you exactly what those would be yet. I think the people who staff 811 would have some ideas about ways in which they could support. Also, when we look at system integration and where it is, they would have the best and highest use if we were to make some changes.

CARMAN KERR: Could I take it one step further? Is there room, or is it on the radar of the minister and the department, to strengthen that alliance between 211, 811, and 911? I know as an MLA we refer to all three services, but my understanding is that they could be closer aligned and work more efficiently. Is 211 in that discussion, as well?

MICHELLE THOMPSON: I believe there is, for sure. We certainly are very appreciative of the work that's happened with 211.

Beyond the community navigation, they actually became a provider with the Men's Helpline through Family Service of Eastern Nova Scotia. That was set up through them with a really soft and kind handover immediately for someone - particularly men initially, but now open to all who call looking for some support. They were immediately handed off to a therapist in order to support them. In terms of support for Portapique, they also stepped up and helped.

I do think there's an opportunity for us to align all these resources that were built at a different time, and trying to modernize these all together as we go. I think that Digital Front Door will be another opportunity, but 211 is an incredible resource. I do think there will be efficiencies and opportunities there, yes.

CARMAN KERR: I think the minister just referenced it, but there are other provinces and jurisdictions that are investing in PR campaigns around 911. Is there any funding or strategy on a PR campaign around the use or non-use of 911?

MICHELLE THOMPSON: I know that there's been some early discussion under way about making sure people know the resources that are available to them, and then how to access them. We want the right care provider at the right time in the right place. I think that is a big part of that. They're having some early discussions about what a campaign could look like around the services available to people, yes.

CARMAN KERR: Most likely my last question. We have a successful PRAP program at Soldiers Memorial. Dr. Michelle Saxon and several others are part of that program. Has the minister and the department looked at funding this program? What is the department and the minister looking at to make sure that this program is sustainable, being a successful program?

MICHELLE THOMPSON: This is just in terms of the optimization teams. There was a lot of work done with Dalhousie Family Medicine. There are two other practices that they are currently working with in order to support the model of care that they are delivering. There are currently two other practices under way in addition to Dalhousie.

THE SPEAKER: Order. We'll now turn it over to the NDP who have until 9:43 p.m.

The honourable member for Dartmouth North.

SUSAN LEBLANC: I'm going to bring the minister's attention a letter that was written to her and to the Premier, and copied to a lot of other politicians and people about gender, sexual, and reproductive health care in Nova Scotia.

A number of people signed the letter, including Stella Samuels, the executive director of Sexual Health Nova Scotia; someone from Stepping Stone; someone from Healing Our Nations; the AIDS Coalition of Nova Scotia; the Sexual Health and Gender Research Lab; a human rights lawyer; the executive director of South Shore Sexual Health; and another person from the Sexual Health Centre. They have outlined a number of actions for advancing gender, sexual, and reproductive health in Nova Scotia.

The first one is this: To develop a comprehensive and equity-based provincial GSRH strategy in collaboration with community partners; community representation at an internal provincial working group on gender, sexual, and reproductive health; funding to develop a GSRH strategy with a dedicated staff member; looking at a review of previous consultations with community partners; looking to other jurisdictions for models of best practice; complete a cost analysis and a timeline to implement a provincial strategy.

They include some key topics to be addressed by a strategy: sexual health education curriculum; access to sexual health testing, treatment, and prevention; universal access to contraceptives, PrEP, and other GSRH medications; rural access to clinical services; and culturally competent clinical services for people of diverse genders and sexualities, newcomers, and Black, Indigenous, and people of colour.

[9:15 p.m.]

That's the first action this group of organizations is asking for. I'm wondering if the minister can comment on that, and give us an update on where the province is with gender, sexual, and reproductive health strategy.

MICHELLE THOMPSON: There has been work ongoing, not on a strategy, but certainly there has been some important work that's been happening around the Department of Health and Wellness gender-affirming care policy in Nova Scotia. Some of the things this policy would look at are it would outline standards of care, coverage eligibility, things like that.

To your point, one of the things in that policy is making sure that we have safe and equitable care - looking at how we work with practitioners, making sure that they have the skills, the training, and the competencies they need in order to be responsive to people who are coming in with sexual health issues, needing gender-affirming care, those types of things.

I think there's really good foundational work that has started. There has been a lot of consultation that's happened. It came from community - the original. There was a policy submitted and it has informed the work. Internal and external partners and a lot of stakeholders have been involved. This is the foundational work around the policy. I think that over time the relationship will get stronger, and it will help us identify how we move forward next.

