HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, March 9, 2021

VIDEO CONFERENCE

Yarmouth & Area Chamber of Commerce
Local Efforts to Welcome Doctors to the Community

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STANDING COMMITTEE ON HEALTH

Hon. Ben Jessome (Chair)
Hon. Keith Irving (Vice-Chair)
Hon. Margaret Miller
Bill Horne
Rafah DiCostanzo
Barbara Adams
Colton LeBlanc
Susan Leblanc
Kendra Coombes

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Yarmouth & Area Chamber of Commerce

Kerry Muise, First Vice-President

Rebecca Cassidy Rose, Community Navigator, Physician Recruitment and Retention

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, MARCH 9, 2021

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Hon. Ben Jessome

VICE-CHAIR
Hon. Keith Irving

THE CHAIR: I call this meeting of the Standing Committee on Health to order. I'm Ben Jessome. I'm the MLA for Hammonds Plains-Lucasville and I'll be your Chair for today.

Today, we're going to receive a presentation related to the local efforts to welcome doctors to the community from the Yarmouth & Area Chamber of Commerce. We'll be joined by Kerry Muise and Rebecca Cassidy Rose.

We are going to move directly into committee business. When our remaining guest joins us, we'll shift gears and deal with the remaining committee business after the presentation.

The first item on committee business is the subject that I asked Ms. Kavanagh to include related to the organizational charts that we've requested as a committee. I'm just wondering if we could have a quick discussion. I know Ms. Adams has suggested those things.

I'm wondering if there's a way that we could be prescriptive of what we're looking for to try and mitigate the size of the document that's produced and what specific information would be useful for the committee. I'll just leave that on the floor for a couple of minutes here.

Ms. Adams, please.

BARBARA ADAMS: I'm going to reference back to a letter that was dated September 18, 2019 where we spelled this out already. We've had this conversation a number of times. It says, "During the meeting, requests were made for the following information . . ."

It spells out exactly what we asked for, which is the hierarchy chart for the Department of Health and Wellness, which they provided, and the hierarchy chart for the Nova Scotia Health Authority, which is about a 17-page document. We have gotten it in the past. We got the Department of Health and Wellness information, but the Nova Scotia Health Authority the last two times just sent a one-page document and not all of the other supporting documents, which are 16 pages.

We have gotten the correct information in the past. Then it stopped and we keep revisiting this same issue with the explanation of what it is that we want. We want the organizational charts for both the NSHA and the Department of Health and Wellness. We voted on it at least three times, to my recollection, to do just that.

THE CHAIR: I appreciate the candour there. I acknowledge that we have had this discussion. What I will say is that I believe it's a pretty sizable document. I only thought that we should revisit this in the interest of trying to be more efficient. If the committee wishes to continue with that, I guess we'll continue to ask the Department of Health and Wellness for that massive document and that's fine with me.

Did anybody have any suggestions on how we could perhaps make that a little more efficient for our folks at the department to put together? Ms. Kavanagh, please.

JUDY KAVANAGH (Legislative Committee Clerk): I think past records show that the committee is satisfied with the level of detail they're getting from the Department of Health and Wellness. It's the organizational charts from the Nova Scotia Health Authority that Ms. Adams is questioning.

THE CHAIR: Thank you, Ms. Kavanagh. Ms. Adams, can you refresh my memory quickly? What level of staff are we looking to bring into the mix here?

BARBARA ADAMS: It's the heads of all the major departments. There are only 17 documents. It's not a big deal to send to us. They should be updating them on a regular basis anyway. Every time there is a change, you just simply go in and take one name out and put another name in. It's not onerous. They should be doing it anyway.

It's just a 17-page document that comes to us. I look at it every single time. I have not had the opportunity to do that. Because there's so much cross-reference between the Department of Health and Wellness and the Nova Scotia Health Authority, this is the one

way that we have of knowing who's responsible for what and which positions are vacant when and to know who to approach about various issues.

I read them every single time. Having worked at the NSHA, I know that staffing changes on a regular basis and who has a position at one point. As a matter of fact, one of the questions we're going to be asked again today is about who we wanted to have represent a department from the Nova Scotia Health Authority for our next meeting. If you don't have organizational charts, you don't even know who works in what department. They're very useful for those of us who are watching what is going on with the Nova Scotia Health Authority.

THE CHAIR: Fair enough. In the past, we've deferred to the deputies to make designates if there was some confusion or an inability to attend a meeting. It sounds like that's pretty steadfast and we're there. Thank you for humouring me. I'll now divert back. I believe Ms. Muise has joined us. Can we do a quick sound check for Ms. Muise?

