



House of Assembly
Nova Scotia

HALIFAX, THURSDAY, MARCH 30, 2023

COMMITTEE OF THE WHOLE ON SUPPLY

3:42 P.M.

CHAIR
Lisa Lachance

THE CHAIR: Order. The Committee of the Whole on Supply will resume discussions on Estimates E11 and E29.

The honourable member for Dartmouth North.

SUSAN LEBLANC: I will begin again. As the minister knows, there are many, many families that struggle to access in vitro fertilization and other reproductive supports. I'm aware that the tax credit was put in place last year and the tax credit will be used in the private, for-profit system. My colleagues and I remain hopeful that we are still considering expanding access to reproductive supports in the public system. Some of these are initially available at the IWK Health Centre, from what I understand.

My question is: Is there money in this budget to expand reproductive supports in the public system through the IWK Health Centre or otherwise? If there's no money in this budget, is this being looked at?

HON. MICHELLE THOMPSON: To the member's point, we did introduce the tax credit last year. This will be the first year that folks will be able to submit that. There is nothing currently to expand, to your point, in this budget for reproductive health.

SUSAN LEBLANC: If there's not any money in this budget, is it being looked at for future years?

[3:45 p.m.]

MICHELLE THOMPSON: I do meet regularly with the IWK Health Centre. There aren't any current talks. That doesn't mean that we can't have them, but there currently are no plans at this time to expand.

SUSAN LEBLANC: I'm glad to hear that the minister is open to talks. Tax credits are useful for those who can afford to pay the upfront costs. That is a particular subsection of our community.

There are many people who would love to avail themselves of the services of the IVF clinic who just can't afford it. The drugs are really expensive, so you really can't do it if you don't have Pharmacare or drug coverage. It can be heartbreaking for people. I really hope that we can continue this conversation and that that conversation can start at the IWK. The place where things like IVF and reproductive help really belong is in the public system.

I'm going to move on to another sad topic. We've seen a number of very concerning accounts lately of health care outcomes in prisons in the province. Recently, Sarah Rose Denny, a 36-year-old Mi'kmaw woman died at the Central Nova Scotia Correctional Facility in Burnside from pneumonia. There is another family that I'm helping in my office who had a family member contract a very serious disease in the Burnside correctional facility as well. It's very tragic.

Is there an increase in this budget for health care in our prisons?

MICHELLE THOMPSON: There is an increase in funding for utilization in the Nova Scotia Health Authority, which would be the deliverer of those services. There is nothing in particular specific to at the Central Nova Scotia Correctional Facility for health. That's not to say that some of that money is not allocated to service delivery. We ensure that the services are open to them, but I don't have anything particular to health care for people who are incarcerated, in this budget.

SUSAN LEBLANC: I just want to get clarity on your answer. You said that there's an increase to Nova Scotia Health Authority utilization. I guess I don't understand what utilization means.

MICHELLE THOMPSON: Utilization looks at both inflationary and utilization, which is the number of people for whom service is required. There is an increase in that. How that is allocated is left to the Nova Scotia Health Authority. We know that there's an increase in funding for utilization, which would be some inflationary but also some demand in services. I can't tell you how that would be allocated. It would be based on their operations.

SUSAN LEBLANC: Then my question is: Is the minister talking about utilization for the Nova Scotia Health Authority in prisons or just in general? There's no way to know if there's any money being allocated to an increase in prisons, yes?

MICHELLE THOMPSON: That's correct.

SUSAN LEBLANC: To clarify, if there's an increase in utilization funding for the Nova Scotia Health Authority, can the minister confirm that that means there are no cuts to the Nova Scotia Health Authority?

MICHELLE THOMPSON: There are no cuts. I know that's hard to believe in a budget session two years in a row, but there are no cuts.

SUSAN LEBLANC: Given that there hasn't been any money targeted to increase health services in prisons, can the minister talk about why that might be? Have there been requests from prisons to the Nova Scotia Health Authority in terms of the health care that goes on in prisons? Has there been any discussion about that?

We hear some terrible stories about health outcomes in prisons. I've just named a couple. People deserve health care no matter where they live.

MICHELLE THOMPSON: There has been no discussion about an increase to health. There's been no discussion from us, or business case brought forward in regard to that.

SUSAN LEBLANC: Thanks for that clarification. FOIPOP documents that our office received show that 2022 had the highest number of emergency room deaths in the last six years. It also had the highest proportion of deaths, meaning that it's not only a higher number of visitors to the ERs. Percentage wise, there were worse outcomes.

Can the minister explain why this has happened in 2022?

MICHELLE THOMPSON: There is some information that I want to gather before I answer that question. The number is one thing, but I actually want to look at rates, so I'll get back to you with an answer to that question.

SUSAN LEBLANC: I will pause my other questions related, then, and wait until we get that answer. There are a couple of times that this has happened. I'm hoping that our researcher will keep track of those because I'll bring them up at the end. I'm sure there are a lot of people listening, too, but I don't trust myself to keep track.

Can the minister provide any statistics on the number of patient feedback complaints that are received? How is the information tracked? For example, can the minister provide statistics on how many complaints are received and resolved?

MICHELLE THOMPSON: Some of these questions are very operational. We, in fact, are not the operators of the Nova Scotia Health Authority or the IWK Health Centre. There will be patient feedback lines where the operator has opportunities for patients to provide feedback. They would manage that, but that would not be something that would routinely come to me as the minister. We really would look at that being an operator's responsibility.

SUSAN LEBLANC: Okay. Yes, I hear that, but I guess if there were a big issue, the minister would hear about it. If there were something going on, it often escalates to that level, so that's why I had the question. Anyway, we can try to get that information in another way.

I know that home care is generally under of the purview of the Department of Seniors and Long-term Care, but can the minister say what in the budget is provided for home/community care under health?

MICHELLE THOMPSON: It is a little bit different because we're focused more so on the acute care side.

As an example, we talked yesterday about the at-home chemotherapy program, chemo to go, a new therapy, which is an investment of \$1 million; expanding some chronic disease management supports which would allow people to access care providers while they're at home, for support; the Oncology Transformation Project, as well as some of the work that's happening with INSPIRED.

I would also consider the SPEAR program and looking at how we would use that single paramedic program in order to support people who are living at home if they have some calls, and also the Special Patient Program through EHS.

Specifically around service delivery, it's a little bit difficult for us to separate that out because it does sit under the Department of Seniors and Long-term Care, but these would be examples of how we're supporting people in community and at home. We've also expanded funding for the Nova Scotia Sisterhood and the Nova Scotia Brotherhood Initiative, as well. Our reach would be into community, but it would not necessarily be in our purview, service delivery in the home.

SUSAN LEBLANC: We know that, obviously, there's a great need for the supports in the community. I hear you say that most of it is under the budget for the Department of Seniors and Long-term Care, but in terms of community care like Sisterhood and Brotherhood, can you say what the budget line is for that kind of thing and is there an increase?

MICHELLE THOMPSON: In terms of support, the Brotherhood and the Sisterhood expansion to expand programs for outreach and support for African Nova

Scotian communities outside of HRM had an increase of \$243,000. Also, we have sustainable funding for the Health Association of African Canadians with \$275,000. That money is given to the Brotherhood and the Sisterhood and HAAC and they distribute it as they see fit.

[4:00 p.m.]

SUSAN LEBLANC: The minister doesn't have any kind of information on how that boils down into full-time jobs or anything like that with that increase?

Through the COVID-19 pandemic, there's been real trouble accessing blood services. Now there is online booking, which is great, except for when capacity is reached. For example, a recent check showed no available appointments at the Dartmouth General Hospital drive-through clinic two-and-a-half weeks out.

Can the minister give an update on access to blood services? Is there a target time for people to be able to book within? Are we meeting the targets in each zone?

MICHELLE THOMPSON: We'll have to reach out to the Nova Scotia Health Authority again. Those are very much operational and frontline, and sometimes it takes us a bit to get that data if we don't know in advance.

SUSAN LEBLANC: The department recently released its financial write-offs for the past year. What amount of ambulance fees were written off last year?

MICHELLE THOMPSON: Last year \$2.67 million were written off.

SUSAN LEBLANC: So \$2.67 million was for ambulance fees? Has there been any discussion of eliminating ambulance fees when we're writing off that much?

MICHELLE THOMPSON: There is an annual revenue of about \$14.3 million related to ambulance fees. We do have a number of people who are insured. Also, there is a program for people who are unable to afford it. There has been no discussion about waiving those fees.

THE CHAIR: The honourable member for Dartmouth North, noting that there are 5 and a half minutes left.

SUSAN LEBLANC: Okay, \$2.8 million of the write-offs were for Nova Scotia Seniors' Pharmacare fees. Given the cost of living crisis, is there a discussion of lowering or eliminating Pharmacare fees?

MICHELLE THOMPSON: There is actually an investment in utilization, and because of a utilization increase for the Nova Scotia Seniors' Pharmacare program and the

Nova Scotia Family Pharmacare program of \$5.3 million to keep that program at the same cost that it is. There is investment in order to keep it at the same cost that it's at now.

SUSAN LEBLANC: I'm sorry. I'm tired. I don't get it. There's money to keep it at the cost now. Does it normally increase every year, so you're stabilizing it? Why is there a necessity to keep it at the current cost?

MICHELLE THOMPSON: The fees have not gone up year over year, but the utilization and cost of the program increases. This year, the utilization increase - the fees have not gone up, but the cost to invest in it is \$5.3 million, because the cost of the program keeps rising. That's how we're squaring it.

SUSAN LEBLANC: Got it. I'm getting to the end of my ability to understand things. We know that many public health services were paused when staff were redeployed to work on the COVID-19 pandemic response, and not all services are yet back up and running. For example, essential neonatal public health was paused for many months. I'm wondering if the minister can tell us what services remain on hold, when they will be available again, and how many public health nurse or other vacancies there are in public health. That's four questions, actually. Feel free to take them one at a time. What services remain on hold? When will they be available again? I'll just ask that first.

MICHELLE THOMPSON: We are double-checking. It is my understanding that services have resumed. We actually have a \$1.2-million investment increase to funding in 2022-23 for the Enhanced Home Visiting program, which allows for greater capacity in Eastern and Central Zones to reflect population demographics, and additional funding for Early Years in 2023-24 that we're piloting the Nurse-Family Partnership program in Eastern Zone for highest-risk families. There's been an investment in our families this year.

SUSAN LEBLANC: The second part that I'll just repeat again: vacancies. How many public health nurse vacancies are there currently, and how many other vacancies are there in public health right now?

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

The honourable member for Annapolis.

CARMAN KERR: To recap, the last year, year-and-a-half, Annapolis remains the area in the province with the highest unattached rate to primary care. Government has removed our emergency in Annapolis Royal. Our emergency in Middleton at Soldiers Memorial Hospital is severely reduced. Three emergency physicians have left, hearing that they haven't received the support from the leadership team at the Nova Scotia Health Authority that they're craving. Several staff have left at Annapolis Community Health Centre in Annapolis, being deployed but also with uncertainty, not sure how long they can

secure their jobs. Ambulances have been blocked from going to Annapolis Royal, and ambulances have been blocked from going to Soldiers Memorial Hospital.

We had public engagement sessions, but only after months of requests, and they didn't even come close to what we requested. In September 2021, Soldiers Memorial Hospital emergency was running 24/7; it went from seven days a week to five days a week to mornings to nothing. Now we're back up to four mornings a week. Given all that, I would ask the minister: How can I, as the MLA, or the people I represent buy into or believe that the commitment is to build capacity at Soldiers Memorial Hospital emergency?

MICHELLE THOMPSON: Appreciating that there have absolutely been some struggles with recruitment, recently there have been more ER hours. The public sessions were attended by more than 400 people. I know that the leadership has been out and about trying to support community and understand their needs. There has been improvement recently. The hope is that we can continue to build on that success.

You're right, stabilizing the services is essential. In terms of people having to work when we do have rural emergency centres, and we have some issues in our regional hospitals, we do have to protect those services. The regional hospitals have different levels of care available. There are times that we have, in the past, had to pull staff in to protect the core staffing in the regional hospital. That unfortunately will continue, if necessary, in order to make sure.

The other piece, too, I will say that part of what's happening in terms of our EHS protocols, there are some conditions that would have typically gone to our more rural facilities that are no longer appropriate to go there. I always give the example of a stroke. We actually have very tight clinical guidelines in terms of when somebody who is experiencing stroke symptoms would go to a regional hospital. The piece of that is around CT scanning.

In fact, some of the things that have happened are related to clinical protocols. There's that, which is why the emergency rooms have different levels. We hear that from folks in terms of that. Some of the bypass of those hospitals could be related to the clinical components of the care of the individual who is needing help, whereas some of it would be related to staffing levels.

It could be a little bit of both. The redirection could possibly be a clinical guideline. Trauma, as an example - our emergency rooms would have a trauma designation and an emergency room designation. Staffing in clinical presentation would be two of the reasons that people would be bypassed.

CARMAN KERR: I certainly understand the clinical designation of taking a case that's high on the Canadian Triage and Acuity Scale to the Valley Regional Hospital.

That's always been the case, is my understanding. If you're a higher-level CTAS, you're being taken to a regional or you're being taken to Digby or Yarmouth. You're not going to Middleton or Annapolis.

[4:15 p.m.]

This seems to be a new action where, in January, it seemed all of a sudden that paramedics and ambulances were told they were no longer welcome or able to come to Soldiers Memorial Hospital emergency. We want paramedics to travel to Kentville. In some areas in my constituency, it's an hour-and-a-half drive, or they're told to go to Digby, if it's open, and then on to Yarmouth - a two-hour drive. We're putting people in ambulances, and we know about the strain on those regional hospitals.

My next question would be: Is there any commitment from the minister and the department on committing to more than four mornings a week that we currently are at Soldiers Memorial Hospital? Could the minister commit to seven days a week within the year or two years? Is there any kind of timeline for that kind of commitment?