SUSAN LEBLANC: The second thing that this group has been calling for is to increase equitable access to clinical and other GSRH services. I want to be clear that this is not just about gender-affirming care, but it's also about gender, sexual, and reproductive health.

To increase clinical hours throughout the province; improved funding for sexual health centres to provide more sexual health education, counselling, systems navigation, programming, and outreach; examining the distribution of care among public health, NSHA, and not-for-profit organizations; equitable compensation for health care and service providers doing GSRH work. That's it for that one.

Wondering if the minister can provide any updates on any of those things: clinical hours; improved funding for sexual health centres; examining the distribution of care

among public health, NSHA and not-for-profits; and equitable compensation for health care and service providers doing GSRH work.

MICHELLE THOMPSON: There has been some early work done. There has been an additional $287,000 allocated for sexual health. There have been new fee codes for those folks who are billing for gender-affirming care introduced. Certainly, there has been an investment in prideHealth, and once it is fully staffed it will be an investment of a further $885,000 a year to support prideHealth throughout the province. It's not specific but I do think it is relevant that there is an investment in the gynecology and urogynecology supports at the IWK - additional resources, which is $2.45 million.

There has been some investment. I think there is always going to be incremental change but that is the investment in this budget.

SUSAN LEBLANC: That's good to hear. The third action that this group has called for is increased coordination with GSRH service providers. So increased transparency and timely updates for community-based organizations under the GSRH files, including scheduled meetings for consultation; government organizational chart to improve clarity, efficiency, and access for community-based organizations; funding that we have already talked about that is sustainable, strategic, and timely; and increased promotion of provincial GSRH services and a dedicated GSRH collective communication hub modeled on Engage4Health. Any updates on those?

MICHELLE THOMPSON: I will certainly get back to the member about what the response was to that letter. Just to make sure that I don't misspeak or leave anything out, I will look for that response. If you are copied on it, I am sure you will probably get a copy of the response.

SUSAN LEBLANC: That's great. Thank you very much. I am not copied on it, but my colleague, the member for Dartmouth South, is copied on it so maybe she will share the response.

I want to talk a little bit about some of the recommendations from the Canadian Cancer Society and the Lung Association. Some of them go hand-in-hand, so I might jump around a little bit. I want to talk a little bit about tobacco cessation and things we are doing in terms of that stuff. First, I will ask about the Canadian Cancer Society recommendations. Their first recommendation in terms of health system transformation is ensuring that there are new investments in the health care system with targeted funding toward cancer care. Is there anything in the budget that is new money for cancer care?

MICHELLE THOMPSON: There is an additional $11.3 million in the budget for cancer care in the province.

SUSAN LEBLANC: The Canadian Cancer Society is recommending investments in certain things here. If the minister has a breakdown of that cancer care money, that would be great.

I'm wondering if there's any money to go towards palliative care; improved cervical cancer outcomes by fully funding the HPV testing as part of a cancer care screening program; and a better detection of lung cancer by implementing a screening program for high-risk populations for lung cancer so we can determine lung cancer more often, when it is in its earlier stages.

MICHELLE THOMPSON: I'll just give you a little bit of a breakdown of where the money goes. There will be stabilization of cancer centres, increasing funding, particularly in Halifax and Cape Breton. Lung cancer prevention and early detection will receive $400,000, so there is funding in the budget for that.

We've invested in the Oncology Transformation Project as well. I don't know if you are familiar with that project. It is in collaboration with the folks with Ethos, which is 3-D imaging and personalized radiation equipment that was purchased. The Oncology Transformation Project is a digital platform for people who are living with cancer to have direct access to their clinicians. They'll also have a bit of AI associated with it.

It is a remarkable project. It's an oncology-specific information system with a single access point for referral, scheduling, triage of patients in real time communication within and between all cancer care programs in the province. They were absolutely thrilled and very, very happy when we announced it. It's compatible with One Person One Record, and it puts Nova Scotia at the forefront of cancer care in terms of information technology.

One of the clinicians said this actually takes us from the last to the first. They were really pleased with it, so that's good.

Increasing access to specialized immunotherapies, targeted CAR T therapies in Sydney and Halifax - enhance the role of physician extenders to maximize the role of specialists. Community oncology clinics as well - looking at enhancing local capacity so people don't have to travel as much, and with that linkage with that Oncology Transformation Project it's almost like the more specialty services can support more outlying regions. Lung cancer screening - the first phase of the program will be planned for the Central Zone in May of this year, and First Nations starting in Sipekne'katik, by Fall of this year and expanded out across the province. That completion would be in 2025-26.

Then there's a new initiative called at-home cancer care. We saw it when we were in Denmark. It was called 'Chemo To Go, Please!' For non-solid tumour cancers people go in, they get their chemo in a pump, and they actually don't sit in the chair and wait for it. They get to go and live their lives with this pump. The benefits of that program emotionally, spiritually, mentally, physically have been fantastic. We are going to be

implementing this test-and-try around chemotherapy. There has been a lot of work done in the Cancer Care Program over the past year and into the coming year.

[9:30 p.m.]

SUSAN LEBLANC: I can tell from the minister's response that this is all really exciting and positive stuff, so that's great.

Anything for cervical cancer outcomes in terms of improving the cervical cancer outcomes by funding HPV testing as part of its screening program?

MICHELLE THOMPSON: We'll check on that. I think it's going to take a bit of time for us to get back to you for that.

SUSAN LEBLANC: Any new money for expanded palliative care programs?

MICHELLE THOMPSON: It would obviously capture HPV, but there will be test-and-try proof of concept for our ability to do home testing for sexually transmitted infections. I don't have a lot of details about it yet - it's emerging - but it is something that would support better screening, and self-testing as well. It'll be interesting to see how that program works. It is one of the test-and-try initiatives, and there is budget money for that. I'll get back to you on the palliative care.

SUSAN LEBLANC: Thank you. As the minister knows, we're in the middle of - I mean, I don't know if we're in the middle of it. Maybe we're still at the beginning of it. Hopefully we're near the end of it - the settlement with tobacco companies for their contribution to tobacco-related disease. We know that tobacco is the leading preventable cause of disease and death in Nova Scotia, and it kills almost 1,900 Nova Scotians each year. It's responsible for 30 per cent of all cancer deaths - not just lung cancer, but fifteen other types of cancer.

The Canadian Cancer Society is calling on the government of Nova Scotia to ensure that significant public health measures are included in any settlement with tobacco companies. I have written to the minister about this a couple of times asking for an update.

Before I sit, I will suggest that there are a number of public health measures that could be taken in terms of tobacco cessation. For instance, the Lung Association, it's my understanding, has asked for money for its QuitNS program. I believe their request, or their budget submission, was to the tune of around $700,000. This is the kind of thing that could be funded with money from the tobacco settlement with tobacco companies. I'm wondering: Where are we with the settlement? Is the government focusing on money that would be directed at public health measures? The $700,000 for the Lung Association for QuitNS - but I'll ask more about that in a minute.

MICHELLE THOMPSON: I'm really not in a position to talk about the court case at this time, and the settlement. I just can't talk about it right now.

SUSAN LEBLANC: Is the minister able to talk about if there was money coming from the settlement, the value of where that money would be placed? Because that's not about the settlement, that's about where we would spend the money from the settlement.

MICHELLE THOMPSON: I would say that we would seriously consider - in terms of where we would invest that money, in terms of our public health supports, if and when it comes along, but there has been no final policy decision made yet in regard to if there's funds, what we would use it for.

THE CHAIR: The honourable member for Dartmouth North.

SUSAN LEBLANC: Is the government considering anything around tobacco tax? The Canadian Cancer Society is recommending an increase of tobacco tax by $7 to $10 per carton, and to close the roll-your-own loophole. I assume that means there is not as much tax on rolling your own cigarettes. I am wondering if the government is doing any thinking about that or talking to the colleagues in the Department of Finance and Treasury Board about that?

MICHELLE THOMPSON: Essentially, that would be something that we would check with the Minister of Finance and Treasury Board about. It would come from them to us as opposed to us to them, but I haven't had any conversations recently with the minister about that myself. That would be something that the Department of Finance and Treasury Board may be able to advise you of.

SUSAN LEBLANC: Yes, this is where things get tricky because I want to ask about radon as well. Radon is the second-leading cause of lung cancer in Nova Scotia, for sure - I think probably Canada. I don't know if it's Canada or not, but definitely Nova Scotia. Radon occurs very naturally and very abundantly in Nova Scotia. There are things we could be doing in Nova Scotia around mitigation. For instance - it's not a Department of Health and Wellness thing - but changing the building codes so that radon mitigation systems are mandatory in any new builds. Or in the way we rebate heat pumps or efficiency programs, rebating radon mitigation systems after a homeowner puts one in - acknowledging that if radon is mitigated properly, then the chance of lung cancer goes down significantly, and it is a huge savings for later on down the road.

I am wondering - this is this jurisdictional thing - does the minister have conversations with her Cabinet colleagues around these things, and is this something that's being discussed right now by Cabinet?

MICHELLE THOMPSON: I think that question is actually best answered by the Department of Environment and Climate Change, around air quality and testing. It would

really fall under them. There may be interdepartmental conversations happening around that air quality and testing, but it would be a question that would be better answered by them.

SUSAN LEBLANC: I hear that, but what I am saying is that radon is the second-leading cause of lung cancer in Nova Scotia, so it is a health and wellness issue. Are there conversations between the Minister of Health and Wellness and the Minister of Environment and Climate Change, for instance, around what we can do to protect people from lung cancer because of radon exposure? In the same way that surely sometime in the past there were discussions with health ministers, and alcohol and gaming ministers or public health people to say that we should stop smoking in bars - are those conversations happening in this case?

MICHELLE THOMPSON: I know that there are discussions happening at the departmental level between the Department of Public Health and the Department of Environment and Climate Change, but I haven't had a recent briefing to learn anything about this issue.

SUSAN LEBLANC: Can the minister outline for us, as MLAs, what our constituents - the people of Nova Scotia - have access to in terms of smoking cessation programs currently?

MICHELLE THOMPSON: I will get that answer from the Minister of Addictions and Mental Health. That would sit under him. I know his time is up, so I will see if I can get that answer for you - not tonight, but I will get it.

SUSAN LEBLANC: Well, while the minster is talking to the Minister of Addictions and Mental Health, maybe she could find out if there's any money in the provincial budget for the QuitNS program.

Here's another question that is perhaps better suited for the Minister of Addictions and Mental Health. I understand Nova Scotia is a signatory to the 5 per cent by 2035 plan, which is reducing our percentage of population of smokers to 5 per cent of the population by 2035. What is Nova Scotia doing to reach that benchmark of 5 per cent by 2035?

MICHELLE THOMPSON: Certainly, that would be part of the work that we're undertaking for Solution Six in Action for Health, looking at community wellness and the root causes of disease and social determinants of health, things like that. I have nothing specific, but I will check with my colleague and see what we can gather up for you.

SUSAN LEBLANC: Great. Thank you very much. Just back to cancer care for a moment. I'm wondering if the minister can point to anything in the budget that would help reduce the financial hardship to cancer patients by extending the job protected leave to 26 weeks to align with the federal job protection benefit.

MICHELLE THOMPSON: That question should really go to the Department of Labour, Skills and Immigration when you have your time with them.

SUSAN LEBLANC: While we're talking about things that should go to other departments, I'll just put this on the record. I'm wondering if there is any talk with the Minister of Health and Wellness and other ministers about introducing legislation that would prohibit tobacco use to anyone 21 or younger?

MICHELLE THOMPSON: There have been some very, very, very preliminary discussions with Atlantic health ministers. I know that P.E.I. has raised the age to 21. We're just kind of waiting to see how that works for them. It is a very lengthy discussion in terms of what the implications would be. I would say simply raising it with Atlantic health ministers, but otherwise, no, there's nothing in the works right now.

SUSAN LEBLANC: With the two minutes I have left, I will say that I have been working with the community in Dartmouth North for six years - almost seven years now - on increasing primary care services in Dartmouth North. Is there anything in this budget that would point to primary care in Dartmouth North?

MICHELLE THOMPSON: Well, there has certainly been some early work done. There is some money allocated to strengthen health neighbourhoods in the local and surrounding areas. There certainly will be more to say sooner than later. That's what I would tell the honourable member across from me. I'm going to sit down very slowly.

SUSAN LEBLANC: I look very forward to getting more information from the minister when that information becomes . . .

THE CHAIR: Order. The time allotted for consideration of Supply today has elapsed.

The honourable Deputy Government House Leader.

JOHN WHITE: Mr. Chair, I move that the committee do now rise and report progress to the House.

THE CHAIR: The motion is carried.

The committee will now rise and report its business to the House. We'll take a brief recess until the subcommittee finishes.

[The committee adjourned at 9:44 p.m.]