BARBARA ADAMS: Can I confirm that we are, in fact, going to ask the Nova Scotia Health Authority to continue to send the 17-page document with the various departments' organizational charts?

THE CHAIR: Yeah, there is no change, Ms. Adams. I'm not hearing from our friend, Ms. Muise. I do see her name so I'm going to continue. I apologize. I'm just going to flip-flop back and forth to get through some of this committee business while we're here.

We received two letters to the committee from Mr. LeBlanc - subsequent response and this is in relation to ambulance services in Nova Scotia. Is there any discussion on that particular item? Mr. LeBlanc.

COLTON LEBLANC: It's a little disconcerting that despite an initial request to call on you for an emergency Standing Committee on Health to discuss this very important issue, that there was no acknowledgement or no feedback to the committee - direction to the committee - any interest into polling the committee. I guess to correct that statement is that only upon subsequent follow-up a week later that I did respond in acknowledgement that there wouldn't be pursual of that.

As a member of this committee, as an MLA for my caucus and as a Nova Scotian who continues to hear from many paramedics and many concerned Nova Scotians, it's a little unsettling that this committee's mandate is to look at the delivery and access of health care in Nova Scotia and we cannot even consider debating or discussing an emergency matter with our Emergency Health Services.

I'm not sure the reason why my letter wasn't acknowledged initially, but if an explanation could be provided, it would be greatly appreciated.

THE CHAIR: Thanks for that, Mr. LeBlanc. I'm happy to respond to that. I guess the sequence of events for me - upon reception of that letter, I believe I took seven days to receive the letter. Apologies - it did go missed by me. That's something I'll acknowledge. What I would add is that only two days prior, we had a committee meeting where this was not brought up.

The second item - and for me, it's kind of a human thing - Mr. LeBlanc, you have my personal cellphone number. We've exchanged messages before. I appreciate the willingness to raise the subject, but as colleagues, if there is an issue that we need to deal with, I would prefer to deal with it face to face or give me a buzz. We're cordial, we're able to have this. If there is a timing issue, I'm happy to respond in writing when the time comes, but let's be clear - if there was an issue with timing, I'm not sure what the issue was for you to send me a text and say, can you take a peek at this, you might have missed it.

The other side of it, too, is that my intention is not to be dismissive of the issue. We have a committee agenda-setting process that I believe we have a responsibility to maintain. We now have an opportunity, only a few days later, to have this discussion. My intention was not to be dismissive of the issue. My partner is a former Emergency Health Services paramedic. The issue is important to me. I understand the weight of those responsibilities second-hand through my partner.

[9:15 a.m.]

My intention was not to be dismissive. Saying that, I would say to any member or anybody, if there's an issue that requires my immediate attention and I've missed it, then I'm happy to take those calls. I'm happy to do that. That's just my two cents in response to that as the Chair of the committee.

Ms. Adams, please.

BARBARA ADAMS: I appreciate the fact that you may have missed the email. It happens to all of us, but there are five members of the government who would have gotten that email. Given that it was a request for an emergency debate, we would have expected somebody to respond to it.

The fact is that we are here now. Mr. LeBlanc would probably like to put this forward as a motion so that we can discuss it now, since we didn't have an opportunity to discuss it through email, which is the normal route when we are asked for this type of debate.

THE CHAIR: What I'll do is, if that's going to be a further discussion, at this point with the committee's consent, I'll shift back to the presenters. I see Ms. Muise has joined us.

By a show of hands, who will be leading the presentation this morning? Ms. Rose? Excellent. Ms. Rose, we'll shift over to you and you can introduce yourself. Ms. Muise, feel free to raise your hand and jump in.

Just as a point of housekeeping, folks, if we have our cellphones or electronic devices nearby, lets put them on silent. If there's any technical issues, please connect with Ms. Kavanagh and she'll help us iron things out with Legislative Television. Is there anything else that I've missed here?

Ms. Kavanagh, go ahead.

THE CLERK: The member introductions.

THE CHAIR: Right. Excuse me. I should have done that right out of the gate. Sorry, folks.

[The committee members introduced themselves.]

THE CHAIR: What we'll do is we'll give you some time to make the presentation, and then we'll shift gears into blocks of time that are allocated. Each caucus will go 20 minutes and then we'll break up the remaining time equally afterwards.

Just for our guests and for our members, if you could wait to be acknowledged by the Chair before starting to give your comments, that would be helpful in terms of us managing the flow of today's meeting.

Without further ado, Ms. Rose, please.

REBECCA CASSIDY ROSE: Honourable Chair and members of this committee, good morning. I am Rebecca Cassidy Rose, Community Navigator for the Yarmouth Region Physician Recruitment and Retention Partnership. It is a pleasure to be here today. Thank you for the opportunity to appear before this committee to discuss our local efforts to welcome doctors to our community.

Our statement today will be divided into three portions presented by the Yarmouth & Area Chamber of Commerce incoming president, Kerry Muise, by Dr. Brian Moses, Internal Medicine at Yarmouth Regional Hospital in absentia, and myself. Kerry Muise will be our first in our statement today so I will allow her to begin.

KERRY MUISE: Thank you for the opportunity to present today. Two years ago, the Chamber of Commerce and local municipal governments realized that doctor recruitment was affecting businesses in our area. Without the hope of getting doctors, people wouldn't move here. Without proper access to specialists at our regional hospital, it was hard for businesses to consider relocating here or expanding. People needed doctors and it's an integral part of any economy.

Our first action as a chamber was to get educated. We talked to health care administrators. We talked to NSHA employees. We talked to Doctors Nova Scotia and other communities that are tackling this issue. Most importantly, we talked to doctors - a lot of them. They were very eager to talk to us.

We realized that action was needed. Together with financial support from the municipal governments, several local businesses, and a three-year funding agreement from the Department of Communities, Culture and Heritage - of which the Honourable Leo Glavine was minister at that time - we embarked upon hiring a position that we called the Community Navigator. This position was to reside within our Chamber of Commerce office. This helped us to incorporate the staff that were already present there. The position is overseen by a committee of all the funding stakeholders.

This has resulted in our community taking responsibility for our part in attracting physicians. It is not all up to government. A community must be welcoming, must understand the needs of the physicians and must provide the assets needed in the community to sustain these relationships for those physicians.

Enhancing the role of NSHA recruitment in essence empowers a community to feel engaged and more in control, and helps to regulate the negativity around physician shortages, which is not a help to anyone. It has been an amazing exercise in connecting our health care community with our community at large and to this point has been seen as a huge success in this area, but I believe it is just in its infancy.

THE CHAIR: Thank you. Ms. Rose, please.

REBECCA CASSIDY ROSE: I will now read a short statement from Dr. Brian Moses. He is Chief of Medicine for the Western Zone and member of both the Navigator Oversight Committee and the Municipal Recruitment Retention Committee from its inception. He states:

> "Recruitment and retention of physicians in rural Nova Scotia is challenging. Over the 12 years that I have been practising in Yarmouth, we have had times of good success, and times with very limited success. Our retention, similarly, has had ups and downs.
>
> What has been clear is that, during times where we have a dedicated person assisting with recruitment and retention in Yarmouth, we have been much more successful. When I first arrived here, that was Shirley Watson-Poole. After her position was removed with the creation of SHA in 2015, we had some lean years, and our physician numbers dwindles (sic) with more retirements and departures than new recruits.

> When physicians feel welcomed by their colleagues and the community at large, the likelihood of success in recruiting them, as well as retaining them for the long term, gets a significant boost. We have always felt that our medical staff is amongst the most collegial you could ever find, which has been a help in our efforts all along. Now, with the community stepping up in a big way by supporting the initiative of a community navigator, and with Rebecca's work in the role, the community is getting the same stellar marks as our medical staff in the eyes of potential recruits. This has helped our recruitment the past two years, and hopefully will do the same for our retention.
>
> Since the establishment of a community navigator to assist with physician recruitment and retention, and with Rebecca assuming that role, we have begun to see great success again. The numbers of residents from our Family Medicine Residency program who decide to stay has increased, due in large part to the programs Rebecca has established to develop a bond with them, and to help them develop a bond with each other. Although we are still in the early days, the trends so far indicate that this position will be of great assistance to us in the coming years to establish a solid physician workforce in the area."

As community navigator, I have the opportunity and responsibility to showcase our local communities and all we have to offer medical professionals looking to set up or move their practice here. It is an opportunity to connect newcomers with established members of our community contributing to high levels of feeling connected and valued. I create opportunities to connect with our current medical professionals making sure that they know they are valued and offer what assistance I can to promote long, happy, and healthy careers here.

The connection and engagement that community onboarding creates is critically important not only because it makes our community more accepting, versatile, and resilient, but also because community involvement is well recognized as helping to combat the sense of isolation that can be felt by newcomers to any community and can greatly add to our physician retention rates.

Discovery into recruitment needs led to our identification of limiters, such as housing for medical learners. Our community member, Coastal Financial Credit Union, decided to help us in that area. They are constructing a new housing project for medical learners which will contain five units designed specifically with medical learners in mind.

This initiative puts forward the message, welcome. We are happy to have you here and we will do what we can to make your stay here convenient, affordable, and comfortable

so you can focus on your studies and decide if this community is a fit for you in the next stage of your medical education or career.

Recruitment and retention are key concepts which are different, yet almost impossible to separate in reality. In my opinion, retention begins with the very first contact. Feeling welcomed, valued, and accommodated create a real sense of ease when undergoing such important life decisions as where to study, practise, and live.

Having said all of this, however, our vacancy rates - specifically family medicine - in southwestern Nova Scotia as of January 2021 reflect that we need all the positive influence we can get. The percentage of our population not yet placed with a primary care physician has risen from 5.9 per cent to 13.6 per cent in the past 24 months according to Nova Scotia health statistics.

My region holds one-third of the vacancies for the entire Western Zone which, in turn, has the highest percentage of unplaced population in the province. These statistics are disheartening, to be honest. The fact that we are further behind now than when we started speaks to a few key points.

One being that this program was launched anticipating an increasing vacancy rate. The situation that we have now is a result of recruitment not being made a priority for a period of time. The reality of a worldwide shortage in family medicine practitioners is a massive challenge for every area. There are retention issues from overwork resulting from being understaffed.

As navigators, we often are seen as advocates by the physicians we work with. We often hear distressing situations which we are unable to impact either as a result of immigration challenges, communication struggles, various perceived biases, and unclear boundary definition.

Geographic location may continue to drive some physicians to more centrally located areas where specialty or sub-specialty training is more accessible. Many of the challenges I just listed are across the province, but some of them are specific to the most outlying areas of our province.

There are currently eight community navigators across the province who have been hired by their communities with varied budgets and personnel. This network has developed organically. We recognize that supporting each other helps to place Nova Scotia well in the national recruiting field. We help build happy communities and hopefully happy doctors. Happy doctors recruit happy doctors.

We all agree that there are ways our positions could be optimized. Examples include building sustainability and long-term investment in medical learners which requires stabilized funding, consistency in staffing that allows for succession planning, rural incentives for family medicine which facilitates pathways among stakeholders in

position recruitment, and a defined advocacy role for all physicians and standardizing Atlantic position licensing.

Thank you for considering our thoughts and our comments on this issue.

[9:30 a.m.]

THE CHAIR: Thank you, Ms. Muise, Ms. Rose, for your time this morning. So, we are going to begin with our friends at the PC caucus. Who would like to begin? Mr. LeBlanc is going to start us off.

COLTON LEBLANC: Thank you, Mr. Chair, and thank you both to our witnesses for joining us this morning. Ms. Rose, my first question goes to you and it goes back to when you first started your job in the Fall of 2019. What was the forecast at that time for the need of physicians and specialists in the area that you provide your community navigating services?

REBECCA CASSIDY ROSE: To be honest, the numbers are pretty much exactly where I anticipated they would be. The advantage of being well-seated in the community and familiar with many of the positions means that I have an idea of who is about to retire, whose children have reached an age where they are going to be heading off to maybe different universities outside the Maritimes.

We had a general idea of how many family medicine positions we might be able to retain from the Dalhousie Family Medicine Program. So while the numbers are disheartening, they are pretty much bang on where I expected they would be.

COLTON LEBLANC: Thank you very much for that. I guess unfortunately in the region, part of which I represent, we've seen a small exodus of physicians and specialists who have left - for a variety of reasons, it has been said.

I'm wondering, do you believe that these departures could have been avoided in any way?

REBECCA CASSIDY ROSE: I think there's always an opportunity to intervene with a physician needing to leave. Sometimes it's a result of the family growing beyond the ability of the community to sustain members of the family. For example, if a physician's spouse has a very specific career, there just may not be the availability for that person to satisfy their own career goals within rural Nova Scotia. That's a reality.

I think there are opportunities that don't get examined in terms of retention. One of the things that has struck me significantly since I took over this position is the fact that a number of physicians don't have as much connection with each other within the community - the physicians' community - to support each other.

Sometimes I hear of issues that they may have and if they had an advocate it might make a difference. It's a very strange little spot that they are in, all as independent physicians who work under an umbrella but they don't necessarily have the same kind of staffing organization for their own needs, as some other organizations might have, so I think there is possibly improvement to happen there that is beyond the position of the community navigator. I am not sure where that would best fit in but it's above my pay grade.

COLTON LEBLANC: Ms. Rose, are you are aware if any of these doctors who have left - if any exit interviews had been conducted with these physicians?

REBECCA CASSIDY ROSE: One of the things we did during COVID, as we've had to pivot like everyone else, was we took the opportunity to create exit and stay interviews because to the best of my knowledge, they weren't being done in a way that I would have access to that information. They might have been done by a different organization but not that I or my oversight committee were aware of.

We did send out exit and stay interviews because although you have somebody who may choose to stay here, that doesn't mean that they don't understand that there are ways that their situation could improve. It's important to know why someone has chosen to leave, in an effort to maybe prevent others, for resolving situations, and for identifying weaknesses within the system overall.

Many of the stay interviews were very positive in terms of community connections that the physician and their families had within the community or have within the community. Many of the exit interviews that people responded to identified probably fairly similar things within any occupation and administration and the number one recurring theme in terms of those exit interviews - so physicians identifying difficulty within the administration of their positions. Does that answer your question?

COLTON LEBLANC: I believe Ms. Muise has a comment.

THE CHAIR: Ms. Muise.

KERRY MUISE: Colton, I just wanted to highlight that one of the reasons for leaving has definitely been workload. When a regional hospital has a specialty department - for example, I'm going to use anesthesiology because that has been an issue here, as you are all well aware - we're supposed to have four anesthesiologists at any one time. We had two leave before we embarked on this project, which brought us down to two. Then we were working with locums. That puts those two anesthesiologists that we had in a very difficult position because they're rotating in a schedule that there should be one in four, now they're one and two with locums being brought in and out and it puts more stress on them.

Workload is a huge issue. Once you are at a deficit position in one specialty, it hastens the strikes that those doctors feel and often exemplifies their reasons for leaving. Any kind of vacancy, the faster we can fill it, the better it is for that specialty. That goes for family doctors as well, especially the emergency department too, so workload is a huge factor.

COLTON LEBLANC: Thank you both for your responses. I really appreciate the fact that stay and exit interviews are being done at a local level to help guide your efforts, but I'm just wondering what your thoughts are on whether NSHA or DHW should have a better oversight of what's actually going on in our rural regions and in all parts of our communities of our province regarding the thoughts and the beliefs of physicians because, quite honestly, what's being experienced probably in Yarmouth is most likely happening across the province. If HR is an issue, for example, or whatnot, I'm sure it's not just a unique issue to Yarmouth.

Unfortunately, there's a doctor that's leaving the province that wrote a piece or provided commentary in the *Chronicle Herald* and he implied that there is no accountability in health care. Accountability is like the Loch Ness Monster when we're speaking about it in health care.

Do you believe that government should be doing exit interviews and what benefit it would bring for them to have more of an oversight and more transparency and accountability?

REBECCA CASSIDY ROSE: Absolutely. I think in any kind of organization exit and stay interviews, as well as job reviews - those are all parts of the key to keeping administration and the kind of boot to the ground satisfied with everyone's position. The problem is, I'm not sure at what level that should be accomplished.

What was communicated to me during the stay and exit interviews was that I was privy to a specific amount of information that those physicians would not have shared with a larger organization. They had a personal relationship with me. They knew that I would hold their information in confidence and that when I reported some of the issues to my oversight committee, there were definitely no names or specialties reported at all, so they had that level of trust.

If a division within Nova Scotia Health or the Department of Health and Wellness were going to take that over, I think it would be very valuable. I think there would be a lot of ground that would need to be built to develop that trust from the physicians so that they would actually speak honestly. That was also a comment that came through those interviews: they did not feel as represented or as supported - those are probably the best words - within their organization.

If there's a way to do that neutrally, where they didn't feel repercussions or that their boundaries of their expectations - as Ms. Muise referred to the demands that can

happen through the overload of work demands - they would have to have some safety with that. I'm not sure how that would happen with such a large organization as Nova Scotia Health or the Department of Health and Wellness.

COLTON LEBLANC: Ms. Rose, you said something that caught my ear and it's trust. Trust is probably one of the strongest pillars of a long-standing relationship. I believe that the relationship between our province's doctors and whether it be NSHA or DHW - trust has to be put on the forefront. It has to be right on the table.

It is concerning. It's not a unique sentiment that's expressed among doctors. There is a lack of trust among other health care providers. I'm interested to hear that, but also value the insight that you provided of how to build a neutral [inaudible] if it was DHW or NSHA.

THE CHAIR: Mr. Glavine, could you please mute your computer? Mr. LeBlanc, back to you - sorry.

COLTON LEBLANC: I'd like to touch on something that you mentioned in your initial comments. It had to do with the geographical positioning of Yarmouth. It is at one of the furthest ends of the province and it does pose various challenges.

One thing I do want to point out for my fellow committee members is, the Western Zone is arguably one of the largest health zones in the province. Like other zones, there are two NSHA physician recruiters. Both of those recruiters are within one hour from Halifax, and from Yarmouth to those two recruiters is another two hours. In my honest opinion, I think that it puts recruiting at a little bit more of a disadvantage in the southwestern part of the province.

Ms. Rose, I'd like to hear your comments on whether you believe there would be a benefit of having either an additional recruiter in southwest Nova Scotia or a modification of the placement of the current NSHA recruitment officers in our zone.

REBECCA CASSIDY ROSE: I think that before COVID-19, the placement of the Nova Scotia Health recruiters was key just because there was so much travel that was expected. A number of those trips have been replaced with forums such as where we are right now. I do think that a number of those - I don't want to say biases, but a number of those factors that might be impacting where they are and how they recruit may be modified right now during COVID-19. I would like to think that at some point the restrictions are going to be lifted and travel will be back again, at which point the difficulty for the region may present itself a little bit more.

I personally have spent a fair bit of time - and I feel I have an excellent working relationship with the two Nova Scotia Health recruiting consultants for our area. They both do excellent work and it's very important that as stakeholders in the health care system -

navigators, recruiters and Nova Scotia Health - that we all work very closely together to the best that we can.

[9:45 a.m.]

It has taken a while for those inroads to be built and those relationships to be built. As a result, I feel like we are getting different representation now than we did, say, two and a half years ago. Part of that is because Nova Scotia Health added the additional recruiter, actually just before I started, so we'll say it was at the beginning of 2019 that they added the recruiter from the Bridgewater-Liverpool area. Before, the workload was simply astounding for one person. It still appears to be quite heavy for two. I'm not sure if there is space to have another full-time employee down at this end of the province or a partial employee, but Nova Scotia Health has adjusted a little bit in terms of recognizing the need for more recruiting specialists, so now there's a new recruiting specialist who focuses just on residents.

I think there are a lot of improvements that have happened. My caution would be to make sure that we don't lose any of the attention that we are getting right now, when COVID restrictions lift and that we end up being equally represented, as either ends that are closer to Halifax within our region.

COLTON LEBLANC: I guess from obviously being the MLA, or one of the MLAs for the region, receiving calls to my office from my constituents who are continually having barriers to accessing primary care, it's frustrating.

As you noted in your initial comments, Ms. Rose, we've seen a significant increase in the number of Nova Scotians who are on the Need a Family Practice registry. Here we are on March 9th, and we're still waiting for the March data, which should have been released not a long time ago.

Looking at the February data, almost 15 per cent of the population in just Yarmouth County and then 13.6 per cent in the tri-counties, it's like two and a half times the provincial average. I'd argue that obviously there's a need for - there could be a need for more NSHA recruiting efforts locally.

I guess my last question to you has to be on this data. There's a lot of discussion on the accuracy of the data and it's based on Nova Scotians who self-identify as being without a family practice practitioner.

In your area that you serve, do you believe there is a greater number of Nova Scotians or residents who are not on the list?

REBECCA CASSIDY ROSE: Yes. Unfortunately, I do think there are people who are not represented. I continue to be contacted by people within the community because I am a longstanding member of the community. A lot of people know me, so sometimes I

get those questions at the grocery store, wherever I am, and the question is: how long is it going to be until I get a doctor? When am I going to get a doctor? Where do I have to go? Who do I have to call? How does this happen? Over and over, it's a matter of explaining the 811 registry and a number of other things that are in place, such as the primary care clinic, to help members of the community understand the system.

With that information, I think that two things are happening: first of all, the initial number from 24 months ago was substantially lower than it actually was and that our number now is lower than it probably is in reality because we are relying on people to self-identify as needing a primary care physician and sometimes they don't do that unless they get ill, because they don't feel like they need one.

Of course, when you look at statistics and information in terms of maintaining a healthy population, prevention and treatment of the smaller issues help prevent a lot of much more impactful health crises.

All we can do is continue to get the information out, to really work on retaining those physicians we have because there will be situations where families leave the area. That's a natural situation for certain families.

I think there's a lot more we could do in terms of retaining the physicians we do have, both in family medicine as well as specialties, and that is going to be key.

THE CHAIR: That's all but perfect timing. We're going to move on to our comrades from the NDP caucus. Ms. Leblanc will kick us off here.

SUSAN LEBLANC: Thank you, Comrade Jessome. Welcome, to our guests. It's a fascinating conversation so far. As Mr. LeBlanc has pointed out, the statistics in your end of the province are brutal, but it does feel familiar because these are the same conversations we're having in Dartmouth North, for instance. I know the Central Zone has done better in the last year or two, but the numbers are going up again. Frankly, that's really scary and that retention issue is a big one.

I just wanted to pick up on a couple of things that were being talked about there. First of all, with your position, Ms. Rose, you said that it was funded - correct me if I'm wrong, but I understand that it was funded through one of the community grants from the Department of Communities, Culture and Heritage. Can you clarify for how long that funding was for? I thought I heard Ms. Muise say three years. I'm wondering if you've had to reapply every year. I'm wondering what the deal is with going forward. What will you do if, for instance, in the budget that we may see in the next week or two, if there's no money for that program or less money or whatever? What will happen to your position and what will happen to the work that you're doing down there?

REBECCA CASSIDY ROSE: I'm going to address the first part of the question and then, if you don't mind, I'm going to redirect to Ms. Muise because she was there at

the onset before I was hired, so she may have additional information in terms of where or exactly how they arrange that initial amount of funding.

Each quarter and each year, I report back to the recruitment and retention committees in the municipalities and I report back to their councils in terms of how we're doing, in terms of numbers, what my initiatives are, and basically how I'm spending their money and making sure that they understand that they're getting their money's worth, but also to find out if they're comfortable with the initiatives and the direction that I'm taking the position. At the beginning of the position, it was one of those things where there were a lot of expectations and not a lot of details in the job description. A lot of stuff falls under the description of other duties as required.

There are some hidden expenses that kind of don't come up and some other changes. For example, the fact that we're not travelling for conferences right now has created a little bit of space within the budget. That allows us to redirect for things like virtual conferencing, which is less expensive and, hopefully, maybe with a better saturation mark.

In terms of where I would be without my funding, I feel like our communities have had a huge impact and they're behind me, and they understand that Nova Scotia Health needs some assistance in this matter and that retention is a huge issue and the best way to facilitate higher retention rates is to have a go-to person for physicians, for medical learners, for locums, for high school students who are considering doing medicine as a career.

For all those reasons, I think that the position would probably continue to some extent. Obviously, the effectiveness is an issue as budgets impact my ability to reach out to connect to create those inroads and to connect to the community and the physicians and their families. Creating all those inroads takes time and I have other navigators within the province who are trying to do this in their communities with part-time hours - 12 hours a week.

I don't understand how they're doing that. I'm full time - often far more than full-time hours and I never leave the office that I don't have more that I can do. Rarely do I have a weekend where I'm not working, where my phone isn't going off, where there's not something that I'm doing - picking up groceries for somebody that's in quarantine. It would be a struggle to do all of those things, which are key to retention, without the budget that I currently have. Ms. Muise, would you like to refer to the financial setup at the beginning?

KERRY MUISE: The budget is around $150,000 a year to run this position, so we got the grant from the Province for $25,000 per year for three years, so it's a portion of that $150,000 budget.

The position, I think, even if that money disappeared, and I don't think it will, I'm in touch with the Department of Communities, Culture and Heritage all the time and letting

them know about our progress and what's happening and they are very supportive. Even if that disappeared, I think at this point the community, and especially the health care community, would step up and make sure that this position carried on, because it has been integral to developing new relationships.

Our doctors now feel supported, the doctors that are here, and you could hear that in Dr. Brian Moses's statement, that they feel supported by the community. The community is aware of their struggles. The community is wanting to help them. That's a very important position to be in.

Through the Chamber of Commerce, we've been able to leverage things here, like IT support, development of wonderful videos, expertise from the community. We currently have a couple of our board members who are helping to negotiate with some of our physicians who need some extra supports. We're able to do that because of this position, because we've gained this trust and set this up.

I know the community is not going to want to lose it, especially the municipal governments, who are very active in overseeing this position and are aware of the support that this position - and Rebecca's the hub of it, but what it has done is extended into the community, so we have many people in the community now helping with this issue, including Coastal Financial Credit Union, who have been key in helping to remedy our housing. One of our local developers is now looking at housing options for doctors because they've been made aware of that.

It's worked itself into much more than just one position; it's now stakeholders in the community who are becoming actively involved. We take our resident doctors now out on field trips to various things in the community, where we invite other young people to join them so they can make friends. It's very extensive in terms of our reach.

As incoming Chair of the Chamber, and this being a huge new aspect of our budget, I'm not worried about the funding. I think that we can argue a very good case. Rebecca is giving you a portrayal of where we are, but where we would be if we hadn't brought this position into place would be much more bleak. We've had 14 doctors come here and sign on since Rebecca came. A lot of those positions would not have signed on if we hadn't taken this initiative. I can get signatures from some of the young family doctors who have said, you made us feel welcome, you helped us find a place to live, you helped us find out what kind of practice we can establish, who we can work with.

It has been a wonderful exercise in allowing our doctors to mentor the younger doctors that are coming in, and that's all been facilitated through this project.

SUSAN LEBLANC: I just want to highlight the importance of this conversation that we're having in the current context of a global pandemic. I'm thinking about what you just said, Ms. Muise, about where we would be without this program, that kind of thing, and also the impact of the issue of not having access to primary care and how much worse

that is as we are situated in a global pandemic. I just want to put that out there and remind us all that we are in the middle of COVID-19 and how important access to primary care is.

Given that, I want to ask - in one of your other comments, Ms. Rose, you read from Dr. Moses's comments, saying that after the amalgamation of the health authorities, or the creation of the Health Authority, that times were lean. I just want to ask a little bit more about that.

I'm wondering if you can talk specifically about how the amalgamation of the health authorities has impacted doctor recruitment in the Western Zone. I think it's clear, but from what you have both just said, there are real benefits to people on the ground in communities working at the community level, and it's essential. Can you talk about that leanness after the amalgamation?

[10:00 a.m.]

REBECCA CASSIDY ROSE: Just to be clear, I have been in and around health care since 1991 in a number of different aspects. In 2015, there was a position for a recruiter, Shirley Watson-Poole, until that amalgamation. When that amalgamation happened and her position ended, basically what she was doing is exactly what I'm doing now. From 2015 until the beginning of 2019, so almost four years, to my understanding, there was one Nova Scotia Health recruiting consultant for this entire Western Region, who was placed outside of Kentville. I could be a little bit wrong on that because it's a bit before my time in terms of this organization.

She worked on her own until a second one was added, the one from Bridgewater, which was at the beginning of 2019. She had been in her position for six months when I started in the Fall of 2019. In essence, we're looking at from 2015 to the beginning of 2019, where there was one recruiter for the entire Western Zone. Basically, it's a matter of you have to stay on top of it. Again, it's so hard to say. The simple impact of being overworked and understaffed for such a massively important aspect of our community and our community's health and our province's health and well-being and our position in terms of the worldwide shortage of family medicine physicians, the sheer impact - three years - that's pretty much all it took for us to get so far behind the ball as we are now.

I have been in the community since 1980, and I never heard such vacancies and so many people expressing the fact that they didn't have a primary care physician, even though there were retirements and people left and people came, the same as before. With that block of time where it wasn't given the priority that it needed to have, that touch, the very high touch, very personal touch - contact with physicians, in those three years, we ended up substantially behind the ball.

Now we have two recruiting consultants for the region. We have at least three navigators within the community, so someone from Lunenburg, someone from the Annapolis Valley, and myself. We have two recruiters, three navigators the communities

have hired, as well as a recruiting consultant just for residents. Now we're at six, trying to catch up from three years of being so vastly underserved.

Then when I look at our physician numbers and specialties, as Ms. Muise had referenced earlier, especially anaesthesia, because that's a hot topic - when we look at how difficult it was for our community to see recruiting successes while we were so understaffed, and then we're looking at doing the same thing to our specialists, the impact - I think it's going to take a long time to catch up, and that concerns me. On the other hand, the fact that we have a couple of new positions and that we have some excellent working relationships that are established now, I'm hopeful that the gap in terms of that recruiting focus will be able to be caught up much more quickly than potentially it could have been.

SUSAN LEBLANC: There were 500 people added to the registry in the Western Zone over the course of the last year, basically, the course of the pandemic. I know that in other parts of the province that is similar. The numbers are going up on the Need A Family Practice registry and also, as we spoke about before, we know that there are a lot of people who aren't getting on the registry for whatever reason. People are falling through the cracks. I also know of people who have thought they've been on the registry, they go online and then lo and behold, they're nowhere on it two or three years later after thinking they'd been on the registry and waiting for a doctor for so long.

So there are some issues with that program. That being said, we know that 500 people have been added to the registry in the Western Zone over the last year. What are your thoughts on the reason for the general backslide during the COVID-19 pandemic?

REBECCA CASSIDY ROSE: That's a good question. The backslide. