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STANDING COMMITTEE

ON

HEALTH

Tuesday, September 10, 2019

LEGISLATIVE CHAMBER

Collaborative Practice Teams and Doctor Recruitment
& Agenda Setting

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STANDING COMMITTEE ON HEALTH

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[Hugh MacKay replaced Ben Jessome]
[Tim Halman replaced Karla MacFarlane]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dr. Thomas Marrie - Interim Deputy Minister
Donald Grant - Senior Executive Director, Physician Services
Jonathan Veale - Chief Design Officer
Denise MacDonald-Billard - Project Executive

Nova Scotia Health Authority

Dr. Nicole Boutilier - Vice President, Medicine
Grayson Fulmer - Senior Director, VP Medicine Portfolio
Lynn Edwards - Senior Director, Primary Health Care & Chronic Disease Management
Dr. Maria Alexiadis - Head, Department of Family Practice

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, SEPTEMBER 10, 2019

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SUZANNE LOHNES-CROFT (The Chair): Order. I call this meeting of the Standing Committee on Health to order. My name is Suzanne Lohnes-Croft. I am the MLA for Lunenburg and Chair of your meeting. Today we will hear from the Department of Health and Wellness, and the Nova Scotia Health Authority regarding collaborative practice teams and doctor recruitment.

I would like to remind everyone to turn off their phones and put them on vibrate. Please exit, should we have an emergency, through the exit doors and go out to your nearest exit, which would be Granville Street. We then go up to the Grand Parade and meet there.

Also, I welcome Dr. Marrie here today as the Acting Deputy Minister of Health and Wellness. This is your first time to the committee, so welcome.

I ask that we do introductions of our members.

[The committee members and witnesses introduced themselves.]

THE CHAIR: I would like to let our guests know that I will acknowledge you before you speak so that Hansard has the time to turn on your microphone. With the fans on, you may have to speak up a little louder - make sure your microphone is directly in front of you so that Hansard can record and everyone here is able to hear. I would like to invite our guests to do opening statements, starting with Dr. Marrie.

DR. THOMAS MARRIE: Good afternoon. This is my first appearance before the committee. Before we get to questions, I will make some brief opening remarks.

Nova Scotians are receiving very good health care by our health care system. There are dedicated, skilled health professionals providing care across this province. Because we have doctors and staff with special skills, we provide specialized care to children and adults for the people of Atlantic Canada. Two such examples of this kind of care are heart and liver transplantations.

I have been fortunate to see our health care system from several perspectives: as a practising physician; as dean of our medical school; and, in the past three months, as Acting Deputy Minister of Health and Wellness.

Over the past three months, I have travelled throughout most of the province. I have left Cape Breton until last because I want to go there in October when the leaves are out, but I have actually been to Cape Breton for flying visits. This one will be a more comprehensive visit.

On these visits, I've talked to physicians and other health care professionals and seen first-hand the state of our health care facilities. I was very fortunate to have Ms. Janet Knox accompany me on many of these tours. I had access to the entire hospital and health care system, so very good visits. Our health care system is not perfect. We know the challenges, but the department and the Health Authorities are working very hard to deal with these challenges.

Our emphasis today is going to be on how we're working to solve these problems. Primary health care is the backbone of any health system, including ours. Access to primary care is a priority. What is primary care? A simple definition is the day-to-day care given by a health care provider. In Nova Scotia, as a simplification, there are three main avenues for primary care: collaborative family practice teams, also known as collaborative care centres, which we'll talk about in some detail today; family medicine practices, which could be either a group of physicians or solo practitioners; and last, walk-in clinics.

Collaborative family practice teams are a key component of our primary care strategy. These teams provide a mix of health care professionals that include physicians, nurse practitioners, family practice nurses, social workers, pharmacists, dietitians, occupational therapists, and others.

When we analyzed physician MSI billing data, we found that patients of these teams had fewer emergency department visits and lower hospitalization rates than patients of physicians who are not part of a collaborative family practice team. We also found that patient satisfaction is high, and the health care providers in these teams are also satisfied. Due to the hard work of many physicians and staff under the direction of Ms. Lynn Edwards, who is here today, the number of teams has grown in a short time to 84, and these

are distributed throughout the province. By the end of this fiscal year, government will have invested an additional cumulative total of $58.4 million in primary care since 2016.

There are many other ways - this is not the only way to try to ensure that we can improve primary care. An obvious example is the $1-plus billion being invested in the QEII new generation and the Cape Breton Regional Municipality redevelopment projects. In addition to providing state-of-the-art facilities, one of the ways that such investments help the health care system in any region is, when you grow the region economically, there's more jobs, and you really influence the social determinants of health. One of the things we're going to do is to measure the impact that these projects have on that aspect of health care.

I'm either fortunate or unfortunate enough to have been a physician for 49 years. A lot has changed over that period of time. People in all occupations work differently. In health care, especially among physicians, it's no different. There's more emphasis on work-life balance, which typically reduces the number of hours worked.

The demographics of our population have changed over that period of time. We are living longer, which is a success story, and indeed life expectancy in Nova Scotia on average is 81 years for a male and 83 years for a female. We do have the oldest population in the country, or the oldest percentage of those 65 and older. That's a good-news story. But it does mean that we need more health care in our golden years because we wear out.

I will now turn briefly to recruiting physicians. Recruiting, like most things in health care, does not have one simple solution. To attract doctors to Nova Scotia, we must have a suite of constant, coordinated efforts that include both long-term and short-term strategies. Just a few weeks ago, you heard from Dr. David Anderson, Dean of Dalhousie Medical School, about increasing the number of medical seats and the number of places for residents; in fact, 25 places not so long ago. This is a long-term strategy. My colleague, Dr. Boutilier, will discuss recruitment in more detail shortly.

I'm sure you have often heard that if we only paid doctors more, our recruiting problems would be over. Consider that Alberta has the highest-paid physicians in the country. If you look at the number of family doctors per 100,000 population in Alberta, it's 121. In Nova Scotia, it's 123 per 100,000.

Compensation is certainly a part of any recruitment strategy, but it's not the only part. We're currently in negotiations with Doctors Nova Scotia and we want to arrive at a place where we're very competitive, but I can't say any more about that because we are at the table.

The Department of Health and Wellness and NSHA are two members of the recruiting team, but there are many other members, including physicians themselves and communities. Communities are most important. Communities have started to take a lead in trying to help the recruiting process. Before I took on this responsibility, I was part of

NOW Lunenburg County which has been working very well and, in fact, was one of the leaders in physician recruiting. That now extends right across the province from Glace Bay to the Valley to Digby and so on.

Communities have come up with innovative ways to entice physicians to their area and to make sure they're welcome when they come. The Town of Kentville recently had a big party for physicians who've been there for a while and that had a positive impact, not only in Kentville, but right across the province. In Glace Bay, my favourite, they went jigging for mackerel, although I didn't know you jigged for mackerel. I thought you caught them on a hook. When I go to Glace Bay, I'll try that out.

Government has a number of financial incentives to help attract or retain doctors. Two such examples are tuition relief and debt relief, but there are many more and my colleague, Dr. Grant, can elaborate on that if you wish. But doctors are also key to recruiting doctors, and I'm pleased to say that Doctors Nova Scotia does participate in that, as well.

My final comment is this: getting to the health care system that we all want will only happen if all Nova Scotians work together as we are doing here today. Over the next hour or so, I look forward to telling you what DHW is doing and hearing your ideas on how you can help.

Thank you and I will now turn over my time to my colleague, Dr. Boutilier.

THE CHAIR: Dr. Boutilier.

DR. NICOLE BOUTILIER: Thank you, Dr. Marrie. Good afternoon. My colleagues and I are pleased to be here to meet with the committee. As a physician, I know how important it is to have access to the right care in the right place at the right time. As Dr. Marrie has mentioned, teams and physicians continue to provide quality care across the province, but access continues to be a challenge for some Nova Scotians. Our population is growing and the demands on our health care system are changing as people in our province are aging and medical problems are becoming increasingly complex. Additionally, more people are leaving the health workforce through retirement than are entering.

These challenges didn't evolve overnight, and solutions require strategic and measured efforts from all of the stakeholders. Adapting to these changes across the system takes time to produce results. Primary health care, as we have heard, is the foundation of the health system. For the last few years, we've been working to create more collaborative practice family teams and strengthen existing teams that are across the province. Today there are more than 80 collaborative family practice teams.

To support these teams, we have hired more than 130 allied health professionals - one of the largest investments in front-line care in the history of the province. Collaborative teams offer comprehensive, coordinated, and accessible care for their patients. Many newer doctors, nurse practitioners, and other primary health care providers have been trained in the team-based approach to care and they look for these opportunities to work as part of a team. Evidence and experience agree that this model improves health outcomes and helps us recruit new providers.

Working with communities and our partners, we have recruited 130 doctors in the last fiscal year; that's a 26 per cent increase from the year before - 58 of these were family doctors. Since 2016, we have recruited 385 doctors to the province. The College of Physicians and Surgeons of Nova Scotia has reported a stable number of active licences since 2015.

While we've seen some success in our recruitment efforts, we'll continue to focus our efforts and evolve our strategies to overcome the identified challenges. Demand for health professionals is increasing globally; we are competing nationally and internationally to recruit. It is important to note that the need is not just limited to doctors. Nursing and other staff vacancies are challenging to fill, especially in rural areas.

[1:15 p.m.]

Today we are working to fill more than 80 family medicine positions and 90 specialist positions. There is more to the story than just these numbers. Unfortunately, it's not as simple as just hiring more doctors. If we were simply able to drop a doctor into every open vacancy, it would not guarantee access to care in the right place for all Nova Scotians. This underlines the importance of community-level strategies.

Physician recruitment was transferred to the Nova Scotia Health Authority in July 2016. In 2017, we provided our first recruitment strategy, which set the benchmark. Since then, we have engaged external expertise and built partnerships to extend our presence in Canada and in other jurisdictions where we had a competitive advantage. We now have a sophisticated brand and a website, tools in place to represent ourselves when we're out on the road, and improved processes and partnerships.

In this short time, we've increased our recruitment team from three employees to eleven. This includes two recruiters in each zone, two administrative staff, and a director who ensures strategic focus and evaluation as a priority.

Our recruitment and marketing plans are grounded in engagement with physicians and partners. We market our opportunities with information provided to us from physicians about what they find rewarding about practice in Nova Scotia. Relocating for any career is a huge decision. We're simply not pitching positions or hospitals to doctors; we're working to match them with a community. This is a decision that impacts their whole family.

We have increased our focus on international recruitment. Doctors from abroad now account for 20 per cent of the new doctors who have started practice in the last year. We have increased our focus on the licensing and immigration with our partners at the College of Physicians and Surgeons of Nova Scotia, and the Nova Scotia Office of Immigration. Since 2018, 31 of the doctors entering the province's immigration stream were from the U.K. or Ireland.

We have also increased our campus visits with residents at medical schools across Canada and doubled our attendance at national and international career fairs. We have created a position to focus specifically on medical students training here in the province, which came about through our work with our partners.

Recruitment is the work of many partners. Our plans are enhanced by the interest in this work that many groups bring and that they have value to bring. We must work together as a province, and we are.

Physicians have always been front and centre in the work to recruit other physicians. We know that peer connection is crucial. We have been working to better embed doctors in our processes and they are key members of our team. Physicians are travelling with recruiters across the country and internationally to events and job fairs. They offer testimonials that we use to promote our province. They host events to welcome new medical staff, and physician leaders have been an integral part of the formation of community recruitment groups.

We have a provincial Physician Recruitment and Retention Advisory Committee that is made up of many partners: the Department of Health and Wellness, the College of Physicians and Surgeons, Maritime Resident Doctors, the College of Family Physicians, Nova Scotia Office of Immigration, Dalhousie University, Doctors Nova Scotia, the Nova Scotia Federation of Municipalities, as well as representation from community groups and health foundations. This committee works together on opportunities to use their shared knowledge and resources to improve recruitment efforts. Our recruitment team also works closely with community leaders to tour interested doctors around the province. These groups have done great work in welcoming physicians and their families for site visits and into their community.

Hosting a welcome event for new physicians is as important as sharing details on practice opportunities and call schedules. These actions are large and small, and are meaningful. They make an impact.

Our progress with recruitment and establishing more collaborative practice teams has been making a difference for Nova Scotians. More than 110,000 people have found a family doctor or a nurse practitioner since we began tracking this information three years ago. On average, about 6,300 people have found a family practice each month over the last year.

There is so much more to do and we continue to recruit every day. As we move forward together, we look forward to sharing updates on our progress. Thank you.

THE CHAIR: Thank you for your opening remarks. We will take questions now, beginning with the Liberal caucus for 20 minutes. (Interruption) Sorry - the PC caucus for 20 minutes. Ms. Adams.

BARBARA ADAMS: Thank you very much. I am very happy to have all of you here today because there's no other topic that is more important to our constituents than their health and the health of their families. What we get answered today is going to help everybody understand a little bit more what's going on. I have some questions that I've prepared, but I want to comment and ask a question about some of the things that were said by our initial presenters.

"The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance." It has to be developed to simultaneously improve three things: improving the patient experience, which includes patient satisfaction - and you alluded to the fact that that was high in collaborative health practice; reduce per capita cost of health care; and improve the population's health.

We know if a patient is given more time to talk to somebody, they generally report a higher satisfaction. That doesn't necessarily mean that they have improved health or that the collaborative health team approach has actually reduced cost per capita, per person, in the province. I'm wondering if you can say of those three aims, where one of them has been achieved in terms of patient satisfaction being high, do you have concrete evidence that this approach has improved the population health or reduced the capita cost per resident in Nova Scotia?

THOMAS MARRIE: Thank you for your question and I did reference one aspect of improvement in population health which is the fact that patients in collaborative care teams don't go to emergency as often as those who are patients in other settings, and they have fewer hospitalizations, so it's indirect evidence for better health care. We have actually started a prospective study to better measure that, but it won't be available for a little while.

There are also many parameters that are monitored through the Health Authority's quality of care program and that are sent on to the Department of Health and Wellness. I will just mention a couple and then I will ask Dr. Boutilier to elaborate on a few more. That's a key priority: to monitor quality in the health care system.

There are a couple that readily come to mind for me where NSHA, in particular - but we do the same for the IWK as well - performs better than the national average. One of those is readmissions to hospital after you've been discharged. It's not uncommon if you're sick and you go home that whatever you were sick with sometimes gets worse even

though you think you're better when you go home, and you have to be readmitted to hospital. That's monitored by hospitals across the country, and the way that we benchmark ourselves is by looking at data from hospitals that are of similar size across the country. This methodology is standardized by the Canadian Institute for Health Information, so that's one of the ways we look at it.

I could go on with more, but if I may . . .

BARBARA ADAMS: We are limited in the amount of time that each of us gets to ask questions, so I want to point that out.

THOMAS MARRIE: I think I've gone over my time on that question.

THE CHAIR: No, you didn't. No, you didn't.

THOMAS MARRIE: I think it's a question that's important for the people of Nova Scotia to know, so if I may, I'd like to ask Dr. Boutilier to quickly point out just a couple more of the key measures that we look at and where we actually do better.

NICOLE BOUTILIER: I think I'm going to ask Lynn Edwards to talk about the quality specific to primary health care collaborative teams, as that's what you were referencing with those three questions.

LYNN EDWARDS: The Triple Aim is a well-known methodology that the IHI has developed. We have seen some provinces in Canada that have added a fourth aim, which includes provider satisfaction. So with respect to what we ask of our teams and how we build a quality environment with our collaborative family practice teams, we ask all of our teams to develop a team agreement and identify how they're going to provide the best care they can to the patients that they currently have in their care. As part of that, they're to look at what kind of hours of service they offer, et cetera.

We're working with our teams to understand quality and what quality improvement is. We just had a large forum a few months back where each of the teams came in and identified how they want to make improvements, where they feel they need to make improvements, and they've gone back with those plans.

We report on how we've been able to develop the teams, the numbers of staff that we have hired over the last number of years. We also report on the numbers on the Need a Family Practice Registry, as some examples of the pieces that we report to the department on a regular basis.

BARBARA ADAMS: I'm not sure if that answers the question as to whether our population is actually any healthier or that we are actually spending less money per capita. The current state assessment of the primary health care system in Nova Scotia released a new document in August 2019 - the primary health care system baseline report. In it, it

outlines a lot of the indicators that were selected, and they narrowed them down from several hundred to 28.

When you look at the stakeholders who were invited to participate in preparing those indicators, there were five physicians out of all of the stakeholders and only one who is really practising full time in family practice. One of the things that we get asked all the time is whether physicians have been included in the stakeholder engagement process, and when I read this report, there was very little physician involvement in that.

I want to go back to the very beginning and ask a very basic question. Since, I think you said, July 2016, the Nova Scotia Health Authority took over physician recruitment, I think a lot of people would argue that did not improve physician recruitment. You can correct me if the numbers suggest differently.

What I want to know is, given the fact that the Nova Scotia Health Authority and the Department of Health and Wellness have to work together, when I look at the list of where all of you work and where everybody else works, it's very difficult to know who is where - who's on first and what's on second. Is there a hierarchy chart that outlines everybody in the Department of Health and Wellness and where the vacancies might be and everybody in the Nova Scotia Health Authority in administration that we can get our hands on that says this is what everybody does, and this is who they report to? Does that hierarchy chart exist anywhere?

THE CHAIR: As in an organizational chart?

BARBARA ADAMS: An organizational chart for the Department of Health and Wellness, an organizational chart for the Nova Scotia Health Authority, and how they interact - as to who reports to who. Does that exist, Dr. Marrie?

THOMAS MARRIE: I'll answer for the Department of Health and Wellness - yes.

NICOLE BOUTILIER: Yes, we have organizational charts.

BARBARA ADAMS: Excellent. I would like to request that those be submitted to us because I've never been able to see one and to know who responds to who.

I'm going to ask a very specific question. If you have a long-term care facility and there are two physicians who work there and they both decide to leave, who do they contact first to say, we're leaving? What is the response supposed to be?

NICOLE BOUTILIER: Every zone has a structure of a zone medical executive director and then there are zone heads per different services. There's a zone head for emergency. There's a zone head for family medicine and so on. Everyone under that structure would have site responsibilities as well or a network lead, in particular for primary health care or family medicine.

In terms of long-term care, physicians typically in our province, our family physicians that are delivering that care, would report to a network lead and that would be their first point of contact. The network lead would report to the zone head. The zone head reports to the zone medical executive director.

[1:30 p.m.]

BARBARA ADAMS: Can you tell me how long a physician who says they're leaving should take to get a response from the Department of Health and Wellness?

THOMAS MARRIE: Typically the physician would notify two parties, as Dr. Boutilier outlined, in an administrative structure. But Mr. Grant works with Physician Services - in fact, he runs that branch for us - and I would like him to respond to that question, if I may.

DONALD GRANT: In terms of how long a physician should wait to get a response, the response time should be fairly immediate in terms of a response time. It will vary depending on what is going on at the branch at the time, but we do endeavour to try to get back to people as quickly as we can.

BARBARA ADAMS: Can you clarify that for me? Are we talking a couple of days or a couple of weeks?

DONALD GRANT: I can't give you an exact timeline. It would be anywhere from days to weeks, yes.

BARBARA ADAMS: On June 18th, two physicians at Ocean View Continuing Care Centre in my community of Eastern Passage indicated and sent a letter to the participants you mentioned earlier, and said, we're both leaving. The target date was September 18th, which is next week. It took six weeks before they got any response, and then that response was to send an email out to some physicians to see if anybody was interested. To my knowledge, the first group meeting was held August 27th or 28th.

Can anybody explain to me why, in this particular situation, two physicians said they were leaving, and nothing happened? I have a cousin living in that facility whose wife is about to find out, if she watches TV today, that those doctors are leaving. How did this happen, that six weeks went by before an acknowledgement and then nothing for another several weeks? I don't understand how that happened.

If this is an example of what happens, the hierarchy may be outlined on a piece of paper, but I don't know how it worked in this situation, and I'm wondering, who is responsible for the breakdown in communication? I don't know who wants to answer that.

DR. MARIA ALEXIADIS: I thank you for asking for the org chart, because that's an important thing for you to have to understand. The org chart also creates networks. In fact, that information was brought to me weeks before, as the doctors were in communication as being a family practice head. The actual particular issue was being worked on prior to all these meetings being held. Recruiters were being notified. We were looking to see who we could have. It wasn't just overnight, but at the same time, you realize the challenges of trying to find people to take over those positions.

As you may be aware, right now, the current medical community is working very hard. The new doctors who are coming out are also looking at how they're going to set up their practices. That includes comprehensive medical care, long-term care, perhaps ED, as well as perhaps in-patient - but they choose how they make that practice up.

We put advertisements through our More than Medicine recruiting place for those physicians. We internally looked at finding other physicians to do it. We almost have a solution. At the same time - I appreciate that in looking at it, it seems like maybe nothing has happened, but much has gone into that issue.

BARBARA ADAMS: From the time that the physicians wrote that letter, how long did it take you guys to contact those physicians to let them know that you had received their notification?

MARIA ALEXIADIS: That letter came afterwards. We actually knew before the letter that was sent.

BARBARA ADAMS: That's different than the information that I've been given. We're going to move on. I appreciate how hard it is to recruit physicians, but I also think that the people who are living in that facility had a right to know what was happening and still have the right to know what's going on because when they stopped admitting patients to a long-term care facility, that's important information for families to know, especially if there isn't going to be coverage during the day and they're going to have to be shuffling off to emergency as their backup plan for care.

One of the questions that I wanted to ask is - we went from 39 collaborative health centres in 2015-16 to 83 in 2018-19, so achieved the goal of creating those collaborative health teams. Yet, the number of Nova Scotians without a primary health care provider for the past year hasn't changed one iota. I'm just wondering if one of the goals of creating these collaborative health teams was to improve access to health care, why didn't it happen?

THOMAS MARRIE: I would like to have two people respond to that question. Sitting on my immediate left is Mr. Veale who runs the patient registry - I should say citizens because they're not patients at this point - who don't have a family doctor. He can tell you what has been done there and what progress has been done. Then Ms. Edwards could answer the second part of the question.

JONATHAN VEALE: With respect to your question about improving access and what is happening there since 2015, I can tell you that as of September 1, 2019, there are about 52,000 Nova Scotians on the Need a Family Practice Registry. This represents 5.7 per cent of the population. As you noted, the registry has stabilized since 2019, so I just want to point out that when we create the registry, it takes a little while to start building up a list of Nova Scotians as people are added to that registry.

The largest percentage of unattached patients vary significantly across the province. The Western Zone is certainly one of the areas where there's a large need and there's a large number of Nova Scotians on the registry, followed by Northern Zone and Central Zone, and then Eastern Zone has remained relatively constant as we've had this registry.

With respect to your point about access, the number of Nova Scotians has been decreasing in Central Zone, while it has been slightly increasing in Western and Northern, and remained relatively stable over the same in Eastern Zone since 2019.

Since November 2016, which is around the time when the registry was created - and Ms. Edwards can clarify more on this - over 110,000 Nova Scotians have found a provider; 57 per cent of them have found it using the registry. While the bottom-line number has remained constant recently, the through-put on the registry has been the 110,000 number.

A big factor contributing to this has been both the collaborative family practice teams, as well as the unattached patient bonus where there have been 41,000 total claims and 16,000 - 40 per cent of the patients associated with these claims were already on the registry. Ms. Edwards can clarify about the access issue on the registry.

LYNN EDWARDS: What I would like to add to that is that our collaborative family practice teams - it takes a while to start a practice, to build a collaboration, and to take patients on from the Need a Family Practice list or from their own practice list. It does take time to build their practices. We have looked at other places and we know sometimes it takes up to about a year for a new physician or another provider to build their full team.

We do know that it takes time. We also have seen that by the addition and building collaborative family practice teams, it has helped to stabilize a lot of our areas, a lot of our communities in Nova Scotia where we've been able to keep our family physicians, maintain the number of people that they're currently seeing, which perhaps they were having a difficult time.

There's a combination of both taking people off the list and, like Jonathan said, over 110,000 people have found a provider, 6,300 a month in the last year. It is also helping us stabilize some communities.

THE CHAIR: Order. Time has elapsed for the PC caucus. We'll turn it over to the NDP. Ms. Martin.

TAMMY MARTIN: Thanks so much. I, too, have some background comments, so I'll go through those and then ask questions after that.

Specifically, when we talk about doctor recruitment, one of the biggest problems we are looking at to solve is the lack of access Nova Scotians currently have to primary care. Thousands of Nova Scotians are still on the waiting list for a family doctor, and those who are lucky enough to be on the roster often wait for weeks for an appointment. People aren't getting the care that they need and they're not getting the continuity of care that they deserve. We are fundamentally interested in primary care, in ensuring Nova Scotians are able to access diagnostics and treatment in a timely manner.

Collaborative Emergency Centres are one of the ways of doing this. The NDP Government established eight CECs in Nova Scotia before the Liberals came to power in 2013. These centres allowed residents to access same-day and next-day primary care appointments during the day, and emergency care overnight with physicians and EHS. A 2014 evaluation of CECs found the patients at CEC sites had better access to primary health care services than they did before the centres were put in place and that patients were far more likely to have access to the right provider at the right time in the right place before the CEC was introduced.

I'd like to ask somebody from the department if they could comment on the experience of Collaborative Emergency Centres and how Nova Scotians could use them to get primary care.

NICOLE BOUTILIER: Do you want the department or NSHA to answer?

TAMMY MARTIN: I'm easy.

NICOLE BOUTILIER: One of the things about CECs for us that has been a challenge since 2015 is the staffing of the CECs and finding family physicians that are interested in doing both emergency care and primary care. Prior to 2015, the College of Physicians and Surgeons of Nova Scotia had a program called the CAPP Program, which was a clinical assessment program for physicians that came in on a defined licence. The CECs were almost exclusively staffed with physicians that went through this program. When that program ceased to exist in 2015, we had a problem with replacing those people as they finished their four-year commitment to Nova Scotia. They would get their full licence and go off to different opportunities in other provinces.

It has been recognized by the college since that happened that we've had a problem with getting family physicians in the province that have what we call a defined licence - not in full licensure - and there has been a program established called the Practice Ready Assessment Program that will have that similar type of thing where people will come in

and work with other physicians and be able to gain an undefined licence. Then the opportunities that exist will help people bring people into their practices. People that participate in this program can't go to the same site where they trained, but they can go to another site that had another trainee so we have a new pathway for that that would help. With Collaborative Emergency Centres, that was a big thing that had changed between 2013 and 2016 around our ability to staff.

TAMMY MARTIN: Has the department done any analysis on how CECs support physician recruitment attempts?

THOMAS MARRIE: May I ask Mr. Grant to answer that please.

DONALD GRANT: With respect to CECs, I am not aware of any analysis that we have undertaken with respect to CECs direct correlation to physician recruitment. What I would echo is that we have started the Practice Ready Assessment Program which has five people going through it at the moment and that will continue into the future, as well.

TAMMY MARTIN: CECs have been put in place in P.E.I. and in Saskatchewan. Could anybody speak to how the physician recruitment has been dealt with in those provinces?

THOMAS MARRIE: Specifically, no, but I have had discussions with the Dean of Medicine at the University of Saskatchewan regarding some aspects of what they've been doing, trying to provide care to rural Saskatchewan. But specifically at the CECs, no.

[1:45 p.m.]

TAMMY MARTIN: Has the department done any financial analysis or modelling around how much money CECs can save the health care system by providing primary care in that setting?

THOMAS MARRIE: I think you referenced in your background remarks an evaluation of the CECs. That had some elements of the financial analysis in it, but that's the latest one that I know of. I have been in discussions with Dr. David Petrie who is head of emergency medicine province-wide for NSHA. Dr. Petrie has been discussing with me CECs, but I don't have a detailed answer to your question in terms of the economic analysis. I don't know if my colleague, Dr. Boutilier, would have more information on this particular point.

NICOLE BOUTILIER: I'm looking to Grayson to see if he has financial information on CECs. (Interruption) I'll get it for you.

THE CHAIR: Can you have that sent? The clerk will send out a letter with a request for that information.

TAMMY MARTIN: Anything like that we can just receive at a later date, that would be great. We have a lot of testimonials from health care workers, from patients, from physicians where CECs work. We see that it's moving forward in other provinces. In Nova Scotia, we seem to be going backwards and people wonder why. We started it in Nova Scotia and now it's going backward in Nova Scotia. Can anybody comment as to why?

THOMAS MARRIE: I'll go back to Dr. Boutilier's comments to you a few minutes ago, which did explain why we went backwards - so not planned. That's something that happened in terms of the particular group of physicians that did staff these emergency centres. I will go back to Dr. Boutilier so she can explain to you the efforts that have been made to staff them. There have been many efforts, and a sustained effort, to do that.

NICOLE BOUTILIER: I just want to clarify - we have excellent primary health care happening at a lot of the CECs. The CEC closure that you may hear of has more to do with the emergency part of the visits than the primary health care. A lot of the collaborative practice teams exist within CECs in providing primary health care. That has not stopped.

One thing with the overnight model that had been noted with the CEC is that a whole lot of people weren't coming overnight. The primary health care actually addressed a lot of the issues that were going on in the CECs.

We've been able to stabilize staffing to a certain degree in some of the CECs, but it came down to sometimes provider preference as to what they're doing. For instance, a new physician coming out - they may be a native of the town or area where the CEC is located, they very much want to practise in the place where they grew up. However, they don't have interest in doing emergency care as part of the practice profile that they've created. We've had some challenges around that in terms of matching the right people to the right place and still being able to provide primary health care.

Some of our CECs have very much had flourishing primary health care and stable primary health care. Others that we've had challenges with staffing have been enhanced by other health providers like nurse practitioners. For instance, in the Parrsboro area, we have a physician and there are four nurse practitioners associated with the different areas to get out to the different communities. We've adapted the original CEC to fit the needs of the communities so we can provide access to places like River Hebert in that situation.

Also, one thing about the CECs is, because it was brought in at a time when there were different health authorities, not every CEC was created equal in that the expectations at each one and how they staffed them and how it was run was not exactly the same at each one. It was adapted by the different areas and how they ran.

TAMMY MARTIN: While I appreciate your answer for those communities that have an ER closed, although there may only be two or three visits or calls per night, they sometimes were life-altering or -threatening conditions where the CEC overnight process definitely helped in those cases.

I'd like if somebody could clarify if the new Practice Ready Assessment Program will help with the staffing for the CECs and also, what is the proportion of CECs that are doing well as compared to those that could be struggling?

NICOLE BOUTILIER: I'll try to address some of it. Just to go back to your comment, our EHS system as well as the rest of our emergency system is a well-integrated system with closures or not. We make every effort to maintain those connections with different communities around closures and that type of thing as well. I want to make sure that everyone knows that the emergency system is there for everyone regardless about their own community. I understand the conveniences in that, but people who need life-altering treatment absolutely should be calling 911.

The second piece about the Practice Ready Assessment - we have five communities now that have them, and I'm trying to remember each one. Some places are where CECs are and some aren't, so it won't necessarily just be for CECs. I don't want to give that impression either, but it's another avenue for family doctors to be licensed in this province and there will be a percentage of those, just like there is in the graduating residency classes, that want to pursue emergency medicine as part of the scope of practice of what they do as a family doctor.

TAMMY MARTIN: I'm sorry, did you address the difference between how well some are doing and why some are doing so poorly?

NICOLE BOUTILIER: I'm assuming you mean in terms of closures.

TAMMY MARTIN: Yes.

NICOLE BOUTILIER: There are different ones. We can get you closure information that's available readily on our website. We publish everything on there. I couldn't speak to which one has been closed more over the summer or anything like that right off the top of my head.

I come from the Northern Zone and part of our challenge was to provide locums as often as we can to prevent any closures. It's very clear that we need to attract more emergency physicians in general. Whether an emergency room is an emergency room that's located in a big centre or a little centre, those physicians need to have the same skills because people can come into the emergency room with anything, so it's that level of training and expertise that we have to have a concentrated effort on in terms of attracting more emergency physicians.

TAMMY MARTIN: I'd like to move on to workload issues. According to a recent survey conducted by researchers at Acadia, 50 per cent of doctors reported experiencing symptoms of burnout. The researchers characterized the state of the physician workforce in Nova Scotia as fragile.

We know the department is focused on recruitment, but what seems to be obvious is that retention is just as important. As well as when you talk to doctors on the ground, they say the work-life balance isn't as the NSHA or the department says it is. When I talk to a neurologist in Cape Breton and they are the only one there and they are on call 24/7, there is no work-life balance.

While I appreciate you're trying to recruit them, saying come here and play in Nova Scotia because it's a great place - and it is a great place to live and work - but how do you justify that there currently is a severe lack of work-life balance; how do you rationalize that in terms of retention?

NICOLE BOUTILIER: Certainly burnout, workload, work-life balance are critical questions right now for physicians both in the workforce and the people who design it. The Canadian Medical Association has actually instituted a program in the last few years, a conference around physician wellness, just to make sure that people are bringing this to the forefront. It's something that's on our radar in terms of exploring further as a medical affairs portfolio in terms of having an actual - some provinces have gone ahead and developed strategies like a full provincial strategy, and things like that. I'm not sure if you're aware, but I did this job a little bit as a shared position recently. I just came in the job in July. We had a meeting recently with our senior leaders around this type of issue about how, as a group of leaders, we want to move forward with some of the more overreaching themes.

Certainly work-life balance, when new physicians are coming, that is something they look for right off the bat. Some of these team environments that we're able to create address some of those issues to a certain point. People who have been in practice a long time in smaller communities have very challenging call schedules for years and years, like one in two, one in three. It's the way they have worked. We talked earlier about the stress of the aging workforce as well as complex medicine. Medicine has gotten a lot more complicated. It's not the same as when I started 20 years ago. It's not the same as when Dr. Marrie started. Every year, the complexities have changed, and it does take a toll on physicians. Alternate providers as part of teams have been a source of something that we have done.

We are really looking to the communities to help us with retention efforts, as well, because we have found, like you say, there are a lot of great places to come in Nova Scotia, but are they great places to work? We are turning more and more to our physicians and the community to address those issues when they're attracting people there so that people know what the community can offer them and what they can expect for their work life and how

people make compromises with each other when you're parts of groups in order to provide the best service to the patients in your area as well as having a reasonable work-life balance.

Some of the things we've had with the Department of Health and Wellness that we've looked at are locum incentive programs and the locum program, which is quite different than in other jurisdictions in that people have a certain number of days that they can access in a year to get time away from their practice. It's really important for people to take that time away.

THOMAS MARRIE: I would like to add one thing and then ask Mr. Grant to add something else the department is doing. Doctors Nova Scotia has a program to try to help doctors who are under stress in terms of workload. Dr. John Chiasson, a well-known figure in Nova Scotia, runs that program. Mr. Grant will mention, if he may, what the department is doing.

DONALD GRANT: I think that's a really important question. One thing that the department has undertaken in the last few months is a red-tape reduction program. We are doing that in concert with the Office of Regulatory Affairs and Service Effectiveness, and they are doing some analysis on some of the red tape that exists for doctors which may or may not contribute to the burnout.

TAMMY MARTIN: While that is all well and good, the community can't help to take away the workload of the physician. We know of cases that physicians have looked at having a part-time family practice and a part-time schedule, and the NSHA and/or the department - because I'm not clear - has not accepted that offer. I just recently spoke to a doctor who is here on a locum, and she said with the work-life balance, it is not in her best interest. When other doctors hear of people coming and saying, I'd love to have a part-time family practice, or I'd love to do a part-time emergency room schedule, and they're being told no, then these people are being discouraged. We can offer them all the parties that they want, but we can't help them with the patient load that they see every day.

It may be different in HRM. It may be different in the Northern Zone. But I can tell you, in CBRM and in the Eastern Zone, these physicians, when they're one or two of, they are working, full stop, no breaks. People aren't coming there because they know there's no work-life balance.

THE CHAIR: We'll turn it over to the Liberal caucus for 20 minutes. Mr. Irving.

[2:00 p.m.]

KEITH IRVING: Thank you all again for being here. I want to thank Dr. Marrie for coming out of retirement and stepping up to play the interim role as deputy minister. We're very fortunate to have you, both for your years of experience and your relationship with doctors and the university, who are key partners with us in working on the challenges within health care.

I'm going to focus my questions primarily on primary care practitioners and how we recruit and retain them. I want to begin by helping us and Nova Scotians best understand the challenge that we've got because there are all sorts of numbers out there that can be interpreted in different ways. Perhaps you could shed some light on this.

The Canadian Medical Association shows that Nova Scotia is third best in the number of doctors. I've seen other stats that put us as the fourth best province in the country. CIHI has shown over the years - particularly the decade between 2005 and 2015 - we had more doctors per 100,000 than any other province. CIHI stats show that Nova Scotians have access to care above the Canadian average.

In the last election, Anna Maria Tremonti did a piece on access to physicians where Nova Scotia was at 10 per cent, B.C. was at 15 per cent, and I understand Quebec is actually 25 per cent. These are Stats Canada numbers and of course they are different than the numbers we're using - which with the family practice list, I would assume that list at 52,000 is probably fairly accurate. As we know, there are many 20-somethings that are living forever so they don't need doctors.

I'm not trying to alleviate the concern of the one in 20 Nova Scotians that don't have family doctors, but I was wondering if someone could comment about how we are relative to this worldwide shortage of doctors and the competitive nature of doctor recruitment. In other words, it would appear to me that Nova Scotia has actually done very well over the years. But because of this tightening worldwide, the competition for doctors, we're needing to fight and work harder at this challenge because so many other jurisdictions are actually worse off than we are.

Could someone speak to where we stand relative to the worldwide shortage of doctors and the competitive nature of this?

THOMAS MARRIE: Thank you for the question. It's a long preamble, but probably an equally long answer, if I had the time.

Let me start on a world basis first. If you look at the OECD countries, the target for most of those is to achieve less than 5 per cent of the people without a family doctor, so France, Germany, and the U.K. are around the 5 per cent mark. The U.S. is actually a lot worse than we are. There's only one country in the world that I was able to find, in doing a literature search on this, that has none of its citizens without a family doctor and that's the Netherlands. I'm not sure how they counted their numbers - I tried to find out, but unfortunately, I don't know anybody in the Netherlands who could give me that answer. If you look at most of the rest of developed countries, a target to achieve is somewhat less than 5 per cent, but important to have care available when you need it.

The absolute numbers though are not the only thing one needs. In a province such as ours in particular, distribution of physicians, urban versus rural, is a key piece and one always has to keep that in mind.

The other pieces that we haven't talked about today - in an ideal world, you would like 50 per cent of your physicians to be specialists and 50 per cent of them to be family physicians. We haven't touched on the specialist component at all in terms of recruiting to that sector of the physician population. That is also important because one of the things that we actually do well in the province is to be able to provide good quality tertiary and quaternary care. There are very few things, as a Nova Scotian, that you have to be referred outside the province for; the expertise is here.

In no small part, it's due to the fact that we have a medical school, so in attracting the specialists, you want to have an environment where they can do research and have state-of-the-art facilities available to them. Having NSHA and IWK facilities with the type of equipment they need is really critical and the Cape Breton Redevelopment Project and the QEII redevelopment project certainly assure a bright future in that regard.

I want to turn for a moment to something that Dr. Anderson covered briefly in his remarks a few weeks ago, but I want to give you my experience about a program which has the acronym LICC, Longitudinal Integrated Community Clerkship. We're starting one in your riding now, Madam Chair.

That program was started for northern Alberta when I was Dean of Medicine at the University of Alberta because northern Alberta had exactly the same problems as rural Nova Scotia. You could not get a family doctor to go to rural Alberta. What communities did there is they travelled to the U.K., had a recruiting fair, eventually come back with a doctor; two years later, that person is gone. It cost them $200,000 for two years for a doctor because they also provided free clinic space, free housing, and so on but it didn't work.

With some help I borrowed from the outback in Australia where they introduced a program that if you take third-year medical students who think they're interested in a rural lifestyle and want to practise in a rural community and set up their curriculum so that they spend all of third year in that kind of a setting, the community has to be big enough that they satisfy their educational requirements. If you do that, the experience in the outback and from North Dakota was that 50 per cent of these students go back to a rural community and spend their entire career there as either a general specialist - general surgeon, general obstetrician - or as a family doctor.

It's now about 18 years ago since that program started in Alberta and it's performing exactly the same way as it has in North Dakota: 50 per cent of the students are going back to these communities. At the end of the year, 50 per cent of them decide that it's not for them. That's been one of the few interventions that has been proven to work. Unfortunately, it's a long-term strategy so it doesn't solve your problems today. It will solve the problems in the long term.

When I referred briefly to an increase in the number of medical seats which Dr. Anderson did, as well, I didn't point out that in terms of the residency programs - the number of seats there - the number of positions for emergency medicine were increased. There are two streams in emergency medicine for training: you do two years of family medicine and a year of specialization in emergency medicine versus the Royal College program, which is a four- or maybe five-year program in emergency medicine. We did increase the number of residency positions there. In subsequent conversations with Dr. Petrie - and I haven't discussed this with any of my colleagues yet - he's of the opinion we need to increase that even further.

I'm conscious I've gone on at great length to try to answer your question. There are other elements to it, but I think I'd better stop so you can have some more questions.

KEITH IRVING: With respect to recruiting doctors in this competitive world that we have, I just want to comment a bit about the importance of the narrative that we have in Nova Scotia with respect to the challenges here. I heard from a doctor recruitment, a recent story of taking a doctor into a community and they were having a look around and the doctor opened the local paper to a hugely negative story about health care within the area and at that point he said, let's move on to the next community.

I think that is a message to all of us as Nova Scotians: the importance of us laying out the positives that we have in Nova Scotia. I think communities stepping up now, as you have alluded to in your remarks, are now playing a much bigger part in creating that more positive narrative about the communities that we're trying to attract doctors to.

Yarmouth municipalities are stepping up with funding, chambers of commerce - and you mentioned what happened in Kentville recently where the chamber brought in businesses with donations for welcome baskets. That was a very positive news story that I actually heard in Ontario recently on the national news. These things are important.

We have a new fund now to help communities get involved - Tina Hennigar of NOW Lunenburg County, of course, as you mentioned earlier. I wondered if you could comment on how important it is for communities to get involved, to taking advantage of this new Healthy Communities Stream fund with CCH: what MLAs can do and what communities can do to help us attract and retain doctors.

THOMAS MARRIE: Thank you for stressing an area that's very important if we're going to be successful in achieving what we need to achieve in health care by having the right number of providers in the right spots.

In my opening remarks, I had one sentence that we all have to work together to make this happen and that's very clear. You represent the best interests of your constituents and I think it's important that we hear that, but it's an overall effort.

Health care, while we have a lot of issues - and you're pointing those out to us today, and a lot of room for improvement - consistently, once you achieve access to the system, the results are very good. Granted, access is a problem.

What I think is also important is some balance in how we portray the results of the health care system in various vehicles that we have for public communication. That becomes important and it really is establishing what the tone is of health care in this province, so that's important as well. But I would like to re-emphasize: if we don't start to work together, we're not going to get to where we need to be.

KEITH IRVING: My next question is with respect to international recruitment. I'm working with the Annapolis Valley Chamber of Commerce and three municipal councillors on how we can do more in contributing to the work of NSHA and the recruitment and retention. Just last week I had the opportunity to tour a U.K. physician around for an hour or so, and it was very insightful to not only show off what we have to offer, but in terms of what they were interested in.

One moment that I thought was poignant was he turned to me in the backseat of the car and said that we will see many more physicians from the U.K. in Nova Scotia in four and five years. He saw a real opportunity for us in recruiting physicians. He said physicians in the U.K. have traditionally looked at Australia and New Zealand, and Canada is now on their radar. He pointed out actually that Nova Scotia has a competitive advantage in our direct flights and our relationship - we're not that far away time zone-wise and physically. I thought that was helpful.

Could you comment on the international recruits? Someone commented on the international recruitment activities. How much effort is being targeted to the U.K. and do you agree with the doctor I spoke with, that there is a significant opportunity with respect to U.K. doctors?

THOMAS MARRIE: I will start and then I will ask Mr. Grant and Dr. Boutilier to follow. You've pointed out something where things are going really well lately, so thank you.

The department has worked with the Department of Immigration to make sure we can streamline that process immigration-wise and Mr. Grant will comment briefly on that. If I may, I think Dr. Boutilier would then round those comments out about what has happened on the ground with respect to the success that we've had lately.

[2:15 p.m.]

DONALD GRANT: To speak to the permanent residency, we have started an expedited process for physicians coming from abroad to get permanent residency on an expedited basis here. I'll turn it over to Dr. Boutilier to talk about international recruitment specifically.

NICOLE BOUTILIER: I'm going to let Grayson Fulmer, who is the most closely involved, talk about that.

GRAYSON FULMER: First off, thank you for participating in a site visit. It's most key and important to have local community members demonstrating why their community is where this physician should locate. We have recruiters spread all across the province, but I cannot highlight enough the importance of having local people - local physicians and local community members - participate in that process to demonstrate the unique aspects of why they should be living and working here in Nova Scotia.

I want to take a little bit of a step back and talk about all of the components that had to go into place to have that physician from the U.K. touring Annapolis Royal and area. First of which is - and Mr. Grant has talked a little bit about this - we do actually have a competitive advantage here in Nova Scotia around our immigration process.

THE CHAIR: Excuse me, could you just speak up a little more? People are having a challenge. It's the fans.

GRAYSON FULMER: I will try to project. If I do not, just raise your hand again.

We have worked collaboratively with the Nova Scotia Department of Immigration to establish a physician nomination program. That's unique across Canada. It's one of those core attractive points that enable our ability to go out and recruit internationally, where we can have physicians come here faster than most other jurisdictions.

The other key point that I want to make is our College of Physicians and Surgeons. One of the core changes that they have made to licensure is that they actually recognize certain jurisdictions and training and experience from certain jurisdictions as comparable to Canada, which eliminates a major barrier to a mid-career physician, which is challenging their exams.

Those combined competitive advantages here in Nova Scotia make the U.K. an excellent recruitment place for us to move into. We also have a geographic advantage relative to the rest of Canada, as you spoke about. It's a five-hour flight to London, which makes it extremely attractive to the U.K. physicians to relocate here.

We've made significant investments in trying to recruit internationally as well as the U.K., Ireland, and to a lesser extent, the U.S. We've moved into that market in terms of marketing protocols, generating a lot of interest in coming forward. Then we've been able to connect our U.K. physicians, or physicians who have immigrated from the U.K. - one of which is Dr. Bonnington in Annapolis Royal, who has been an extremely strong advocate on our behalf - and make those connections locally, so physicians can recruit physicians.

We established this program and our international presence in 2017. Our first few cohorts coming through, we had a lot of feedback, hearing what went well and what didn't go well. Now we're moving forward in terms of trying to address and streamline that process even further, making sure that we're addressing where those concerns are and continuing to market on our competitive advantage while moving forward and trying to get people in the communities where they best match.

THE CHAIR: Mr. Irving, you have one minute-ish.

KEITH IRVING: I probably won't go on to my next question; I perhaps just want to give a bit of feedback. I was going to do this offline, but since I have a minute, if you could direct this to whoever it needs to be directed to. I think one thing that can be improved upon with respect to communities' involvement in the recruiting process is more notice and information to communities about the doctors and their families. I think there's some room for improvement there, having been involved in it. I just want to pass that along, that I think that could help enhance the work that we're all doing together. Thank you very much.

THOMAS MARRIE: Very quickly, I asked Dr. Ray LeBlanc, who's a retired ophthalmologist, to work with communities to help us to optimize that process.

THE CHAIR: Order. Time has elapsed. We'll turn it over to the PC caucus for eight minutes. Mr. Halman.

TIM HALMAN: Eleven years ago, when my eldest child was born, I recall - when you called your family doctor it would only take a few days to get an appointment. It's my understanding even up to a few years ago, 50 per cent of doctors were able to provide care within five days.

I'm hearing - anecdotally, of course - it's becoming more and more challenging for parents and guardians, if they have a family doctor, to get an appointment with their family physicians. Oftentimes, it takes up to three to four weeks. In our community of Dartmouth, as my colleague would know, that often manifests itself in parents taking their children to walk-in clinics.

I'm curious if the department has any statistics on whether or not they know how many patients have to wait two to four weeks in order to get a regular appointment.

THOMAS MARRIE: I'll answer your question from some personal experience in visiting a number of clinics around the province, and then Dr. Alexiadis in fact has been working on that problem in her practice, and she'll tell you first-hand what she has been doing.

I did visit Clayton Park West, which is a private practice facility in Clayton Park - I think six physicians. It's extremely well run. They recognize the problem that you just alluded to, that they have found that they couldn't see their own patients as quickly as they would want when they had a problem that they felt needed to be addressed that day or within that day or so. They actually started a walk-in service for their own patients, which has actually started to work very well.

Dr. Alexiadis recognized that issue and has actually done something about it.

MARIA ALEXIADIS: I think it's very important to first recognize the fact that physicians in this province have been providing care every year, when new changes and more struggles have happened. They have always stepped up to bat to do that care. It's getting harder because medicine is getting more complex. Patients are getting older. Patients also have more illnesses. I have been in practice over 30 years in this province as a family doctor. I remember the days when a patient could come in in two days and see me, up to six weeks was sometimes my wait-list because I also have interest in mental health.

What we're talking about here today is collaborative care teams. We have opportunities now to look at the health care that we provide in primary care, increase the flexibility and the adaptive nature of family practice in order to be able to address those population needs. In collaborative care teams, what you're doing is you're actually creating teams where you have the right person, the right provider, for the right treatment.

For example, if you have a team of physicians and you add a nurse practitioner or family practice nurse, then the patient comes to their health home. I'm using a term that we're now alluding to, talking about health homes. The patient may not have a specific doctor all the time or a specific nurse practitioner all the time, but they come to a practice where they know that they'll get their needs met. The difference between doing this health home where you'll see different providers versus a walk-in clinic, say, is that the health home has all your health information, whereas in a walk-in clinic, you'll go and they may not have your past history, your allergies, and your medications. The health home will have that because they'll access it through the technology that we're now using, which is the electronic medical record.

I'll give you an example. Say someone comes in and they want their blood pressure checked. In the old system, I would see the patient, do their blood pressure, and if it was good, I would give them their prescription and have them come back or give them advice. In a collaborative care team, I may not have to see that patient all the time. The family practice nurse could in fact do that blood pressure check, leaving me time to have another space open for another patient to come in.

Currently, we don't have teams across the province. We have 84 teams and hopefully, by the end of the year, 88 teams. What doctors are trying to do right now is create same-day, next-day access appointments. There are a lot of physicians who are solo physicians or in family practice - just their own groups where there are doctors who try to accommodate their patients. It's just the fact that we have these opportunities now to open up, become more adaptive, and recognize that by looking at the status quo and pushing it to the side and saying, let's see what we can do and what opportunities exist, you will see that there will be that opportunity to have more patients seen.

Not only that, the previous question from your last set of questions talked about emergency visits. You're going to have less tertiary care because in those teams, it's not that you'll see the patient for a longer period of time - it's that you'll see the right provider for the right time, as well as having issues of your lifestyle risk management, preventive care, as well as doing the acuity of medicine that we always have to do and chronic disease management. That's why for me these are the opportunities that we have, and we need to move forward and invest in primary care which is the backbone of health care in this province.

THOMAS MARRIE: To provide a more direct answer to your question, Ms. Edwards has designed one of the 28 criteria for collaborative care teams, which is exactly on that point. Madam Chair, if I may, I would ask her to answer that question.

LYNN EDWARDS: As Dr. Alexiadis has mentioned, the development of collaborative family practice teams, we have required as we develop teams for those providers to come together and identify how they're going to address people who have urgent care needs in the population that they serve. We're in the process of monitoring that.

We do expect, as we add more providers to a collaborative family practice, that opens up some opportunity. It's quite a business to run a practice and it is actually office efficiency, which is another component of running a family practice and a collaborative team. We have actually been able to assist some teams in a quality improvement where they've actually looked at how they see people, how many people we have to look after, and how we can improve that.

We're in the process of working with a number of teams right now on that particular endeavour. It has been identified. It is an issue. We want our teams to be able to see people who are urgent when they need to be seen.

TIM HALMAN: Am I correct in saying we don't have a quantitative measurement of how difficult it is for some people to access a family doctor? If they have a family doctor, it's more qualitative. We know anecdotally that there are issues and you're saying that this is something that we're working on. This isn't something we're specifically measuring - am I correct in saying that?

THOMAS MARRIE: No, we're not measuring as well as we would like, but we are measuring it. This is what Ms. Edwards was discussing. It's one of the 28 parameters that's being looked at within primary care teams. A challenge now is to go beyond that to look at the entire province. In that sense, we don't have that for the people that are not in the collaborative care teams.

TIM HALMAN: I'll bypass the question. A comment that was made by the deputy minister - care when you need it. I know we're all sort of united to make sure the system is there for patients when they need it. Obviously, we know there are great challenges there. The question I asked illustrates that an area where we definitely need to improve . . .

THE CHAIR: Order. The time has elapsed. We will turn it to the NDP caucus - Ms. Leblanc.

SUSAN LEBLANC: Madam Chair, I'm going to talk really fast because I have a lot of things to ask. I wanted to say thank you for your answer, Dr. Marrie, about the balance we need in terms of good news stories/bad news stories. We've got to call a spade a spade sometimes. We do need to celebrate the successes, but we also have to look the problem in the eye. From the outside, I think looking the problem in the eye and the good news story becomes, look at how we are seeing this problem and dealing with it - that is the good news story.

I am encouraged when I hear talk about the link strategy and what's going on at the medical school. All these things seem very exciting to me, but one of the things you also said in that comment was we need to be flexible. I want to pick up on that and ask a question about Dr. Donald Curtis. In theory - and I will go back to this if I have time - I think that the collaborative practice teams, I'm sold, sign me up and sign up Dartmouth North, but we know that there is more to it than that. We know that those teams work really well, but then we're in a system that has a bunch of different systems going on.

At the end of August, Dr. Curtis announced that he'd be closing his practice at the Weymouth Medical Centre effective November 30th. In his notice, he talked about - he got a letter from the NSHA terminating his existing APP contract and offering him a new contract with different conditions, other than the ones he was practising under and he chose not to accept the new contract. He could have continued practising in Nova Scotia under the fee for service, but he did not have the financial reserves or the emotional and physical stamina to continue practising under that model. The Weymouth Medical Centre, where Dr. Curtis practised, was connected to the Digby collaborative practice team.

I understand you can't talk about individual cases, of course, but I'm wondering if a representative from NSHA could explain if it is common at the Health Authority to alter contracts or to change contracts in the middle of the APP ones under which a physician is practising.

[2:30 p.m.]

NICOLE BOUTILIER: Contracts are managed by the Department of Health and Wellness for APPs. It was a letter from the Department of Health and Wellness, so I'll have to redirect.

THOMAS MARRIE: I'm fortunate I have Mr. Grant with me, who administers these contracts.

DONALD GRANT: I think this is an important question. Obviously, we can't speak to specifics, as you said. From the perspective of contract management, I don't think it's common for us to change contracts in the middle of a contract. That isn't something that we traditionally do. We do look to try to find flexibility for physicians where we can, ensuring that patients get care in Nova Scotia.

SUSAN LEBLANC: Can you talk about - I'm glad to hear that it's not common practice, and you can't tell me why in this case this happened, but just a quick comment on your view on whether or not you think this kind of practice is helpful for physician recruitment.

DONALD GRANT: I can't speak to specifics. I would say that we are doing a lot of really important work on recruitment in this province. The circumstance that you're discussing in this instance is not something I can speak specifically to. I think we've made great strides with recruitment, and we continue to focus our efforts on incentives and keeping physicians in this province.

SUSAN LEBLANC: Going back to the flexibility issue, I was just talking to one of my MLA colleagues about this, that in many departments or in many services that the province provides, we run as though it's 40 years ago - not to say this is what's happening at the Health Authority or at the department right now. For instance, when things like schools are cancelled because of hurricanes, for instance, jumping around and trying to figure out who's going to take care of the kids - that often falls to women or the primary care provider for a child. It feels like sometimes things can't be as flexible as they need to be.

Can you talk a little about what the Health Authority is doing to ensure that there is more flexibility for people who want to work in different ways? Maybe doctors want to work part time. What is being done to accommodate people who want to work in different work models and for lots of good reasons?

NICOLE BOUTILIER: I understand those complexities. I have no power and three children, so I know the problems of hurricanes and others.

It's hard to have one pat answer for you that every situation would allow there to be a half-time person. What I can say is that our leaders are working with individuals and teams and departments to figure out the way that the complement of their physicians can achieve the results that they want to achieve and have the lifestyle that they want to have within that group. Can I give you a couple of examples to illustrate this?

The department in Truro had two males and two females in their radiology department. The female physicians wanted to cut back on the time that they worked. They worked with the leaders in that department and with the replacement committee to put a proposal forward that they were going to reduce their workload by X amount, and that would allow them to hire someone else at X amount of an FTE. They had a person they recruited, and they did that. It worked out for them, the department agreed, and everybody was happy with that arrangement.

It's working internally with the departments, with the processes we have, to create the conditions that people want to improve their work-life balance, and it's not the same for every department.

SUSAN LEBLANC: I just want to go back quickly to the collaborative practice teams. You make a great case for them and I want to know, if this is the way of the future, then what is the ask of the NSHA to the department for the upcoming budget year? Are you going to ask for continued and more funding to establish more collaborative practice teams around the province?

LYNN EDWARDS: Yes - in a word. We've had an investment already to date, as Dr. Marrie has identified the $58.4 million, which has allowed us to increase our primary care team. Our staff increase has been 150 per cent over the last couple of years. We've seen the impacts over time that it's starting to make. We will continue to look at the investment going forward and put in our business case as usual.

THE CHAIR: Order. The time has elapsed. We will turn it over to the Liberal caucus for eight minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: I'm happy that she ended it with collaborative care because that is the most exciting thing for me - to see the number 80 collaborative cares. I have worked - five years ago, I believe it started with Tim Holland, the refugee clinic was the biggest collaborative care. I would love to give a lot of the details that I saw, but definitely the efficiency and the work atmosphere that collaborative care brought for the doctors and the patients was wonderful. I have an amazing doctor who has his own clinic. I honestly wanted to move to be with that because I would be called as an interpreter to work one day with the nurses, one day with the dieticians. They worked so well together.

Also, I know that one doctor brought the other. They brought each other. There were five graduates from the same year, so it helped bringing the others. They were an incredible team. The efficiency of that collaborative care was really renowned, in my opinion, and I'm hoping that this is what is happening with collaborative care.

I would like to ask the question: What is collaborative care? This one just had a dietician and nurses. What are your hopes for the future? You have 80. How much of our long-term or five-year plan - how many do we hope to have and how do we set them up across the country? I don't think each collaborative care is equal in different parts of the province - if you can explain that for us.

LYNN EDWARDS: You're right, we did start with 39 collaborative family practice teams and at the end of this year we'll have 88. When we say a collaborative family practice team, we're talking about three providers, two of which are from two different disciplines. That would represent a small size of a collaborative team. In some parts of our province, that's who is there in that small rural area. Also, our teams will vary in size, so we'll have some very small ones, medium size, and larger.

We know that what we have done is we have increased the number of nurse practitioner seats through Dalhousie, so for some of the hard-to-recruit-to areas, we'll be having 10 seats that will be filled in those areas - we'll be adding to strengthen our teams that we have now. We also have incentives for our nursing staff.

I also want to mention that our nurse practitioners - we've been successful in recruiting about a quarter of those nurse practitioner positions from outside of Nova Scotia as we continue to educate more nurse practitioners in the province.

A team may represent a group of family physicians, along with a nurse practitioner, there will be a family practice nurse, and also other providers - we call them community adaptive team members. We're not there in all of our teams; we don't have all of those people on all of our teams. The community adaptive team members may be pharmacists, they may be dieticians, they may be social workers. We've increased the number - and we still have more work to do on that.

We'll continue to look at the teams that we currently have, how we link them to the other providers in the system. If we have solo physicians or group practices that aren't in a team environment, how do we start to work across and share some of the resources as well as adding more team members as we go forward?

RAFAH DICOSTANZO: Do I understand that they have the liberty to seek what the needs are for that area, and they come to you with their requests? They have the freedom to choose who is collaborating in that practice, am I correct?

LYNN EDWARDS: What we do is we ask the group coming forward to look at the needs of the population that they serve and to identify what is the best professional from a scope of practice; what do we need to help serve this population? We get those requests on a regular basis.

RAFAH DICOSTANZO: I'm also wondering, with the new immigration stream, if these doctors are requesting to be part of collaborative care, or are they more wanting to be - because they're coming with very little established things - collaborative care would be a very attractive thing, I'm assuming, but I'm not sure.

MARIA ALEXIADIS: The easy answer is yes. Collaborative care teams, when you say how many - I think as many people that want them, we should have them for them. There's a lot of physicians here in the province who want them. A lot of our students are trained in team-based education, so they want teams when they graduate, but also the U.K. doctors who came over, as an example, were all on teams there and they are requesting to be part of teams. I think they have experience as to how their teams worked that they can share with us as we go forward and create these teams in the province.

RAFAH DICOSTANZO: I also had another question in trying to relate community health centres to collaborative care. How do they work? Do they have collaborative care within the community health centre? How does that work?

MARIA ALEXIADIS: I'll start, but someone may want to add on. I'm trying to think of an example in my head and the answer is yes. When you heard earlier how they were set up, where the CAPP physicians were staffing them, now they've adapted so we have other doctors who are not CAPP physicians who are working the CECs. They have a primary care practice, but now there are some that have nurse practitioners that have been added to their primary care clinic and actually offer the primary care piece in those CECs.

RAFAH DICOSTANZO: Maybe more of a comment rather than a question is: how are we thinking of taking the load off doctors in certain things because of collaborative care? A lot of the patients who came did not really need to see the doctor; a nurse or others could deal with the situation. How are we at the front desk when the issue is there? These collaborative cares, are they able to categorize before they ask to see a doctor? Is that happening and releasing some of the pressure from our doctors?

MARIA ALEXIADIS: You bring up a very important point, because this is a new thing. We try to offer support to practices that create those collaborative care teams to see how they want to work together. Different people within a team have different expertise. Someone may have a mental health expertise; someone may have a dietician expertise. The team needs to sit down together and see who will do what. Will the nurse do some home care? Maybe not. Maybe the nurse practitioner wants to do it. Maybe the family doctor wants to do a little more mental health. Again, we're not dictating how to do it.

THE CHAIR: Order. Time has elapsed. This is the end of our questioning. I'll ask Dr. Marrie for closing remarks.

THOMAS MARRIE: Thank you. As I stated in my opening remarks, my goal today was to provide information in context for the two topics that you chose for us to address. You've heard a lot from the Department of Health and Wellness and the Nova Scotia Health Authority on collaborative care and doctor recruitment, and it was a good discussion. I hope we met your expectations on the topics that you proposed. The department will endeavour, as well as NSHA, to provide to you any answers to the questions we couldn't answer today. I think you've already asked for some answers in that regard.

While we still have challenges, what has been achieved in health care in this province is impressive. Let me remind you that people are living longer. They're able to watch their grandchildren and even their great-grandchildren, if they're really lucky, grow up.

New technologies are transforming health care. Health care in the province is being modernized to take advantage of these new technologies and the improvements in care that they can provide. In that light, the QEII development and the Cape Breton Regional development will provide us not only with good infrastructure, but also new equipment as well as improving the economy and the social determinants of health in these regions.

I have left what I consider my most important message until last: my health is my responsibility. Thank you.

THE CHAIR: I'd like to thank our witnesses for coming. You'll probably be meeting the press just outside the doors. We're going to have a short business meeting, so we'll recess for two minutes while you exit the Chamber. Thank you.

[2:46 p.m. The committee recessed.]

[2:47 p.m. The committee reconvened.]

THE CHAIR: Order. We have a bit of business, but I wanted to allow you to have as much time to ask questions today. The opening remarks were longer than what we usually have, but they were important to hear.

We may need this meeting extended so that we can carry out the business, because we are sort of planning our schedule. Would anyone entertain making a motion to extend our meeting time? Ms. Adams.

BARBARA ADAMS: I would like to make a motion that we extend the meeting time past 3:00 p.m., until business is concluded.

THE CHAIR: All in favour? Okay, we will proceed.

We have some correspondence - I'm sure they're included in your packages as well as mine - from Ms. Paula Bond of the Nova Scotia Health Authority. Any questions?

We also had correspondence from Dr. Marcy Saxe-Braithwaite from NSHA, in response to a request for information from our July 9th meeting. Any questions about that? There was also a letter here with a chart, so that's all there.

We will go to our agenda setting. We should end up with six topics: three Liberal, two PC, and one NDP. I think we will start with the Liberal caucus. If you prefer to bring all three together, we can do that as one motion or you can do it individually. It's up to you. Mr. Irving.

KEITH IRVING: That was my question for you. Let's try to do the three together.

Topic number one would be 811 Nova Scotia, witness being Dr. Todd Howlett, Executive Director of 811 from the NSHA.

Our second topic we'd like to propose is the Youth Mental Health Outreach Program, the CaperBase Program, witness being Samantha Hodder, Director of Mental Health and Addictions, Eastern Zone, NSHA.

We'd like to pick up the walk-in from the Canadian Cancer Society who have written us with respect to youth smoking and vaping. As you know, the Legislature recently worked with them with respect to flavoured cigarettes, and this issue of youth smoking and vaping seems very topical and important.

We would like to ask the Canadian Cancer Society and also the Lung Association of Nova Scotia to be witnesses to talk about this very important subject. I would like to move those three topics with the associated witnesses.

THE CHAIR: Are there any comments? Ms. Adams.

BARBARA ADAMS: Can you clarify what the third topic was?

KEITH IRVING: The third topic is youth smoking and vaping. It was a request from the Canadian Cancer Society to the committee. We felt it important to defer one of our topics to bring that forward due to its important nature and timely topic. We've made room in our three choices to accommodate the Canadian Cancer Society.

THE CHAIR: Is that a motion, Mr. Irving?

KEITH IRVING: I did make that motion.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We'll move on to the PC caucus for two topics. Ms. Adams.

BARBARA ADAMS: We would like to move that the first two topics on our list, the pharmacists' role in health care and scope of practice, as well as Doctors Nova Scotia and the ongoing doctor shortage as our two topics.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: The pharmacists' role in health care, that's wonderful. The other topic, Doctors Nova Scotia - we would prefer if that can be after the negotiation. It would be an inappropriate topic if the negotiations are still on with them. We will still accept, but reschedule it to after the negotiation has been completed.

BARBARA ADAMS: Could you clarify for me exactly when that would be, because negotiations could go on forever? Do you have a target date for when those negotiations are going to be finished?

THE CHAIR: I think what we could do is have the clerk put it towards the end of this rotation of meetings. Should they not be able to come in for that reason, you could substitute another one of your topics - would be the alternative.

BARBARA ADAMS: I'm not clear on the reason. Negotiations are going to be ongoing for quite a while and the issue of doctor shortages is the number one critical issue in this province, so I don't understand why we would want to delay it until negotiations are done, because as soon as those negotiations are done, they're going to start working on negotiations for the next time that we go to negotiate.

Obviously, the Liberals can do what they want because they've got the majority, but since we have no idea when those negotiations are going to be completed, I don't believe that we need to push it to the end of their negotiations, unless we have a target date for when those negotiations are going to end.

RAFAH DICOSTANZO: It is totally inappropriate to have those questions that may affect the negotiation, so we will wait until after the negotiation. It's possible that the negotiation could be over and the subject will be put through at a normal time as their second subject. It should not be a huge issue at the time. They can pick another topic and

put that forward as their number two if this one doesn't get - if we get to it before the negotiation is over.

BARBARA ADAMS: I'm still not understanding this because the topic is Doctors Nova Scotia and the ongoing doctor shortage, not Doctors Nova Scotia and the ongoing negotiations with the provincial government. There are all sorts of questions we asked here today that could impact negotiations. We could have asked about the blended model of payment that might affect negotiations, so anything we say could affect negotiations - any stance we take on anything.

I don't want to substitute. If you're not going to allow this topic to go forward, then I want to call for a recorded vote on not allowing this topic to go forward. I'm making the motion. If we don't want to have it included as a topic, then it will have to get voted down.

THE CHAIR: I don't think there was a request to have it excluded. It was to put it at the end of the rotation of meetings.

BARBARA ADAMS: I don't see the need for that either.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: We are not not accepting the topic. In fact, we definitely would like this topic. It's just the timing of it. We can just delay the timing until the negotiation, and we can deal with it at the time. All we're asking is that the clerk schedule it at the end of the rotation. That's all we're asking.

THE CHAIR: Are we ready for a vote? Oh, sorry.

Legal counsel has said you may have to make an amendment to the motion to have that go forward, that this be scheduled towards the end of the cycle.

RAFAH DICOSTANZO: I would like to make an amendment to the motion put forward, that we have that topic at the end of the rotation, and it will be the last one that will be heard by the committee.

THE CHAIR: There is an amendment. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The amendment is carried.

We will go to the motion. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We will turn to the NDP caucus for their topic. Ms. Martin.

TAMMY MARTIN: Our choice would be children's oral health, with representatives from the College of Dental Hygienists, and the Deputy Minister of Health and Wellness.

THE CHAIR: Mr. Irving.

KEITH IRVING: I appreciate our colleagues bringing this one forward. We would just like to suggest an additional witness with respect to the dental association. We would like to add the witness of Angela Purcell, the dental association executive director, or designate. I would like to move that the additional witness be added to the NDP's motion for the topic of children's oral health.

THE CHAIR: There's a motion to add an amendment for an additional witness to the oral health topic. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Ms. Adams.

BARBARA ADAMS: I just want to ask if there's a reason why we're identifying just children's oral health and not everybody's oral health and whether there would be an opportunity to discuss seniors' oral health or whether there was a specific reason why we only wanted to target children.

TAMMY MARTIN: Because we feel that that would be a different topic, and we just had a very fulsome discussion and presentation from the dental hygienists' association of Nova Scotia about children's oral health.

THE CHAIR: Does that answer it? Okay.

The motion is on the topic for the NDP being children's oral health with the added witness. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Thank you for making up the witness list for the next while. Our next meeting will also take place October 8th. Note the time. We're saying 9:00 a.m. to 11:00 a.m., because we're thinking that the Legislature will be sitting at that time, so we will not meet at the usual 1:00 p.m. to 3:00 p.m. It also does not fall on the long weekend - there was a little worry there.

We will meet again on October 8th from 9:00 a.m. to 11:00 a.m., the topic to be determined. I'm sure as soon as the clerk knows what the schedule will be, she will let us all know.

Business is concluded, and I adjourn this meeting. Thank you.

[The meeting adjourned at 2:59 p.m.]