MICHELLE THOMPSON: Again, the April emergency room schedule is providing predictable and consistent, reliable scheduling to the best of the ability within the resources that we have. We do continue to recruit to there. Really, the commitment is that we continue to recruit because if we can't recruit to that specific area, then it is very hard for us to increase the hours based on the ability of the clinicians that are there.

We do continue to recruit. Again, we will look at all the different options, but recruitment is the key. If we're going to have it as an emergency room, we need emergency room physicians there. That's a very sub-specialist skill set which narrows the pool of recruitment, so it's hard for me to give a timeline in terms of when that could happen. I do want to say that we are continuing to recruit to those positions.

CARMAN KERR: I, too, would acknowledge that recruitment is key, but I would argue that retention is just as valuable and just as important.

That led to a question last night to the minister: We had three emergency room doctors in Soldiers Memorial Hospital a few months ago. We lost all three of them. I couldn't sleep well so I was up early reviewing the tape, and I didn't seem to get a really detailed answer.

That would lead back to - the minister did agree to have a private conversation. I hope that's still the case. Is there anything the minister can speak to on a higher level about these three ER doctors who we lost recently at Soldiers Memorial Hospital in Middleton ready to practice?

MICHELLE THOMPSON: Again, it's around a number of issues. Work-life balance, recruitment, and retention are all of the conversations. It's very difficult to talk about people's personal reasons or the reasons that we discuss with people about HR, in terms of why they are or aren't there.

I don't think this is the forum to discuss some of the reasons that those clinicians have moved on. There are some work-life balance issues in regard to that, and we'll continue to work in that community to see what it is that the clinicians need in order to provide that stable, predictable number of hours in that setting.

CARMAN KERR: I'll move on because I do respect that privacy, however rumours, and stories, and all kinds of things are throughout the community amongst hundreds of people. We're being asked to provide more detail and more information, and I'm not able to do so, so that's the reason for the ask.

Moving on to the Action for Health plan, or parts of it, and the health care tour. I certainly appreciate the minister and staff travelling the province, however Annapolis seemed to get skipped on that tour. Can the minister confirm if that was true or not?

MICHELLE THOMPSON: It is hard to be everywhere, is what I would say. On our original Speak Up for Healthcare Tour, we did have an opportunity to go to Annapolis and speak with folks there. I have visited Soldiers Memorial Hospital on my own to hear from staff and meet with leadership there. I really do work very hard to be out in the community as much as possible.

We did do 20 of those sessions. Some places we did double for sure, but we tried to go to places where we hadn't been on the Speak Up for Healthcare Tour to give feedback. There had also been places that had seen leadership fairly regularly - I would say recently in terms of access for staff. It really is a balance of trying to be everywhere. There really is no science to it. On the Speak Up for Health Care tour, we were there, and I have recently visited Soldiers Memorial Hospital, probably within six months of the tour beginning.

CARMAN KERR: I appreciate that from the minister. We have had public sessions that I asked for for months and months. It was finally granted. I know senior leadership was there, maybe 15 members of senior leadership were there. A few took most of the questions. I appreciate them taking the time.

However, I think it would go a long way for morale and support and otherwise if the minister and the CEO of the Nova Scotia Health Authority could at some point come visit Annapolis over the coming year and speak to health care staff once again and speak to the public, maybe in a public forum. I think it'll be a lot more friendly than the minister realizes.

Would the minister commit to coming to Annapolis in the coming months to come speak to the people I represent?

MICHELLE THOMPSON: I am out and about a fair amount. I was in Lawrencetown, as well. I don't actually remember where else I was on that tour. (Interruption) Were we in Middleton? Oh, so I've been there. I was there. We did have the opportunity to go to Lawrencetown.

We are committed to getting out throughout the province. I will admit that as much as I enjoyed those sessions, it is very hard to balance. I have my own constituency work. I can tell you when I'll be down that way and we can see if there's something that we can line up. I appreciate trying to be everywhere and I'll do my best, is what I would say.

CARMAN KERR: Thank you to the minister for committing to being everywhere or trying to.

I'd like to go back to a question that I asked yesterday or last night about Canadian Triage and Acuity Scale Level 4s and 5s - low acuity patients being picked up by paramedics. Because Soldiers Memorial Hospital isn't open, because the Annapolis Community Health Centre is closed, because Digby General Hospital is unreliable and struggling to find their own staff, I don't know the number, but I have a large number, it seems, of patients being taken to Yarmouth Regional Hospital, 2 hours away or 1 hour, 1 hour twenty minutes to Kentville.

I've told the people I represent that I would talk to the minister about this. That's what I'm trying to do. I've heard from paramedics. Why aren't we able to take lower acuity to Soldiers Memorial Hospital in this case and free them up to be in the zone? When they're taking lower-case CTAS 4s and 5s and heading to Yarmouth, we often have no coverage by paramedics in the ambulance when they're making that 2-hour, 3-hour, or 4-hour return trip.

What I would ask the minister is: What is the commitment, or what are we working on, or why aren't paramedics allowed to drop these low-acuity patients at our local hospital, freeing up those paramedics for better coverage?

MICHELLE THOMPSON: I would have similar wonderings as well. In that localized area, I think we can certainly reach out and ask EHS and Emergency Medical Care Inc. to look at what's happening there. I'm not really clear why someone who was recognized as a CTAS 5 would be transported in an ambulance.

With the work of that RN in the EHS Medical Communications Centre, that would be some of the work that that RN would be doing, looking at creating care plans in the community and looking at the resources. Is there a pharmacy walk-in? Is there a primary

care clinic that supports unattached patients? Are there virtual care options? Those types of things. Similarly for a physician, as well.

I think if it is frequent, we would be able to work with EHS and EMCI to look at it. In some cases, if someone is a CTAS 4, the paramedics can treat and release. Is there a special patient program, as an example? We do see sometimes people repeatedly calling EHS because they need the service, and they don't know what else to do.

I think if it is an ongoing issue, we would work with EHS, look at Special Patient Program protocols, look at how to support with the doc in the box and nurse in the box, and also kind of supporting people in navigating. If they're 4 and 5, the emergency room actually isn't the right spot necessarily for them either.

I think there's more to tease out and understand there in terms of the delivery of care in that area and using EHS to inform some of those decisions.

CARMAN KERR: I'm thankful for that answer. I'm thankful that the minister suggests that they could talk to EMCI and EHS, maybe at the working group level with Jeff and others, and have a mini-review or see what's going on on the ground and freeing that up. That's appreciated.

Another thing that I mentioned last night was the idea that the wording - I think it was "renewal", I forget what the minister's wording was for Soldiers Memorial Hospital. We're in a renewal phase, or a regeneration of building up capacity. The questions were around why we can't introduce certain pilots that have been rolled out in other areas.

The answer, I don't want to quote directly or too much, I think was that we need to regenerate or build that capacity before we can entertain new positions like physician assistants or new pilots that have been proven successful. My question to the minister would be: Why is this?

MICHELLE THOMPSON: If we're talking specifically about the emergency room, I think when we have a designated emergency room, it really is physician dependent. That's part of the complexity of it. We do need to have emergency rooms staffed by physicians.

For example, a physician assistant can't work in that environment by themselves. A nurse practitioner, while they're autonomous and can do primary care, they couldn't in an emergency room, as an example. It's not the skill set that they have. They're not emergency room physicians.

The concept of emergency is 24/7, and when we can't staff 24/7, regardless of CTAS score, we're always prepared for 1s and 2s, but 3s, 4s, and 5s are generally what we would see. The urgent treatment centre model - and I'm not saying that's what's there - that

urgent treatment centre model allows for lower acuity, CTAS scores of 3s, 4s, and 5s, to be able to go and receive care for unexpected issues. That's what I would say.

Some of this is emergency room dependent. We know, as an example, things get rolled out at regional hospitals first because we know that those services are protected, virtual care and those types of things. The stable and predictable hours allow us to have the opportunity to put virtual care in there for those hours, or what have you.

It sounds like semantics, but it's actually far bigger than that. An emergency department is very different from an urgent treatment centre, just in terms of who can present there and what things they're able to manage. It is a bit of a balance.

The mobile clinics, as an example, are a test and try that's been moving along. There have been 400 visits; from January to March, there have been 400 people who've received care and been well-received through the mobile clinics. We are currently looking at what the opportunities might be. Can a pharmacist, for example, work in the hospital to support people who are there for prescription refills?

Really, nothing is off the table. In terms of putting it in the capsule of an emergency department, it's a very finite, defined model, whereas we need to look at other ways to provide primary care or urgent treatment, which is what the folks are doing. I'm not saying that it's changing to that, but these are the stable, predictable hours and what it allows people to do is to go for those 3s, 4s, and 5s.

CARMAN KERR: In reference to what the minister just mentioned, the mobile health clinic is a good pilot. It serves a function. I don't look at it as a sustainable long-term function.

I just got the notice 30 minutes ago that the mobile clinic will be there for a few more days, which is promising, but there are several restrictions to what the mobile health clinic can offer such as prescription refills. Until we get that pharmacist in that hospital or in that setting, people are still showing up not able to fill those prescriptions. I certainly appreciate that background.

I'm trying to get a win for Soldiers Memorial Hospital, so another thing for Soldiers in Middleton would be the X-ray machine. It might be the oldest machine in the history of the province. I don't know, but it's hanging on for dear life. That X-ray machine was down again last week.

I think there is a CAR request to fund the new machine. Is there anything in this new budget that could help Soldiers Memorial and the residents of Middleton secure a new X-ray machine?

[4:30 p.m.]

MICHELLE THOMPSON: I will say that there's \$63 million in capital grants across the Nova Scotia Health Authority (Interruption) - I'm not saying that on tape - with \$32 million designated for capital medical equipment, but we will check specifically on that. I think I've asked in the past, but I just can't remember the answer, so I'll check.

CARMAN KERR: I appreciate the minister checking on that. Not to leave anyone out, could she also check on the Annapolis Collaborative Practice and see if there's anything that they're requesting that might fit into that capital expenditure?

Sorry, there was a bit of a gap there. I was asking the minister if she could also check the Annapolis Collaborative Practice to see if they have any infrastructure or equipment asks that they have through the foundation or through other means?

MICHELLE THOMPSON: We can check on that and see.

CARMAN KERR: We heard the minister talk this week about strengthening collaborative health centres. How many of these will be associated with the Soldiers Memorial Hospital catchment and the Annapolis Collaborative Practice's catchment? If that's too in the weeds, maybe the minister and the department can get back to me, but I'd be happy with Western Zone numbers as well.

MICHELLE THOMPSON: They are strengthening four clinics in Western Zone, initiating three new, and strengthening four of the primary care clinics, so - different. They're the unattached patient clinics, so those will be strengthened throughout the zone.

CARMAN KERR: Could the minister confirm with more detail if any of those are in the Soldiers Memorial Hospital or the Annapolis Collaborative Practice catchments?

MICHELLE THOMPSON: I don't have the exact detail down to the community level; I have more of an overview. I think that the planning is still rolling out, so I don't know that I could get you that detail yet. There will be more in the coming months around where those strengths and new clinics will be.

CARMAN KERR: Could I ask the minister what the criteria are for that process in identifying those initial sites?

MICHELLE THOMPSON: There would be a couple of things that go into that. There's service planning that is under way now.

Some of the criteria that they're looking at would be the number of unattached folks, what services are available in the community, in terms of ability to access primary care, et cetera. Then looking at community clusters, geographically, how close are people

to certain amenities, regional hospitals, et cetera. We do look in a regional way; I know that service planning is under way. We hope to have that document in the coming months.

CARMAN KERR: I'd like to ask the minister how much funding is being invested into collaborative practices, both in Middleton and Annapolis Royal?

MICHELLE THOMPSON: There is \$1.8 million allocated for the Western Zone specifically. It is a bit tricky to give you an absolute number because it doesn't account for recruitment and retention, it doesn't account for work that's happening with EHS, it doesn't account for the work that's happening around primary care pharmacy clinics, et cetera.

It's embedded in other places, but specific, targeted funding for that work is \$1.8 million in the zone. That's not to say that's the only money, it's just the easiest number to pull directly out of the budget.

CARMAN KERR: Speaking of pharmacies, expanding services and scope to pharmacies and pharmacists certainly was a good idea. I'll admit that.

How many pharmacies are part of the pilot in the province and how many aren't, as of today?

MICHELLE THOMPSON: I think there are over 300 pharmacists in total in the province. The primary care is distributed across 12 - these are part of the Community Pharmacy Primary Care Clinic program - there are 12 now, and that will be increased to 24 in May. That work is happening through the Pharmacy Association of Nova Scotia. That's where those decisions are predominantly being made.

There are currently four primary walk-in clinics with pharmacists and nurse practitioners. We'll be looking at expanding that with about three sites in this budget year.

CARMAN KERR: Is Lawrencetown one of those potential three sites?

MICHELLE THOMPSON: I have the targeted number, but I don't have the exact sites. I think there are still negotiations happening with the Pharmacy Association of Nova Scotia as well as some of the other spots. I don't have that level of detail in front of me.

CARMAN KERR: I think the minister should consider all pharmacies in Annapolis as part of those pilots.

My question would be around the pilots and around those initial 12 moving into 24 sites. Has the minister and the department heard about barriers to access or reasons why certain pharmacies and certain pharmacists wouldn't be part of that program?

MICHELLE THOMPSON: Overall, we've heard really good feedback about those pharmacy clinics. There are some things, of course, that are outside the scope of a pharmacist. Sometimes people present and they're not able to be seen there for certain things.

[4:45 p.m.]

The pharmacy walk-in clinics in those four locations so far have seen over 9,000 patients. By the end of August, the estimate is that there would be another 15,000 to 20,000 patients who would be able to be seen on a regular basis in the seven sites.

The community pharmacy primary care clinics, there are 12 pharmacies. I don't have the numbers, but they are quite high in terms of the number of people seen. They estimate that they could have 42,000 appointments available by the end of August. It's really broadening access significantly.

Overall, the primary walk-in clinics with the nurse practitioners and pharmacists were well-received when we first opened them, and we hear lots of great things about them as well as the new primary care clinics. People are quite pleased with them.

CARMAN KERR: The minister referenced being in Lawrencetown. I certainly appreciated her joining me to go visit the Lawrencetown medical clinic. We've got a great pharmacist and pharmacy there. It's a team that's willing and they have applied to both of these pilots. I think I've talked to the minister and her staff several times about them wanting to be part of this initial pilot. I've asked about it for the last year and a half. They weren't successful in that.

I do believe that the Lawrencetown clinic has applied for this recent pilot. I don't know if the minister could confirm if the Lawrencetown medical clinic and that pharmacy, or any pharmacies in Annapolis, are part of those 24 that we're going to see onboarded.

MICHELLE THOMPSON: Obviously, Lawrencetown wasn't in the first 12. It really is the Pharmacy Association of Nova Scotia that's working directly with their association members with a bit of support from the Department of Health and Wellness. They really are the drivers, so I don't have that level of detail about who the next folks are.

CARMAN KERR: I have one example of a pharmacy in Annapolis that the barrier to access was the amount given to their pharmacy would barely cover the salary of the pharmacist. It didn't cover administrative staff or scheduling, et cetera. I know for them that was prohibitive, along with the fact that there just simply weren't enough pharmacists to recruit to the area. It was a problem seen by both sides.

Switching gears here, we have a successful Practice Readiness Assessment Program, PRAP. I mentioned it last night but I ran out of time. It's run by Dr. Michele

Saxon and others. They do a tremendous job training international medical graduates who then fan out across the province and hopefully come back to Annapolis or rural Nova Scotia.

What is the minister and the department doing to support this program and ensure that it's functional and sustainable long after the current year that we're in?

MICHELLE THOMPSON: The PRAP is a collaboration between the College of Physicians and Surgeons of Nova Scotia, the Nova Scotia Health Authority, and Dalhousie University. We're so grateful to the physicians in the province who take on Practice Readiness Assessment Program responsibilities because we know that it's a big responsibility for them on top of very busy practices. It really is around finding those placements and working with those providers to understand the requirements of the program.

To your point, there are some very dedicated folks who support our internationally educated physicians. What I would say is that we are looking at that model. We've gotten a lot of feedback about it, the pros and cons of it and all those things. It is a program under review. We would ideally like to see that there are more PRAP spaces available. It's a good program and I think it really orientates people to the province in terms of the medical system and supports their practice, but it also builds relationships.

There is some feedback about what would be more helpful. We know that the physicians tend not to do their six-week placements perhaps in the community where they are going. To do that has some pros and cons as well.

It's sometimes hard to oversee someone who actually is necessary for your replacement in your position. It's just a lot of feedback about that program. It is under review and we are looking at increasing seats in order to make it a bit more robust across the province.

CARMAN KERR: I'm appreciative of that answer. I mostly wanted to flag it for the minister. I'm hearing concerns that it may not be sustainable. Certain physicians may be getting tired. I'm just looking at future planning. It has seen so much success, so it would be a shame if we didn't build that out. I know that there are multiple partners, so I'm glad that that's flagged for the minister.

I had two more questions around pharmacies and pharmacists. Could the minister confirm what a pharmacist is paid per visit?

MICHELLE THOMPSON: The model right now is essentially a pilot. It's not a fee-for-service type of environment. It's not overhead, so in lieu of a fee-for-service environment or what have you, there is a lump sum instead of billing fees.

As the pilot goes on, we'll be able to see why people present, what it is they're doing, time, and things like that. We really need to get a sense of the utilization of the program. From there, we'll work out tariff fees with the Pharmacy Association of Nova Scotia.

We're going to continue to roll it out because we know it's successful and it provides access, but there's some analysis that has to happen in order for us to understand. It is an overhead. It's actually in lieu of billing that they get this lump sum.

CARMAN KERR: Around pharmacy technicians, I don't know if the minister can confirm if we have a shortage of pharmacy technicians. I see her nodding her head. Are we looking or entertaining tuition rebates for pharmacy technicians?

MICHELLE THOMPSON: There is a shortage of pharmacy technicians, for sure. You can, obviously, take a program through the community college, for example, but we recently passed regulations, so that has now allowed an opportunity.

You can have people who are pharmacy assistants. They're building a program so that they can have Prior Learning Assessment and Recognition, similar to maybe CCAs, as an example - recognition of prior learning and bridging them to pharmacy technicians, which is great. Then we need to fill in behind with pharmacy assistants.

We have had conversations with the Pharmacy Association of Nova Scotia. They flagged it for us, so that work is starting now about how we bridge assistants to technicians and then how we would come in behind and support the pharmacy assistant role. It's on the list, for sure.

CARMAN KERR: I've mentioned this several times before. In Annapolis Royal the emergency was taken away and replaced with an urgent treatment centre. The urgent treatment centre only operates three days a week. It's only available during office hours. It's only available via phone appointment. No emails permitted or being received.

We talk about access versus attachment. I'm getting dozens and dozens of asks: Why don't we have better access with that urgent treatment centre? The question to the minister and the department is: What are we working on to increase hours and capacity at the urgent treatment centre in Annapolis Royal?

MICHELLE THOMPSON: I'm always careful when I say this because I don't in any way want it to look like I'm not being supportive. We're working with the current clinicians who are available there in the community, respecting what they feel they're able to take on.

I know that the physicians there are long-standing physicians in the community and probably, in the later part of their careers. In order to provide consistent access, which is

also what they wanted in the community, this is the model that we landed on in collaboration with them. I know they've served the community tremendously well over their careers. This is the model that we have now. I think prior to, when it was open all the time, it felt quite overwhelming, so here we are.

I will say that it does provide some consistency for folks. Again, we go back to the recruitment efforts. We really do have some significant gaps, I would say, in the Western Zone. It's persistent across the Western Zone, so it is important that we continue our recruitment and retention efforts there. We need to continue to find those folks who find the community and the practice of choice that they want.

There is a provincial shortage, but we see that it is national and global as well. We are focused on it. We need to look at what providers are available in that area and what the models could be. We're open to those discussions ongoing, is what I would say.

CARMAN KERR: Could the minister highlight what the requests are from the physicians and staff in Annapolis Royal for building capacity at the urgent treatment centre?

MICHELLE THOMPSON: The zone medical director, Dr. Cheryl Pugh, would be the person who would work directly with the physicians there around the model of care that they are looking for, as well as the assets in the community. That would be in direct conversations with her, as well as the vice president of operations there. Predominantly, I think Dr. Cheryl Pugh would be the one who would be dealing with the physicians around the model of care in that space.

CARMAN KERR: I have a number of both practising and retired health professionals in Annapolis Royal and Middleton. Several other MLAs would as well. One such person brought the idea of nurse practitioner-led clinics.

Currently, there are 26 nurse practitioner-led clinics in Ontario staffed by 2,200 nurse practitioners, each serving around 800 patients. There's a name here that was flagged, Dr. Tammy O'Rourke. She apparently is a nurse practitioner who trailblazed and advocated for full-scope, nurse practitioner-led clinics in Ontario and British Columbia. She lives in Cape Breton, apparently. Has the minister spoken to Dr. Tammy O'Rourke and if not, could we consider doing so?

MICHELLE THOMPSON: I have not heard of Tammy O'Rourke. The Office of Healthcare Professionals Recruitment would be happy to speak with her. Also, if she's in Cape Breton, Dr. Don Brien is the medical lead there and Brett MacDougall is vice president of operations. Cape Breton's not all that big. I'm sure she probably knows them, so they would be available to her to reach out to. We're certainly open to hearing from her if she wants to engage.

CARMAN KERR: Just flipping back to my previous question, the minister mentioned physicians in Annapolis Royal at the end of service or toward the end of their careers. Is there any succession planning specific to that area, knowing that?

[5:00 p.m.]

MICHELLE THOMPSON: Again, that goes back to recruitment, to say that this is the type of practice that these individuals have, these are the needs of the community, and these are the opportunities in the community. There's opportunity for urgent treatment and there's opportunity for different places where they could work.

Again, we're always speaking with potential recruits around what type of practice they want to do, whether it's full-time, part-time, hospitalist care, emergency care, or palliative care. Everybody's kind of got their niche in terms of the training they have. We're open to discussions around the needs of the community and matching them with candidates as we move forward.

CARMAN KERR: I have a few minutes left. On Page 9 of the Action Plan - I have lots of questions on the Action Plan if I have time later or tomorrow - it talks about accelerating the support of international doctors and an immigration strategy. Is that immigration strategy public? If so, could I see it?

MICHELLE THOMPSON: It does sit between the Department of Health and Wellness and the Department of Labour, Skills and Immigration, is what I would say.

As an example, we are looking at areas where we know that we have more similar educational programs. I'll give you the example of all of those seven countries that the Nova Scotia College of Nursing, as an example, identified as the easiest to license. Really, it's incumbent on us in the Department of Health and Wellness, knowing the easy licensure pathway, to create reciprocal relationships with these folks.

We are looking at MOUs with particular universities in some of the countries that are listed, trying to get a natural and consistent opportunity for nurses who are training in some of those countries, particularly India, the Philippines, and Nigeria, as examples.

We are building those relationships as opposed to just the one-offs. We want to get an immigration program. Then we have to look at, for nurses in particular, how to settle them in. There is a bridging program that the Nova Scotia Health Authority has looked at. There's also Nova Scotia's International Community of Health Workers Engagement Program, NICHE, which looks at specific rural immigration and settlement.

We're looking at our opportunities, as well, to take families because we know that when we settle an individual, sometimes our chances of keeping them are different than if we settle a family. There are a number of things that are undertaken.

With physicians, it would be similar. We are working with the college. The U.S. licensure is exciting for us. We're looking again at other opportunities, and also looking at how we settle folks with people with boots on the ground and our orientation with the college and with Doctors Nova Scotia to support them in practice. Those are our predominant two, but we'll look at expanding to other professions as well.

CARMAN KERR: There's an issue locally in Bridgetown: Mountains & Meadows Care Group long-term care. I know that could also go to the Minister of Seniors and Long-term Care, but I want to flag it.

I've spoken to the Minister of Labour, Skills and Immigration about this as well. There are a number of employees who, I would argue, are stuck in limbo as far as support letters from the province. I know that the federal government is also involved.

I've met with several who have come to the office of their own accord. I flagged it with the Minister of Labour, Skills and Immigration, but I just want to ensure that the two departments are talking, and they can sort that out. Maybe it has been sorted out.

I don't know if the minister could comment on that, or if there's any update on that situation at Mountains & Meadows in Bridgetown.

MICHELLE THOMPSON: I don't actually know about that, but the Minister of Seniors and Long-term Care would really be the person to best answer that question because it is a long-term care facility. Or is it a residential-care facility? It's long-term care, so the minister now knows that there's a question coming.

CARMAN KERR: I mostly want to thank the minister and staff for their time. I've got lots more questions. I know I've only got a few minutes left, but I might let a couple of my colleagues ask a couple more while I regroup and come back later.

THE CHAIR: The honourable member for Clayton Park West.

RAFAH DICOSTANZO: I have only three minutes and six questions.

Let's go to a question from last night that I asked about a gentleman who's probably watching right now. The question was about the faxes and the different access points, whether it is virtual care, emergency, or pharmacy. If they have a family doctor, all their information is being faxed back to the family doctor.

I gave him your answer from last night. I spoke to him this morning and he almost laughed. I can't remember the name of the group, but he said that instructional engineers can come and help you figure out how to sort this out. He said that he spoke to the IT department at NSHA and he's giving them the information. This is not about what we are

doing wrong. This practice is run most efficiently because he's a businessman and his wife is a family doctor, so he knows.

The issue is a policy issue. You're allowing these faxes. First of all, faxes are so archaic; somebody has to enter this information when this could be entered at the emergency or at the pharmacy for the EMR, the electronic medical record. Why aren't they being entered and are being faxed instead? It's very inefficient. It's the wrong way and it's costing a lot of staff headaches for the doctors.

This is a policy thing. Stop the faxes. What can we do to help family doctors, please?

MICHELLE THOMPSON: This is the point of the investment in One Person One Record. These antiquated systems - there are so many of them, that don't talk to one another. They're historical. They're antiquated.

We just announced an e-referral system for surgical referrals. We're trying to get rid of the fax. This has been an ongoing lack of investment, so we're investing in that surgical wait-time list by the e-consult. We're investing in OPOR in order to give family practices the opportunity to log into one system. This is the issue.

There are a whole bunch of things. We can't move it fast enough, we know that. We're not holding anything back. These programs are going to take some time. They're huge. If he has an electronic medical record, it will, as part of the phases of OPOR, be connected so that he doesn't have to use faxes. He'll be able to log into the system to see, but it's going to be 18 to 24 months as we roll out OPOR. We can't just drop it. That work is under way now.

RAFAH DICOSTANZO: I have two seconds, so I'll wait until . . .

THE CHAIR: Order. Order. This now ends the Liberals' time of the hour.

The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: I was listening in on the discussion, particularly around emergency care and decisions around emergency rooms versus urgent care clinics.

I was curious, too, about what data is kept about those decisions as they're being made. If an ambulance is called or an RN is on the phone trying to triage treatment, what data is kept about what decision is made? How is the success of that decision reviewed?

Do you at the department have a chance to, every month, look at what happened with emergency room treatment in Nova Scotia this month - who went where, and what

happened? Are there benchmarks? How do you measure a successful month, for instance, in emergency care in Nova Scotia versus what changes might need to be made?

MICHELLE THOMPSON: That's, like, the hugest question ever, but I'm going to try and make it kind of concise.

In terms of EHS, the work of the medical director, Dr. Andrew Travers, and the team around the physicians, as an example, there are some numbers that we get. Response times, as an example, is one measurement, but if you look at clinical datasets, it actually probably is not the best or only. We should actually be looking at clinical outcomes, which we are doing. We're becoming more and more robust in terms of that.

As an example, if somebody calls EHS and it's not an absolute emergency, but absolutely needing help, a response time may not be the appropriate way to measure that call. If they're connected with the medical communications nurse and they are then transferred to a queue, a waiting time, where the SPEAR unit comes out and supports them in accessing primary care, as an example.

We're looking at the dataset that tells us what clinical outcomes are. Response times are one measurement, but very static. It's a very finite number, so we really are trying to match clinical outcomes.

In terms of the question around urgent treatment centres, we would be looking at utilization in urgent treatment centres. We would be looking at making sure that the right folks are coming. All of the different innovations that we have, we do look at utilization, at outcomes, and at demand as best as we can manage it.

There is a very robust data review that happens on a monthly basis. Then if there is a sentinel event in any way, an unexpected outcome, those automatically go into a different review as well. We're very much data informed. We're definitely maturing and looking at what we have done historically and how we can really attach the care and the analysis of clinical outcomes as opposed to just singular numbers.

LISA LACHANCE: I think that's really important. Not being a clinician but having done a lot of evaluations, I would say that response time would not always be a great indicator of the effectiveness.

Can you share with us some of the clinical outcomes that you might be measuring? What would a typical dataset look like? Then what happens? If there's a month and the patient outcomes that you as a department and EHS are expecting and working towards are not met, what's the next step after that?

MICHELLE THOMPSON: I will get you a couple of examples of some of the clinical outcomes. I have an idea, but I'd rather hear directly from them.

The Department of Health and Wellness acts as the regulator and EMCI is the operator. Our medical director would actually look at the clinical pieces of it and make sure there are pathways. We do work in concert together and that work is ongoing.

[5:15 p.m.]

The other piece, too - and I don't have them in front of me, but there would be protocols and standardized approaches to certain events. There would be quality and thresholds and when those thresholds are not met, they would look at that and have quality initiatives. Similar in the Nova Scotia Health Authority, which is what I'm more familiar with, which would be the accreditation process.

You look at what the benchmark is, whether you're above it or below it, what the issues are, and how far below you are - red, yellow, or green. They would have a quality program, and I'll get a couple of examples of indicators, but there would be an established quality program that would work around the clinical outcomes for health services.

LISA LACHANCE: I'm going to switch gears. Last night I had a chance to discuss Estimates with the Minister of Agriculture. He suggested I bring one of my questions to you.

What we hear about in so many sectors and so many industries in every part of this province is a labour shortage. Obviously, in agriculture that labour shortage is largely filled through temporary foreign workers in specific agricultural streams. I'm wondering if the department and the minister are supportive of extending MSI to temporary foreign workers who are here in one of the two agricultural streams?

MICHELLE THOMPSON: My understanding is that it is practice that the foreign workers who come need to be insured by their employer in order to come. They would have a 12-month work permit, so I think that work permit is dependent on that insurance.

We know there are times that special circumstances arise. We have been able to work with people to support that, but the current process is that they are insured by their employer if they have a 12-month work permit. They get first-day coverage if they have a 12-month work permit.

LISA LACHANCE: I think the challenge, Minister, for temporary foreign workers who come along the two agricultural streams is that they're not here for 12 months. They're usually here for 5 or 8 months, so they don't hit that threshold. In many cases, they've been back for 20 or 25 years. This is someone who comes regularly back to be part of our workforce.

We also feel that it's a matter of rights. It's a priority for the producers I've talked to that they have their workers well-supported by this province while they're here. I also think

it causes some consternation amongst workers in terms of making sure they understand what private insurance they have and if it's adequate.

Because agricultural workers are not likely to meet the 12-month threshold, this will be a special request. I'm wondering if the department is considering expanding that for our folks coming in the agriculture streams.

MICHELLE THOMPSON: Because there is a requirement that the employer have private insurance for folks, we are not pursuing that at this time.

LISA LACHANCE: I wanted to go back to some questions around gender affirming care. I believe that my colleague for Dartmouth North might have posed some questions. I'm just wanting to catch up and make sure that I have all the details.

We were previously talking about the current services covered by MSI for gender-affirming care and what additional services will need to be covered by MSI for gender-affirming care in order to be World Professional Association for Transgender Health, WPATH, compliant. I understand that policy work is ongoing in the department.

Obviously, unique situations arise and people can appeal decisions. In 2021-22 or to date in 2023, has anyone received support for gender-affirming services, or had them approved, that are currently not officially covered by MSI, such as female vocalization surgery?

MICHELLE THOMPSON: If there were individuals who received uninsured services, the numbers would be very, very small and, as a result, would make those folks potentially identifiable. The numbers be would small enough that I would not be able to speak about them on the floor. If there were people who received those surgeries, they would be identifiable in some places. There have been some people who have received uninsured services under special circumstances.

LISA LACHANCE: Certainly, I recognize the need for confidentiality and privacy. I'm wondering how that's insured. Did the department sign a non-disclosure agreement with folks who got normally uninsured services provided?

MICHELLE THOMPSON: Again, I would say that the things we fund at the Department of Health and Wellness that are not insured, we would not necessarily have an NDA, depending on the person and the individual circumstances. It really is specific, and it would certainly be only around the treatment that they received. It would not be in relation to anything else.

LISA LACHANCE: I appreciate that clarification. My question is: Has there been an NDA signed with someone who has received gender-affirming care, not normally insured by MSI, to cover that specific uninsured service provision?

MICHELLE THOMPSON: Again, the number of individuals would be so small that it would be identifiable, so in this forum I'm not going to speak about that.

LISA LACHANCE: Have NDAs been used for the provision of uninsured services in other circumstances? Not to do with gender-affirming care, but a service normally not covered by MSI that someone requests, has appealed, is approved for, and is paid for by the province - do they typically sign an NDA about the receipt of those services?

MICHELLE THOMPSON: What I would say, at a high level, is that there are some times that there is a settlement around uninsured services and that may include an NDA, but there are other times that it does not. It really is very much case-specific. It's very hard for me to just apply a general rule to that. That's what I would say about that.

Certainly, if there has been a settlement, sometimes there is a settlement agreement but it's not a routine practice.

LISA LACHANCE: I guess I'm wondering - and I hope that this is an okay forum to ask this question: The answer is yes, sometimes NDAs are signed when people receive uninsured services and there has been an approval and a settlement. I guess I'm wondering why are they used? Why are they signed in some cases and not in others?

MICHELLE THOMPSON: I guess what I would say to that is that it really does depend on the settlement agreement. It would depend on the circumstance and the settlement agreement around that. There's not a tick list. It would be a negotiated settlement and it would be part of those negotiations.

There's not a laundry list of the things that we choose. It is very, very case specific, which is why it's very hard for me to give you a generalized answer about that.

LISA LACHANCE: Recognizing that and, of course, seeking health care and seeking solutions for health challenges are very unique, it's usually because each of us is.

How does the department then monitor when it's appropriate to use an NDA or not? Who keeps track of that? Who thinks in this case it made sense, in this case we shouldn't have done it, in this case we should have done it? How is that monitored?

MICHELLE THOMPSON: Again, it would really depend on the circumstance and the parties who were involved in the negotiation of the settlement. I can't even presuppose who that would be because, again, that fluctuates as well.

LISA LACHANCE: For you, Minister, when we're in a context where we're talking about the appropriate use of NDAs and the inappropriate use of NDAs, which were developed for a very specific purpose, I can see where they may be requested as part of

service coverage through MSI, but I'm wondering how do you satisfy yourself, Minister, that the department is using NDAs appropriately?

[5:30 p.m.]

MICHELLE THOMPSON: This would be around a settlement for services received. It's certainly in no way in terms of silencing anyone who has been victimized. It's not in regard to that at all.

We have legal counsel and the individual would have legal counsel. There may be other bodies involved that are advocating for the individual. It's worked out together. It's never just the department and the person. It's certainly not used in a way that anyone who's been victimized is silenced. It's around a particular parameter where an uninsured service is delivered. It would be very particular to that. It's not used in any way to silence somebody who's been harmed or victimized. It would be specific to the treatment that was received, and it would be worked out with legal counsel, the individual's legal counsel, and any advocates that the individual is working with.

LISA LACHANCE: I think there's still - in that context of advocating for yourself, or perhaps having legal counsel or an organization involved, for medical treatment, particularly feeling a certain amount of duress, it's actually a very vulnerable activity, I would think.

Certainly, when I've had to go forward and advocate for services that were not being readily provided to my family, it is a very vulnerable place to be. I guess I would say that monitoring how they're used - so they're not used with the intent for silencing - but just monitoring their use is really important.

I think that when people are advocating to have access to health care that's not being provided by the province, inherently the province has more power. There is an inherent power differential right there in that negotiation, so I do think that making sure that they're being used the right way in the right circumstances would be appropriate.

I am happy to hear that some gender-affirming care has been approved that is not currently officially covered by MSI. I am happy to know that the minister and the department were able to assess the need for care for those people and recognize that it is an essential part of the health care that they needed, that they couldn't find here but that it needed to be done and would be supported by the province of Nova Scotia. That's exceptionally good news.

I'm wondering: What about the rest of folks who don't feel that they are in a position to appeal what is currently covered by MSI? This is the whole point of this province becoming WPATH compliant. It's so that all of the medically necessary

gender-affirming care services that have been recognized by an international body of health professionals and specialists are actually available to Nova Scotians.

I think there are lots of Nova Scotians who want access to the types of services that are not currently covered. The power is in the hands of the province. This idea of standing up and appealing and fighting for that is tiring. Lots of people don't have the kinds of resources to be able to do that.

I guess I would invite you to comment, that the department has recognized that these are essential medical services for a few folks and yet you're still holding the line and not approving them for others. I think that's unfair. I'm wondering if you could comment on this process.

MICHELLE THOMPSON: I would say that as a province we are most certainly on a journey. We have worked recently on developing a more holistic policy and looking at ways in which we can reduce barriers. We heard from community that there are a number of barriers to the insured services.

I would say that we are on a journey and we will continue on that journey, working with individuals from the community. That's where we are today. We feel that we have made some advancements. There is always going to be more to do. We're committed to continuing that dialogue.

LISA LACHANCE: I appreciate the reference to being on a journey. I think that's where - when we have international bodies like WPATH in certain areas, that they do the work and they do the engagement and they develop the standards so that, as a province, we don't have to go around and develop standards for the care of a lot of medical issues and medical conditions.

We don't have to go and decide what the current best practice is for dealing with a broken ankle, or what is the current best practice for a certain kind of cancer. WPATH exists so that - respectfully, we don't have all the expertise in this province. I don't think we have anybody working from a viewpoint of being responsible for considering 2SLGBTQ+ issues in the Department of Health and Wellness. There is no specialist.

You don't have the expertise in the department, but you have a whole international body that has developed standards. Sure, you're on a journey, but I will tell you that people who wait a long time - decades, really - to access the care they need so that they feel themselves, that their gender dysphoria is addressed and resolved - that's a journey that we shouldn't be forcing Nova Scotians to take.

I think the community really got excited last year. I think people really got excited and we thought that this province was going to become WPATH compliant. Now we're a year later and all we hear about is a journey.

I will tell you that when I asked you questions before - I went back, and you said that there had been all these engagements, and a draft, and this and that - I don't know who you're engaging. I've asked you for a table of those engagements and the dates, because the folks I would think of who you would be engaging with have reported no contact for several months.

I'd love to know: What's the most recent engagement? I'm sure you can tell me of an NGO here in Nova Scotia doing that type of work - what's the last date of engagement that's happened? I'm certainly not hearing anything from community of being engaged.

MICHELLE THOMPSON: The draft policy has been broadly discussed. There's a representative from the Cape Breton Transgender Network, the executive director of Sexual Health Nova Scotia, and the director of prideHealth. Clinical members of Sexual Health Nova Scotia also attended a meeting in December. This meeting was positive.

There have been other discussions that have been happening between the Department of Health and Wellness staff, Tanya Penney, who has been leading the work and Dr. Sam Hickcox. These discussions, by all accounts, have been very positive. The policy is coming.

To the point about the WPATH standards, the expectation was that they would be out sooner. My understanding is that they actually were released a little bit later than we anticipated. Version No. 8 of WPATH was completed in September, which was later than they anticipated. That's when they were released. We've been working with that document to make sure that the policy is reflective of those new and updated WPATH standards.

LISA LACHANCE: I thank you for looking into that. A whole season has passed since December, so I'm hoping that this is indeed a Spring policy announcement. People are waiting.

My office received a question from a specialist who leads a team that works in an arrhythmia clinic and specifically is focused on a genetically predisposed condition that affects folks in most of the Northern Zone. This clinic is supposed to be operating with eight specialists. That's since 2007, when the problem was first identified and assessed and responded to. The advice was to establish a clinic of eight physicians. It's currently at six and has been at six for some time.

There's a specialist ready to come from the U.S. They're ready to come and just can't wait to get back to Nova Scotia. Say the word. They're working at the Mayo Clinic and are a well-respected physician. The folks at this clinic were told that the Department of Health and Wellness MD table won't review this proposal for a year.

At the same time, they are seeing growing demand at their clinic. Most of them have, for instance, a wait-list of 12 to 18 months. I'm just wondering: Can we not move

forward with this specialist who's ready to come and fill a vacancy that exists, and also make the work of all the other folks involved in this care much more effective? Why is it going to take a year for the table to review that case?

MICHELLE THOMPSON: I think I would need more details to understand - the clinic, where it is - there are probably more details that we would need. Certainly, the clinic is able to reach out. I think what we'll do is we can follow up afterwards. I'm really not familiar with all the details. I have some, but not all and I think there's probably more to understand about the clinic.

KENDRA COOMBES: Hello again to the minister and staff. I'm going to centre some of these around Cape Breton, again. One of my questions is: How many paramedic vacancies are there in Cape Breton?

MICHELLE THOMPSON: I'll get back to you with the zone-specific number of vacancies.

KENDRA COOMBES: Would the minister have the Eastern Zone numbers for vacancies? Okay, the minister's going to get back to me with those zone numbers.

I'm wondering: Does the minister have an update on the department's plans to add care providers and patient advocates to support patients in waiting rooms at the Cape Breton Regional Hospital?

MICHELLE THOMPSON: Patient advocates are in Cape Breton Regional Hospital and St. Martha's Regional Hospital in Eastern Zone, and the waiting room care providers are expected to be in place by the end of Quarter No. 1.

KENDRA COOMBES: In Quarter No. 1 - I'll be looking for it.

I'm just wondering if the minister has an update providing health care teams with real-time data on where beds are available across the system, and what tests or other actions are needed to get patients well more quickly at the Cape Breton Regional Hospital?

MICHELLE THOMPSON: This is a little bit of an update on the Care Coordination Centre, C3. At the QEII, most of the tiles are up and running. The Capacity Expediter Tile went live earlier this week. It's a bit of a soft launch in all the regionals. That provides at-a-glance, real-time situational awareness of hospital-wide patient census, bed availability, and hospital surge status.

We are expecting that the ED Expediter Tile will be coming in the first quarter. It provides emergency department flow managers, team leads, and providers with real-time awareness of ED arrivals, where the patients are queueing, and where the pressure's building in the system.

[5:45 p.m.]

The provincial rollout is beginning.

KENDRA COOMBES: I'm just wondering: Does the Minister of Health and Wellness keep track of mortality rates of individuals who present at the emergency rooms, but due to sometimes feeling so sick and unwell that they can't sit and stay in the emergency room. I'm not sure if the minister's ever felt that, but I know I myself have been there. I just felt too sick to even be in the emergency room.

I've seen other people who were too sick to even be there anymore. They weren't well enough to even sit in those seats and they leave. I'm just wondering if the government tracks those who present at the emergency room, don't get seen, they leave, and then they pass away. It's similar to what happened to Mrs. Charlene Snow. I'm just wondering if that's been tracked.

MICHELLE THOMPSON: There's no formal program to track whether someone leaves, whether it be an emergency room, if they've been seen by their physician, or seen in an outpatient clinic. If they've been seen in a period of time, there's no automatic cross reference if someone were to expire at home or in the community.

They may be notified by family or that person may come back through with EHS, in which case there would be a second registration. It is variable in terms of if somebody re-presents to an emergency room or if somebody was seen in a physician's office, as an example, to seek care and then had a sentinel event. It's difficult, whether or not the individual comes in through EHS, or if it is a medical exam, or those types of things. There is no formal way that we would find that out.

KENDRA COOMBES: The reason I've asked this question is because we've seen a pattern of this over the last number of years. We've heard of people going to an emergency room or going to, now, non-urgent care centres as well. We've seen it where they presented themselves there and either have had to go back to the emergency room or, as the case previously in Cape Breton, a person died.

I'm just wondering is there any plan to track that? With all these new systems that we're putting in, such as the real-time data on bed availability, I'm just wondering if we're looking at that to start tracking.

MICHELLE THOMPSON: Again, it is difficult to track what happens in community. If somebody's not happy with the care that they receive or feel that they've been misdiagnosed and they re-enter, we would look at that re-entry. If someone's discharged from hospital and they are re-admitted within a certain period of time, we do track that, as an example.

If someone has an event and we are notified that someone has left the emergency room and there has been an unexpected outcome as a result of that, then that would be reviewed. Really, because folks are in the community, we don't have a way to track them. We need to be notified of it. If they come through EHS, as an example.

It really is the second touchpoint on the hospital. If someone doesn't get the care that they required, or felt that they weren't treated appropriately, there is a patient feedback line that people can call, and that case can be reviewed at the patient's request.

KENDRA COOMBES: Last night I asked the minister about the rate of sepsis at the Cape Breton Regional Hospital, which sees 10.5 patients per 1,000 admissions contracting sepsis, which is double the national rate. I was just wondering if the minister has been able to look at that article. I know it's been long days and long nights, but I'm just wondering if the minister or any of her staff were able to look at those rates and are able to tell us why we're seeing this rate occur and what plans can be put in place to lower these concerning rates.

MICHELLE THOMPSON: The staff are gathering that information. It'll be available tomorrow.

KENDRA COOMBES: I look forward to it. I'm just wondering if the minister can talk to me with regard to rural ERs, which are routinely unexpectedly closed. This has carry-on effects for the entire system, as I'm sure you appreciate and are very much aware, as paramedics and patients have to go farther and wait longer for help.

I'm wondering how many emergency medicine vacancies are there today and how does that compare to this time last year?

MICHELLE THOMPSON: I think what you're asking is about the ER accountability report. It's really essentially looking at the ERs across the province. That was tabled for the last fiscal year in December. It actually will finish tomorrow, and the analysis will start.

KENDRA COOMBES: As the minister knows, there is critical work that is happening in street outreach in some parts of the province. The Ally Centre of Cape Breton in Sydney is one that I'm very proud of. I think they do exceptional work. So is the Mobile Outreach Street Health team in Halifax.

We have a rapidly growing homeless population; unfortunately, it seems to be growing by the day. I'm just wondering if there are investments in street outreach health programs in this budget.

MICHELLE THOMPSON: There is some money allocated for the MOSH program, which includes support for Out of the Cold Community Association in HRM.

KENDRA COOMBES: I'm sorry, I may have misheard the minister. Have there been any other monies allocated to areas of the province other than Halifax?

MICHELLE THOMPSON: There's been \$50,000 allocated to the Ally Centre of Cape Breton.

KENDRA COOMBES: How much to MOSH and Out of the Cold?

MICHELLE THOMPSON: There's \$1.4 million for MOSH, and it also is funding for Out of the Cold, so it would be between those two.

KENDRA COOMBES: Shortly after the government was elected, the department estimated that there were as many as 2,100 health care vacancies across the system. What is the situation presently?

MICHELLE THOMPSON: Just some clarification on that question. Is it total vacancies or is there a particular designation that you would like?

Total? We'll have to get that for you.

KENDRA COOMBES: The COVID-19 pandemic is still ongoing, though we are now three years in and there are many lessons we have learned. I'm just wondering: Is Public Health planning any kind of post-mortem review of the COVID-19 pandemic that the public will have access to? If so, what are those timelines?

MICHELLE THOMPSON: Certainly, there has been work begun not only provincially, but nationally and internationally. Those are in the early days. The pandemic has not been declared over as yet, so that work will be ongoing for a period of time. Public Health teams are looking provincially, nationally, and internationally about some of the lessons learned, and working through committee work on that topic.

KENDRA COOMBES: For our own reviews - because I believe that's what you said in your answer, that we were looking at it as well - I'm just wondering if we have any timelines for Nova Scotia.

MICHELLE THOMPSON: No, there's no timeline.

KENDRA COOMBES: My colleague may have already asked this, but I may have been somewhere else, at another Estimate. I'm just wondering if there are any new monies for Public Health.

MICHELLE THOMPSON: There is an increase in the Public Health budget. There's \$3.2 million for oral health and early years. We are looking at increased funding

for the Enhanced Home Visiting program, which allows greater program capacity in the Eastern and Central Zones to reflect population demographics.

[6:00 p.m.]

Also, we will be doing the Nurse-Family Partnership program in the Eastern Zone for highest risk families. There is also a \$2.1 million increase to Public Health staffing, to increase capacity.

KENDRA COOMBES: When this PC government was in Opposition, they had promised a Lyme disease strategy. Is this being developed and, if so, what are the timelines?

MICHELLE THOMPSON: We heard at a number of stops on the tour that this was something that was very important to folks. There is a clinic in Manitoba that we are looking into, but we have nothing concrete at this time. The Nova Scotia Health Authority has reached out to that Manitoba clinic to understand the model and the services that they offer.

KENDRA COOMBES: I think it's safe to say that there's no strategy yet, but you're looking at Manitoba.

Within Lyme disease, what are we doing to ensure that health care providers have the necessary resources to assess those at risk of Lyme disease, including testing? Also, what are we doing to increase awareness of Lyme disease in Nova Scotia, particularly related to prevention?

MICHELLE THOMPSON: Annually, there is a campaign around tick awareness and prevention. Last year we funded pharmacies to be able to do assessments and provide prophylactic treatment so that people who found a tick did not have to present to the emergency room in order to get preventive care.

In regard to the testing, we work with the Infectious Diseases Expert Group, the Diagnostic Microbiology Laboratory, and Public Health to inform the testing modalities that we use in the province.

KENDRA COOMBES: I appreciate that. As great as pharmacies and pharmacists are, once a tick has been discovered, the biggest problem that many face is that they don't know they've been bitten. They don't have the tick with them to test for. Many of these people don't know that they have Lyme disease until after sometimes years of seeing doctors thinking other things are wrong with them only to find out that it was actually Lyme disease.

Are we doing anything in looking at making this, for particular areas where the rates are high for Lyme disease, one of the standard tests that we test people for, rather than going through all kinds of different treatments that put them through the wringer mentally, physically, emotionally, as well as financially with missing work.

Are we looking at making this a standard test for areas where ticks are prevalent?

MICHELLE THOMPSON: In terms of the testing, we would take our advice from clinical protocols and the experts. We are reaching out to understand what other jurisdictions are doing.

KENDRA COOMBES: I appreciate that, Minister. I hope it moves fast because the more time somebody is left untreated with Lyme disease - I'm sure you're aware, as a health care professional - the more chances of them becoming severely ill. Also the more chances of them being unable to recover and having long-term Lyme disease. I know a few people who are suffering the effects three, five, six, ten years later, still suffering those side effects and still trying to seek treatment for them.

With 27 seconds left, I also hope that there'll be more patient outreach with regard to those who have gone through Lyme disease treatment and talking with advocacy groups. Again, I thank the minister for her time. My colleague will see you in the next round. Thank you very much.

THE CHAIR: Order. The time for the NDP has elapsed. Before I look to the Liberals, I'm going to call a brief recess.

We will have a 5-minute recess.

[6:08 p.m. The committee recessed.]

[6:13 p.m. The committee reconvened.]

THE CHAIR: Order.

The honourable member for Clayton Park West.

RAFAH DICOSTANZO: If I may start back on that quick question that we had only two minutes for before. I know the minister said One Person One Record, and there's no one more excited about OPOR than I am.

I was very excited; however, OPOR is going to be at least two years, as you said, and up to 10 years before we see any advancement on that. Even with all that time, the family doctors are never going to be included in the contract that you just signed. Family doctors' offices are not part of the OPOR that you announced.

Let's put that aside. That's not helping the family doctors. How can we help them right now with the faxes and the information that is coming to their offices because of the expanding access points through virtual care, pharmacies, and emergency rooms? They're getting inundated with faxes and information, where the family doctor has not seen the patient, has not received any compensation for that, and they have to hire staff to enter the information.

[6:15 p.m.]

The question that my constituent has asked - and he's actually watching now, I believe - is: Incoming faxes to be integrated into electronic medical record systems at the start or end point still involves an upload into EMR. He wants whoever is seeing the patient to enter that information into the electronic medical record system. Could the minister explain who has EMR?

He's also saying that they're receiving faxes from Cobequid Community Health Centre and mail via post from the IWK Health Centre. He has raised this issue with the IT team at the NSHA. This to me is so backwards. What can we do to help these doctors right now? They're already struggling with the amount of load on them and we're giving them more work because of the expanded access points.

I also know that the doctor can send information to the pharmacies. If patients are being seen by pharmacists, why can't that information come back to the doctor? Can you explain what can be done to help doctors? If you can't help them, why aren't we compensating them for that?

MICHELLE THOMPSON: I appreciate that there are a lot of interoperability issues because we have so many systems. I'm certainly not going to be able to develop a solution here tonight in terms of how the interoperability works.

I do think that that individual should call that practice support line to see if there's any way we can expedite that or have a look at what some of the systems are. There are a number of different systems, and I can't speak to which ones they are. There is a support line.

We are looking at red tape reduction for physicians. That would also help if we could really understand the platforms that are being used around some of the red tape reduction. I think it would be very important for that physician to reach out so we understand first-hand what some of the issues are.

The other thing I would say around the compensation is that it would be important information. We're now in the middle of negotiations with Doctors Nova Scotia and we've heard that there is a lot of red tape. I think it's important that that be brought forward through Doctors Nova Scotia at the negotiation table around the compensation.

As part of that, we know that in practice supports, moving forward, we do need to look at some of the barriers for access to care for patients. Those would be the avenues in which that individual could share his concerns and have individuals support him in terms of how to problem solve.

RAFAH DICOSTANZO: I hope my constituent is happy with that answer, but he already has reached out to NSHA and given them all the information. He has talked to the IT department about all his issues. Nothing has happened. Just to leave that.

I'll move on to the second point. This one I've heard from at least two or three different doctors. That is when doctors are ready to retire, they notify you at least a year, maybe two years in advance. That's what's happening. I know in my family doctor's practice, this other one, five, that I know of. They notify - because they feel guilty about leaving their patients - to let you know that they intend to retire in a year or two years.

In this case, they did. There is a doctor who notified you two years in advance, he was telling me, and nothing has happened in over a year. Now the doctor has left, and all those patients have no doctor attachment at all.

He also said that he hears there are so many doctors coming from England and wherever but nobody's bringing them to his office. They've been taken to outside and he knows why. It's because there is an incentive. There is no incentive for them to go to a Halifax clinic.

His request is that the priority should be for any doctor that you bring in from outside to go where there is a doctor about to retire, so that those patients will have some interaction with the new doctor before the family doctor retires. They can help mentor them, especially if they're from other countries. They can help them with the system.

It makes sense, but this is not happening in Halifax at all, probably because of the incentive program, unless you have another reason why. Can the minister tell me how many doctors have come in the last year and how many of them have settled in Halifax, please? Just some numbers of doctors that we've brought from outside - how many of them and in which regions they have settled.

MICHELLE THOMPSON: In the past year, Halifax Peninsula Chebucto has had 14 family physicians. In the Central Zone total, there have been 27 family physicians.

RAFAH DICOSTANZO: That is out of how many? In one year, we've received how many and what percentage went to Halifax?

MICHELLE THOMPSON: These are the recruitment numbers that I have up until January 31st. In Central Zone, 27; Eastern Zone has 10, Northern Zone has 9, and I'm

confirming the number for the Western Zone. It says that there have been 20 in Western Zone.

There have also been specialists attracted: 26 in Central Zone, 17 in Eastern Zone, 6 in Northern Zone, and 11 in Western Zone.

RAFAH DICOSTANZO: Just to look at that. It says 27 for - 50 per cent of the population is in Halifax. We have 39 outside. That just tells you where they're going instead of here. In the past, everybody wanted to work in Halifax. You can give the incentive to both, right?

We've caused a problem in Halifax that we didn't have. When this government came in, Halifax saw a huge number of unattached patients. It is seven times the number it was when you took it over. That is clear.

I also have received an e-mail from a doctor in my constituency. He's having a hard time, as it's been one year that he's been trying to get his wife here. I'm glad the Minister of Labour, Skills and Immigration is sitting here as well. The doctor is dealing with the MP, Lena Metlege Diab's office. Is there anything that you are working on with doctors here to bring their wives and family members here? Is there a program? Is there something to help doctors, before we lose him as well?

MICHELLE THOMPSON: We actually are working on a program called NICHE, Nova Scotia's International Community of Health Workers Engagement Program. It's a proof of concept. We've been working with and talking to our federal counterparts across departments and working with the Department of Labour, Skills and Immigration. Perhaps the Minister of Labour, Skills and Immigration will have more to say about it.

It is a program where we would look at immigration and settlement of health care workers and their families. We feel that the retention rate will be better if we include family members.

We are looking at that program. We did expedite it when Ukrainian nationals who have health care experience came to Nova Scotia. It actually provided an opportunity for us to look at how we support folks, particularly those who are displaced unexpectedly. There was a lot of learning from that program.

First of all, credentials were not available because of the devastation in Ukraine, as an example. We had to look at how to look at credentialling in a different way, but also how we settle families. Some people have health care experience. Initially, if they couldn't be credentialled immediately, bringing them in.

We do want to support families. It's an extensive program and it is around settling the entire family and, wherever possible, finding opportunities for health care workers'

families to work in health care systems. They provided a very good example where partners of some of the health care workers actually worked as navigators in order to support.

[6:30 p.m.]

We're actually working, as well, with the Nigerian Nurses Association. We met a couple of Nigerian nurses who talked about that. We are working to bring people in and settle them. If there's a particular case, that's not going to be solved here. We need to know the person's name and support. We can't do individual cases on the floor of the House.

RAFAH DICOSTANZO: I have your permission to send that file? We've been working with the MP's office. Even though he's a doctor, we should send the file to the Department of Labour, Skills and Immigration? Okay, I will make sure that the Minister of Labour, Skills and Immigration gets that file. Hopefully she can help him. It's been a year that he's been waiting to reunite with his wife.

The next one I have is a really long question, so before I get to that, there were two questions from my colleague that you offered some statistics as an answer. You said that for the pharmacy appointments, you're hoping that the pilot would bring 42,000 appointments. When he asked you what the cost was per visit, you couldn't give it. I think that whatever the contract is, if you divide by 42,000 visits, it should give an average of what you're going to pay the pharmacy for each visit. That should be easy to do to give me an approximate number.

MICHELLE THOMPSON: As I mentioned before, this is a pilot program. We worked with the Pharmacy Association of Nova Scotia and agreed that the pharmacies in the pilot project will get \$7,000 a month to support the seeing of clients.

Based on the utilization of that program, what people are coming for, and how many people come, we'll then take that data as part of the pilot and go back with the Pharmacy Association of Nova Scotia and look at what the tariffs would be, moving forward.

Rather than delay it, we're gathering how it's utilized, what the services are, and all of those things. We've agreed with the Pharmacy Association of Nova Scotia that this is the cost - \$7,000 per month - and we will work on tariff agreements with them for payment, moving forward.

RAFAH DICOSTANZO: With the \$7,000 per month, you must have given them some parameters such as: We expect so many visits. What are your parameters? What is your expectation of how many visits they have to do? Can they do 10 or 200?

MICHELLE THOMPSON: That is part of the work that's happening. The expectation is that they would see three to four patients an hour and they would work a full week. They may find, because of that flat funding, that it's too much or too little. This is some of the work that has to happen. We need to understand the utilization, the things that folks are coming for.

The things that people come for is based on the scope of practice of the pharmacist. As an example, there may be someone who makes an appointment and if a screening is required and they present, they may not be able to be seen because it's outside the scope of a pharmacist.

This is an innovation pilot. It's not happening anywhere else. This is the way that we will evaluate and move forward. There is a lot to learn. I'm sure there will be adaptations as we go, but \$7,000 a month is what each of these pharmacies is being offered to support seeing a variety of patients.

RAFAH DICOSTANZO: I'm very happy. I just want to know if the pharmacists are being paid the same as a doctor. That's where I was trying to go. If you're saying that they see two or three patients an hour, how many patients is a doctor expected to see in an hour?

MICHELLE THOMPSON: It's really not very comparable. There's no way to say that. We have fee-for-service positions; they decide how much or how little they work. Advanced practice providers are another different funding formula. There is a panel size requirement. They have blended capitation, which is something else.

It's not apples and apples. What we're trying to figure out is - some people come and they're 15 minutes, some come and they're 30 minutes, which is why physicians like the salaried approach versus a fee-for-service. I'm not trying to be obstructive. It's very complex; it's not A-B-C.

It's very difficult to compare. They're two different professions. They're two different scopes of practice. Their ability to provide service is very different. It's not really comparable. They would have a skill set of seeing people with certain conditions, and some people will need more. There may be some people who need 45 minutes, based on their chronic disease management. It really does depend, which is why there's a flat fee until we understand the utilization, and it'll help inform next steps.

RAFAH DICOSTANZO: I'll leave that one for now, but I just want to make sure that they are paid adequately for their time, or this is not going to be successful. There was another program that was started for mental health. When I was speaking to the pharmacists, they said that they were paid so little and now they're so busy that it's not feasible for them to even encourage people to come for a consult for mental health.

It's important that they get paid reasonably. Also, my concern is: is it the company that gets the money or is it the pharmacist? I know that during COVID-19, when the pharmacists' scope expanded, the actual pharmacists received very little money. My daughter got 60 cents in three years. There was very little that went to the pharmacist.

All the vaccines and everything that happened with COVID-19, it didn't reach the pharmacist. The government gave it to Loblaws or Sobeys - whatever the contract was; it did not reach the pharmacist. It is an important thing for our government, when you negotiate, that this money does reach the pharmacist. They are all burnt out. They're not getting the support. They're having a hard time as well. I just wanted to give you that idea.

This is many pharmacists. I've met with two in my constituency, and they tell the same story. I know that my colleagues have heard the same. We need to look after pharmacists or we're going to be losing them as well.

My next question is from Elizabeth, who sent me a question about the \$10,000 thank-you incentive that the government just announced only three weeks ago. I showed the minister this morning that the closing date Elizabeth was given in writing was March 27th, which was Monday. She said they had very little time to get to register. She gave me three pages and I'm going to just read some of the stuff that she gave me.

I have reached out to HR four times and various government agencies to clarify if I will be receiving the thank-you bonus. I needed to know whether to apply for the retention bonus this year or next year. No one has reached back out to me except my MLA's office. I have been e-mailing and calling for over a week. As you will see in the image below, the deadline for the NSHA posting for the return-to-service retention bonus was March 27th, not the 31st.

I have it in writing, and I already forwarded it to the minister. She also says:

I lost my seniority when I was an external applicant. I accepted a temporary position with the NSHA in November of 2020. Fourteen years of full-time RN experience within the Nova Scotia health service is now 2.5 years of seniority on paper within NSHA.

She's just not qualifying because she took a temporary for two years. Then she says that for the past year, she took maternity leave and now she's not eligible, but the person who is on maternity is eligible for this thank you. For this thank-you bonus, why are all frontline nurses not being recognized and honoured for their service during the pandemic? Why does permanent versus temporary versus casual matter? Is one nurse's sacrifice and effort not equivalent to the other?

She really wants to know if she qualifies, and tomorrow is the deadline. I don't understand how you expected nurses who have complicated issues like this, to whom nobody is replying, and you give them less than three weeks to register. They're already disqualified before they even started.

What was the reason for the short timeline that you gave them? The announcement was made the day before we started on the 20th. You gave them 10 days to register to qualify for this? I'd like to have a reason . . . (Interruption)

THE CHAIR: Order. Order. I don't mean to interrupt or be rude to the member, but I've been pretty lenient on the use of "you." I'd respectfully request that the questions go through the Chair, please and thank you. It makes it a little less of a one-on-one battle. If you're finished your question, I can recognize the minister or I can let you finish up.

RAFAH DICOSTANZO: I apologize. I should know that.

Through the Chair, I have the letter and I already spoke to the minister about this. She's familiar with it. We sent it to her assistant this morning. We needed an answer by this afternoon. I also received a very vague answer from the assistant. The deadline is unreasonable. What is going to happen to so many nurses who qualify, or should qualify, who only have ten days to register? Can you give us a reason, please?

THE CHAIR: Order. Through the Chair, please. Thank you.

RAFAH DICOSTANZO: Through the Chair, please give us a reason.

MICHELLE THOMPSON: We're moving as quickly as possible to fill the vacancies that we have. We know that the timelines are short. We understand, though, that it's resulted in 200 people already returning to the system. That's a very complicated story, so I think if the person is in a term position, based on their FTE equivalent - I don't know if it's full-time, term, temporary, or part-time temporary - then that person does probably qualify for it.

I think when you talk about moving, I'm not sure if she's moved collective bargaining units. There are a lot of questions in there. There is a team of individuals who are responding. They've had over 2,000 emails and are working through that. She will be responded to. I appreciate that it's stressful, but if she's in a term position, I do believe that she would qualify. I certainly can double check.

The effect that we wanted was to have people come back into the system. We're pleased with the response that we've had. We're not trying to exclude people. We want people to have that bonus and come back to the system. Again, there's probably more to say. I think it's a very complicated case and we can speak about it. I have the posting, but I don't have all of that information you just shared.

THE CHAIR: I would like to ask the member to table that entire document that was referenced in the earlier question.

[6:45 p.m.]

RAFAH DICOSTANZO: I will do that with pleasure. I'd be more than happy to give that letter. There are many questions, so I won't go through them all.

What is important is this timeline. If our intention is to get as many nurses as possible, why was it limited to 10 days? She's called and she's asked for help. There's no one who's replying to her. Why wouldn't we extend it so that we can get more nurses to sign up, to come back, and to benefit?

Her question is: If a nurse qualifies for a thank-you bonus, they have been told that they can sign a 2-year retention bonus by March 31st and receive an additional \$10,000. However, if a nurse does not qualify for the thank-you bonus, they can apply for a return-of-service retention bonus if they're willing to accept a permanent position.

It is complicated. What you're offering is so complicated. Information hasn't reached them. She said that she didn't even know about this. There was no announcement for the nurses. This was not given proper time, especially for complicated cases, for them to reach you and nobody was replying to them. There are many nurses who should have qualified who are going to be denied because of the deadline. Is this fair?

I'm just going to leave that and I'm more than happy to table what I have here. It has my scribbles on it but it's all her information.

The other question I would like to ask on behalf of a colleague of mine is: When will the palliative care unit at Fishermen's Memorial Hospital in Lunenburg be open? It was ready for opening in the Fall of 2021, yet it's still closed.

MICHELLE THOMPSON: We and the Nova Scotia Health Authority are working with Fishermen's Memorial Hospital. The nursing vacancy rate is the predominant issue around supporting that clinic. We do also need some support around palliative care. I know that the teams are actively looking to recruit the staff required for that organization.

RAFAH DICOSTANZO: Sorry, but it was ready in 2021. That is the answer - there is no staff to staff it.

All right, I think I'm done for now. I'll move it to my colleague here to have his questions. I may have a couple after, if he leaves me any time.

THE CHAIR: The honourable member for Northside-Westmount.

FRED TILLEY: Thank you, Minister. I know that it's been a long week-and-a-half. My questions are going to be really, I hope, simple and basic. Being from Cape Breton, you know where I'm headed first. I would be remiss if I didn't mention my colleague from Sydney-Membertou.

There's been significant investment made in the health care system of Cape Breton over the last number of years. Your government is to be congratulated on continuing with those previous investments and then adding on some new ones. A lot of those investments will help residents of Cape Breton long into the future.

Something that would help right now is the PET scanner. We have a foundation that has been raising millions of dollars for this PET scanner. We'd just like to get an update as to where we stand with the province's portion.

MICHELLE THOMPSON: I hope the member for Sydney-Membertou is glued to the television. I expected that he would ask me.

I will let you and the folks know that we did commit to doing a feasibility study, which has been completed. There were some complexities that were identified through that feasibility study, as we expected.

There is some more to learn and understand around the operations of what a PET scanner could look like. There are issues around construction, maintenance, and staffing. There is a re-agent that's required as part of the PET scanning process, how that production would work.

This review has identified areas that need a bit more of a deeper dive to understand what the sustainability could be and what's required. That's where the project is right now. I know it's taking a long time, but the worse thing would be to have it and not be able to use it. We want to make sure that we understand what is required, and we're moving forward with that second and deeper-dive review on the PET scanner.

FRED TILLEY: That's great news that we are digging deeper into this file. It is very important to the people of Cape Breton who have to travel long distances to receive those diagnostic tests.

I just wanted to check in and ask the minister: Can you give a bit of a timeline as to when you think the feasibility study might be finished?

MICHELLE THOMPSON: I don't, actually. I can check to see if there is a finite timeline, but I do know that it's been identified, and it is under way.

If you wouldn't mind, I just want to talk a little bit, too, about an investment that we made around your point about the travel. We are adding a fixed-wing air ambulance - not

EHS for emergencies, but an actual fixed-wing ambulance for Cape Breton, Yarmouth, and Sydney so that when people have to travel, we would have an opportunity to have four people sitting in the fixed-wing aircraft and two people on stretchers. That puts a minimum of five ambulances per day back on the road.

I just also want to talk about that because, really, I appreciate that. From Sydney, Cape Breton, or Glace Bay to Halifax is a pretty long drive. We are looking at ways to be more efficient, one, for time, but also for comfort for patients because it is a long drive, either in a car or in an ambulance. I just want to highlight that there is another support that's coming for other things that people have to travel to Halifax for.

FRED TILLEY: That's great with the fixed-wing piece. From my own experience, when my mother was in, she was slated to take EHS LifeFlight to Halifax but because a more emergent case came along, she was bumped. I absolutely understand. That's great, so we can get more access to that.

I'm going to switch gears a little bit, over to the Northside General Hospital. I'm just wondering if we could get a little update - I drive by there a lot and there's lots of activity on the site - as to whether we're on time and on budget with the Northside General Hospital redevelopment.

MICHELLE THOMPSON: That's another much anticipated question. My understanding is that Northside General Hospital is on track. It will have ambulatory, specialty clinics, mental health and addictions, community support and wellness teams, and short-stay beds. I think the scope of that project has stayed the same and it is on target.

FRED TILLEY: The redevelopment of the Northside is a really exciting thing for the community. I'm glad to see that activity taking place.

I just want to ask another quick question around psychiatry in Cape Breton. We know that we've had some losses with psychiatrists. I'm wondering if we can get an update on how recruiting is going and where we stand with recruiting for psychiatrists in Cape Breton.

MICHELLE THOMPSON: What I will do is check with my colleague, the minister responsible for the Office of Addictions and Mental Health. I know that they've had some luck recruiting clinical assistants in the Cape Breton area, but I think I'd prefer to get the exact numbers from him, and I'll share those with you.

FRED TILLEY: Great, thank you. One other question. It's not in my constituency, but it's a neighbouring one. It affects the ER at the Cape Breton Regional Hospital just because there's more activity. It's a question around the Victoria County Memorial Hospital ER in Baddeck and if there are plans to re-open it to a full ER in the near future.

MICHELLE THOMPSON: I'm smiling because this is the way Cape Breton works. I could almost anticipate every question.

I do want to assure the member that we continue to look at the hospital in Baddeck. It is currently functioning as an urgent treatment centre. I know that discussions are ongoing with the clinicians there about the restoration. I would say that it continues to be on our priority list. We continue to have those discussions. We are hopeful that there will be a restoration of services there, but I don't have a timeline.

Being from there, I provide regular updates when I get home to Cape Breton. It is still on the radar. I know that they are all working very hard to find a solution in order to get emergency services there.

FRED TILLEY: That's good news as well. I don't have any further questions. I'm going to pass it back to my colleague.

RAFAH DICOSTANZO: I just have one short question and then I'll pass it on to my independent colleague.

You started this with my colleague earlier on, describing the difference between urgent care and a family walk-in clinic. I'm trying to envision it for Bayers Lake. We're getting a walk-in clinic, but I'm asking for urgent care. What is the staffing difference of both options?

MICHELLE THOMPSON: The member is correct. Currently, within the scope, it is a primary care facility. There will be a primary care clinic there, but that clinic will also have the fortune of being embedded with diagnostic imaging and blood collection services, et cetera.

At this time, there is no attempt to expand the scope of the practice. We would have a collaborative practice, so I anticipate that you will see physicians, nurse practitioners, and a variety of other allied health care professionals working in that practice. For now, the scope will stay the same. We're staffing to and moving towards that model.

Potentially, there might be some evolution over time, but we'll start there and look at the utilization. It could very well meet the needs that we have and may be able to do some of the things that an urgent treatment centre would do. We're open to it. We're going to stay within the scope, make sure we get it open and get it moving, not change anything just yet. We'll see how the utilization goes and what the opportunities are in the future.

RAFAH DICOSTANZO: I thank the minister for that. I'm still trying to understand what urgent care is. Please define urgent care so I can differentiate from a walk-in clinic. If you called it urgent care, what would be the difference? Why are we calling one a

collaborative family practice and now we're calling it urgent care? What is the exact difference if I called it urgent care?

[7:00 p.m.]

MICHELLE THOMPSON: There will be a lot of crossover between primary care clinics and a collaborative care clinic, especially one that's embedded with diagnostic imaging and a lab, et cetera. There are some differences.

At an urgent treatment centre, you could present with some abdominal pain, as an example, and maybe have that investigated. Fractures could be casted there, as well as sutures and things like that - unexpected things. There would be some subtle differences around it. That's what I would say. We can go for unexpected things in primary care, as well, but there are things around urgent treatment that are different. The equipment is a bit different and the model might be a little bit different.

It would not be usual to get stitches in your physician's office. It would not be usual to have your fracture casted in your physician's office. It would not be usual for you to have an ultrasound in your physician's office. There is a lot of overlap, in terms of ear infections, urinary tract infections, and things like that, but there are some differences as well.

Again, it's the unexpected injuries or illnesses in urgent treatment that would require kind of a different intervention, while there will also be primary care things that are seen there. It's harder to see urgent treatment in a primary care setting, but you can see primary care in an urgent treatment setting, if that helps at all.

RAFAH DICOSTANZO: I'll leave this. Maybe you can provide it to me tomorrow. If you're moving this collaborative care that you have offered at Bayers Lake into urgent care, what are the exact things that we need and how much would that cost? I'm not going to stop asking for urgent care.

Thank you and I'll pass it on to my colleague.

ELIZABETH SMITH-MCCROSSIN: Minister, I was just going to ask a few questions about recruitment - I'm not sure if the minister would have that information or not - specifically for the community of Pugwash.

Dr. McFarlane retired a couple of years ago. He's still in the community and he's keeping an eye on the new hospital build. I think he takes a tour every day and has a look. I'm wondering if the minister has any information that I'd be able to share with the community on possible recruitment.

Right now, Dr. Peter Blaikie would be the only full-time family physician working in the community, although I believe Dr. Semenov is helping out some there as well.

MICHELLE THOMPSON: I'll get back to the member about that. I don't have that right in front of me. Certainly, if there are physician vacancies, recruitment would be active within the zone.

There are two recruiters in that zone who share the recruitment position. One is in the Amherst area and the other is in the Truro area. We'll have to get a line-of-sight on how things are going there.

ELIZABETH SMITH-MCCROSSIN: Minister, I'm going to ask the same question, but for the Town of Amherst. Dr. Brian Ferguson retired - I'm going to say about three years ago - and Dr. Brittney MacDougall did come and was able to take over a certain number of his patients, but not all of them.

There are a large number of Dr. Ferguson's patients who are still on the 811 list. Since Dr. Ferguson retired his family practice, we have had the family physician, Dr. Hydorn, retire due to illness. Dr. Rubio-Reyes had a very large practice. He did not work in the emergency department, so he was in his office five days a week and I believe had around 2,000 patients. Dr. Halina Bienkowski retired as of December 31st.

They were all family physicians and the 811 list has gotten quite large in the Amherst area. I'm wondering if the minister would be able to provide any information that we could share with the community on potential recruitment efforts for the Town of Amherst.

MICHELLE THOMPSON: The recruitment efforts are continuing. There have been several site visits, but there are no offers currently out to physicians. Again, there is interest and they have had some success in the zone overall. Four family physicians have come to the zone recently.

There are ongoing efforts, and we'll continue to work in community. I know that a couple of community organizations got money, as well, in Cumberland in order to support recruitment efforts working with the municipalities and their recruitment committees.

ELIZABETH SMITH-MCCROSSIN: Continuing on the same topic with regard to recruitment efforts, one of our obstetricians, Dr. Helen Sandland, gave notice about 14 months ago that she was going to be retiring. She was a solo obstetrician/gynecologist in Cumberland for several years, where she was literally on call 24 hours a day, 7 days a week.

We're very thankful for her service to our community. She is retiring in May. I should add that a second obstetrician/gynecologist did join the team. I believe she has a 0.7

position: Dr. Heather Sullivan. We've had two for the last couple of years. I'm wondering if the minister would have any update for the community on replacement efforts for Dr. Helen Sandland, our obstetrician/gynecologist.

MICHELLE THOMPSON: There is active recruitment happening for that position now.

ELIZABETH SMITH-MCCROSSIN: I know it is a worry for the community and it's a worry for Dr. Sandland, knowing that, as of right now, there is not a replacement for her. Of course, that will impact obstetric care in our area. I'm assuming that there is no update there, based on the response that you'd be able to give the community.

What about psychiatry recruitment? We've been looking to add psychiatrists to the Cumberland mental health team for a number of years. I'm wondering if there's any update on recruitment efforts for psychiatrists for the community.

MICHELLE THOMPSON: Similar to another colleague across the floor, I would have to check with the minister responsible for the Office of Addictions and Mental Health and see what the plans are. He would have line of sight on that.

ELIZABETH SMITH-MCCROSSIN: I did have an opportunity to ask the minister responsible for the Office of Addictions and Mental Health that yesterday, I believe. He wasn't aware of any ongoing recruitment efforts there, but he was going to look into that as well.

I want to just add a comment around the lack of family physicians. I know that it's not unique to Cumberland for people to be without a family physician. Our demographics are such that we have a lot of people who are in the older category and are not comfortable using virtual care. They're quite nervous about it.

My constituency assistant and team do their best to make sure that people are aware of the virtual care option. There is also a local team set up to see people who we would consider orphaned patients and we're very grateful for that service. People can call that number - it's based out of Springhill - and get an appointment with a primary care provider.

We are grateful for that, but I did want to let the minister know that we have a lot of people without a computer at home. Some don't have the Internet, so it makes the virtual care option difficult. I'm not sure if it's the same in other communities around the province, but I would assume it may be similar in other lower economic regions in the province.

I wanted to ask the minister if she was aware of what's been happening with our surgical department. Unfortunately, we've lost a lot of our surgical nurses due to a change that was made in the arrangement of acute care beds. The surgical floor was changed

completely to house patients who are awaiting long-term care and the surgical beds were moved to become part of the medical floor, so it's now a med-surg unit.

The surgeons were not consulted. The surgeons were not part of any conversations before these changes took place. Listening to the member for Kings South today in Question Period speak about what happened there with the chapel, it's very similar to what happened at Cumberland Regional Health Care Centre with the surgical unit. There wasn't any consultation with the surgeons.

We have a fairly large surgical team. We have ophthalmology that does cataract and other eye surgeries. We have three excellent general surgeons. We have two ENT surgeons who are really the best in Atlantic Canada. Of course, we have our obstetricians and gynecologists.

We have a large surgical team and they're pretty discouraged right now that they weren't consulted in part of the decision to, in their words, take away their surgical unit. I was contacted by a lot of the surgical nurses who made a decision to leave our hospital because they didn't want to work on a med-surg unit. Many of them were trained specifically for surgery and wanted to stay on the surgical floor, so they just chose to leave altogether. It's really hurt our surgical service.

Also, our surgeons in general surgery were told that instead of doing three major cases a week, they can only do one. The number of surgeries that are happening has actually decreased.

I'm wondering if the minister might be able to comment on that.

THE CHAIR: Order. This hour of Liberal questioning has elapsed. We shall move on to the NDP caucus.

The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: The Independent member will start this hour off.

THE CHAIR: I appreciate the information.

MICHELLE THOMPSON: I had an opportunity to also speak with those surgeons briefly, with the MLA for Cumberland South. We talked about the surgical program. There were a couple of things. They did talk about their concerns.

It was my understanding at that time that they would prefer to have a surgical unit and we talked about the ability to stabilize nursing services in that facility. Their surgeries were not being cancelled as a result of the changes. Their surgery is not impacted directly,

is my understanding. There may be some disruptions at times, but it's not overall disrupting the number of surgeries that are done.

[7:15 p.m.]

We do know that, ideally, they want to go back to a designated surgical floor. The efforts that we have around recruitment and retention of nurses, particularly internationally educated nurses, will be very important.

We did speak to them at that time. Dr. Aaron Smith was with us and we did talk to them about some of the things that could possibly extend. If the nursing were stabilized, what would be the opportunity, as an example, to consider an RN first assist to support the surgeons there?

I know that Dr. Aaron Smith was following up with the surgeons about possibilities. I don't have an update about that, but Dr. Aaron Smith had a good rapport and is working with those physicians, as well as the VP of operations.

ELIZABETH SMITH-MCCROSSIN: Thank you for meeting with them. One of the surgeons did tell me that he went to the public meeting that was held in Springhill and shared his concerns at that public meeting.

As you know, the morale is pretty low across the entire province right now. It is definitely low in the surgical department with the changes and, as I mentioned, the fact that there was no consultation with them. They said they found out about the changes in a letter. It's very similar to the situation as the member for Kings South.

Knowing the importance of surgeries and the importance of our physicians and our surgical team, I would ask that the minister consider talking to the team at the Nova Scotia Health Authority to try and improve communication and encourage, before major changes are made that would affect an entire surgical team, conversations.

In the past, whenever I've studied change management, consultation is a big piece of effective change management before changes are made. I want to make sure that the minister knows that, on behalf of the surgeons and the entire surgical team at Cumberland Regional Health Care Centre. They're just doing an incredible job.

I did have a conversation with Bethany McCormick, the VP of operations, about this. She did share with me that there was no change in the number of surgeries; however, the surgeons are telling me something different. The surgeons are telling me that instead of doing three major cases a week, they're told that they can only do one. I'm not sure where the discrepancy lies, but there certainly seems to be a discrepancy in the information. I just wanted to make sure that the minister was aware of that.

I wanted to bring up another thing, also to do with the Cumberland Regional Health Care Centre. I put forth the 16-point action plan, and four of those action items have been completed. We're grateful for that and hope that the minister and her team are looking at the other 12 options.

There are a couple of other things I haven't had an opportunity to share with the minister yet, that the staff are looking for at the hospital. One is a daycare. I did have a conversation with the Department of Education and Early Childhood Development about that.

The staff at the Cumberland Regional Health Care Centre are asking that when the expansion and renovation is done, if the minister and the team would consider, as part of the design plan, to put a daycare in the hospital. The staff believe that will help with retention and recruitment, and I agree that probably would make a difference.

MICHELLE THOMPSON: We've heard from a number of folks across community in conversations that there are a number of work-life balance possibilities that would support individuals, daycare being one of them. We heard that in a number of different constituencies across the province.

What I would do is encourage the staff to work through the management team in order to express their thoughts. I also know that something very novel happening in the area is stay interviews. The senior leadership team in Northern Zone has been doing a lot of work with staff around stay interviews and identifying things that would support them in staying and finding out why they stay, appreciating that there are always retention issues around money, but also what are some of the things that could be offered in the zone that would help and support people staying.

There is work ongoing for retention. I would encourage the staff to work through the leadership in the facility in order to bring that to the forefront.

ELIZABETH SMITH-MCCROSSIN: We have done that. They asked me to meet and then we shared that information with the zone leadership, as well.

Another thing that has come forward - and this has also been shared with the zone leadership, as well as your department, but I want to just bring it up again - that is cancer care.

Our regional hospital is the only regional hospital that has not been administering systemic chemotherapy. I know there are some changes in the works for the positive. I'm wondering if the minister might be able to give us an update on that. I know there are some recruitment efforts to find a family physician who would be interested in oncology for our regional hospital, so that's promising.

What the community is looking for, and this has all been shared in a letter, is to have cancer care at our regional hospital so that people don't have to travel to receive chemotherapy. Included in that would be a virtual option so that if someone had an appointment with their specialist in Halifax or Moncton, there would be an option to have a virtual appointment that maybe could be held in the cancer centre at the hospital.

The third piece of it would be early screening and prevention. They're looking to have consistent well-woman clinics, consistent screening clinics for melanoma, and other education measures to help prevent cancer, as well as early screening. I'm wondering if the minister would be able to comment on that.

MICHELLE THOMPSON: I'm just going to go back to a question that the member asked a little earlier. I want to reassure the member that things are going well. In fact, for the last four months in a row, Cumberland has done more surgeries than the equivalent months in 2019-2020. Just to reassure you that the surgical program is well in hand there. Kudos to the staff for working so diligently to make sure that those surgeries happen.

In regard to cancer care, there's been a number of investments recently. The first one I'll mention to you is around the Oncology Transformation Project. The folks that we were able to share this announcement with were so pleased.

It is an oncology-specific information system with a single access point for referrals, scheduling, and triage of patients. It also allows real-time communication with and between all cancer care programs and specialty sites. It's actually something that the patients themselves can use, especially around symptom management at home and just staying connected with the cancer treatment.

To your point, there is some virtual work that can happen there to support them. It is going to be compatible with One Person One Record and it will streamline care coordination, reduce wait times, improve patient safety, and provide better outcomes. That's the work of that Oncology Transformation Project. It will put Nova Scotia at the forefront of cancer information technology. That will certainly be a benefit to folks in your area.

Also, we are looking at some community-based oncology clinics that would be expanded throughout the province. Lung cancer screening actually is also included in the budget.

We are starting the first phase of the program. It's planned for Central Zone and it starts in May 2023 in the First Nation community of Sipekne'katik by Fall of 2023. The program will then expand over the rest of the province and be completed by 2025-26. We are looking at also recruiting for a vacancy for the chemo program up there.

I will also say that we are investing in a program we saw when we had the opportunity to travel to Denmark in a test-and-try environment. It's called chemo to go. Appreciating that chemo right now is not available there, it is an option and may be something that people will benefit from. There have been some investments in terms of the cancer care program in the province.

ELIZABETH SMITH-MCCROSSIN: Going back, it's great to have the comment about the surgeries. I won't ask for this, but when you're looking at the breakdown, whether it's cataract surgeries or a major case, what I was referring to was more the major cases, such as bowel or large gynecological cases.

What they've communicated to me is that they were told they were not allowed to book three a week but only one major case. The smaller cases, like ear tubes by the ENT and those types of surgeries, I think, are going on as normal. It would be more the major cases, where people need a hospital bed.

Anyway, I think what it highlights is that there is a need for some communication and consultation with the Nova Scotia Health Authority with our surgical team. It seems that what I'm being told may not be what they're communicating.

I was wondering if acute psychiatry service is under your purview. No? So, acute beds would still be under the minister responsible for Office of Addictions and Mental Health. Okay, I wasn't sure about that.

One last question. Like many of the other MLAs I've heard speak today, I am continuing to still get e-mails from nurses who are not happy that they're not eligible for the retention bonus. We're really happy to see the retention bonus put in place. I had spoken in November about some of the good work that New Brunswick was doing around retention and recruitment, so I was happy to see that.

Can the minister just share with me again who I should be directing people to for answers? Some people have said they've e-mailed the retention e-mail address that was given, but they're getting back an e-mail saying that due to large volume it won't be responded to. What should we be communicating to those nurses who contact us and would like to talk to somebody about their unique cases?

MICHELLE THOMPSON: We're eight days in, or whatever it is now from then. I think if those folks wanted to reach out to their manager directly, we're a little bit further into it now than we were in the early days. I would encourage those folks to reach out to their manager to get clarification.

ELIZABETH SMITH-MCCROSSIN: I'll turn the time over to the NDP caucus.

LISA LACHANCE: I wanted to ask some questions around endometriosis care in the province.

[7:30 p.m.]

I have a couple of constituents who have really had a long struggle, a lot of pain, a lot of ill health, and have constantly brought my awareness up in terms of limited access, wait times, and those sorts of things.

I know that endometriosis was mentioned in the budget. I'm wondering if you can tell me specifically what's happening this year to improve care in the province.

THE CHAIR: Before I recognize the minister, I have just another very gentle, very respectful reminder to try and use "the minister" or "the member" and not use "you" when asking questions or responding to questions.

MICHELLE THOMPSON: There is a \$2.4-million investment in the IWK Health Centre gynecological and urogynecological services. That money will be used towards faster access to the clinic.

They do have a chronic pelvic pain clinic there. Initially, the group was enrolling folks in cohorts every 12 weeks. They brought in a certain number of patients every 12 weeks, but they've now moved the model to two patients per week, which will allow more access to that clinic.

In terms of the gynecology work that's happening, they're looking at increased operational hours, looking at the addition of after-hours clinics; bolstering of urgent care services, which include implementation of process changes to improve access for urgent gynecological patients; expansion of the endometriosis and chronic pelvic pain clinic for patients assessed by physicians but who have not responded to routine management or pain control strategies. There are more opportunities for them.

Also, the expansion of the Maritime Centre for Pelvic Floor Health clinic. That's how the money will be utilized.

LISA LACHANCE: I understand that, in fact, there's only one expert at the IWK Health Centre in pelvic pain and endometriosis. I'm wondering if this funding, or elsewhere in the budget, there is an intent to increase the number of specialists in the region or increase FTEs in other roles to support this work?

MICHELLE THOMPSON: This is maybe not as specific as you'd like, but I will tell you what the utilization will be in terms of folks coming into the team.

In terms of clinical staff, we do see with that \$2.4-million investment an additional just-over-two FTE physicians, a clinical resource nurse educator, 3.5 FTEs for nurse practitioners, and some other staffing to support the team so that the clinic would be expanded. It is a significant investment in that clinic to support expansion of services.

I would also say that in terms of the expertise, this will give opportunity for our regional obstetrician/gynecologists to be able to get some advice. The Virtual Hallway that we're using, I think, will also help for more rural access for this clinic.

LISA LACHANCE: I hope that my constituent was watching your answer. If not, I'll make sure to share those details with her.

As we work through the surgical backlog and there's a commitment to catch up, prior to the pandemic, people were often given estimates in terms of their surgical wait times. Then that was sort of officially ended.

I'm wondering if the minister could describe the practice now. Is there going to be a full return to estimating for folks when their surgeries, or whatever they may be, will happen? How is that communicated to people?

MICHELLE THOMPSON: The announcement we made yesterday will be a significant step forward for that. I think currently, people call their surgeon if they're waiting for surgery and they have a line of sight based on their utilization, et cetera.

The implementation and the announcement we had yesterday will track a couple of things: one is the time from referral to consult, which we really don't have a good line of sight on because not all consults result in surgery. Then we will be able to look at the surgical wait times for each physician and have a better line of sight.

This is why it's so necessary. It's a very antiquated system and it's not coordinated across the province in a way that it could be with the eReferral and centralized booking process. We're looking forward to the fruits of that investment really supporting us in moving the surgical wait list forward and having a better line of sight on each physician's wait time. The condition-specific line of sight will help us reach benchmark.

LISA LACHANCE: With regard to the revised process that was announced, how long will it take to have that online? Is it ready to go? So, it's ready to go and it's online. When will we first be able to look forward in the information and understand when surgical wait time benchmarks might be met in certain areas?

MICHELLE THOMPSON: That work will be ongoing. Some of that we can do now. As an example, Nova Scotia is tracking to meet the national benchmark of a wait no longer than 112 days for cataract surgeries by Fall, because we have an opportunity to do more surgeries.

Each of those wait lists is being monitored. We don't have to wait for that. We'll be looking at how we do, and then at how we increase capacity with the investments in surgical services. As an example, designated beds at Dartmouth General Hospital or looking at the hybrid surgical suite. We're trying to expand the infrastructure we have, as well as some of the contracts we have for those outpatient surgeries.

For example, year-to-date we've completed 1,098 hip and knee outpatient arthroplasty surgeries. That same number year-to-date was 72 in 2019-20. The teams are really gaining momentum in terms of their ability to complete surgeries. It is encouraging. It will take some time, there's no question.

Our surgical growth rate ratio for the third quarter is below the target of one, which tells us that we're taking more people off the list than are being added. There are some really good and encouraging signs that the surgical wait list is being addressed.

LISA LACHANCE: That definitely sounds like good news, and I can't help but say that it would be great to have gender affirming care there on the list and be tracking. Is gender affirming care, or specific aspects of gender affirming care, on the list?

I guess I'm wondering also: When we have surgical services that we just don't provide in Nova Scotia - we're not even trying to provide them, so we're always relying on sending people out of province - do we also watch the national surgical wait-time benchmarks for those situations?

MICHELLE THOMPSON: I will check. I don't know what all of the surgical benchmarks are. I'll have to check and see if that's there.

I mentioned earlier about the time to consult. That's one thing. I just want to mention that there has been work done, in terms of the referral process, to reduce that first waiting period of time to consult. I'll get the information about from consult to surgery. We're certainly trying to shorten that length of time, as well, with the work that's happening in the department around the assessment process. We're hoping that will also, from start time to completion, make a big difference in the wait times overall.

LISA LACHANCE: Not always connected to surgical wait times, but, obviously, we have specialist vacancies that can affect what can be done and how fast it can be done in the province.

It's my understanding that we only list the current specialist vacancies, not necessarily by type of specialist, on the Nova Scotia Health Authority website. I think that's done for privacy reasons. I'm wondering, still safeguarding privacy, if the minister is able to talk about specific areas where specialists have been particularly difficult to recruit to Nova Scotia and areas where it's been easier.

MICHELLE THOMPSON: I don't have the exact numbers in front of me, but I would tell the member opposite that psychiatry is one of the more difficult specialties to recruit for. Anaesthesiology is another one; there's a limited supply of physicians. We're actually looking at piloting family medicine anaesthesiology in Yarmouth to support, and emergency room physicians as well.

Those would be three that stand out. I know there are others. The more sub-specialist you get, of course, the fewer the vacancies as a result of that sub-specialty. Those would be the three that I would say off the top of my head are the most difficult.

LISA LACHANCE: Based on that, I have two follow-up questions that might be more than four and half minutes, but I'll ask them anyway.

I'm wondering if the minister can reflect on what makes the recruitment difficult in those three areas and if there's anything specific to our context in Nova Scotia that makes the recruitment difficult.

Also, as the minister and the government are looking to create the Cape Breton University medical school, I've previously asked questions about the fact that all the discussion has been about 30 family doctors every year once the medical school is rolling, but not everybody who goes to medical school wants to be a family doctor.

Would there be consideration of allowing folks to specialize and giving similar support? If, as I understand it, there is going to be some kind of return for service for family doctors, could that be extended to folks who start their training at CBU, do their residency elsewhere for their specialty, and then return to the province?

MICHELLE THOMPSON: I forgot your question twice, but I remembered it three times, so it's good.

In terms of those three specialties, they are hard to find everywhere. I had the opportunity to meet a physician the other day who is an anaesthetist from out of province. I told him he was like a unicorn because there's not many folks around, and he laughed and agreed. The challenges that we experience here, he's experiencing out West, in rural parts of the West. It is a bit of a global shortage.

We are looking again. We have to look at the equivalencies and hopefully that work that's happened around the U.S.-trained physicians will open pathways for us to bring folks home who've trained in other places.

The first four years of medicine are essentially the same. That's where we're starting. I think that as we get to the place, those residency seats and potential return to service are always going to be open. Our priority right now is family medicine because we

know that we have so many gaps - there are gaps across the country in terms of primary care - and the number of retirements that we anticipate.

[7:45 p.m.]

We'll start with family medicine. Again, as they work through that, the expertise at Dalhousie University and under the leadership of David Dingwall and Kevin Orrell, as well as working with us, there will be more to say about how that second campus evolves.

LISA LACHANCE: In terms of specialist recruitment, perhaps in the three areas that we've been discussing that are the hardest to recruit to, is it a challenge for Nova Scotia to match compensation offered in other jurisdictions?

MICHELLE THOMPSON: We're in negotiations now, but my understanding is that we are competitive in terms of those positions.

LISA LACHANCE: I think if we're competitive and we move forward in surgeries, I don't see why we're dragging our feet in terms of gender affirming care. I'm not sure that we need to increase our capacity here, but we need to increase the access to gender affirming care in Nova Scotia.

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

The honourable Government House Leader.

HON. KIM MASLAND: Mr. Chair, I move that the committee do now rise and report progress and beg leave to sit again on a future day.

THE CHAIR: The motion is carried. The committee will now rise and report its business to the House.

[The committee adjourned at 7:48 p.m.]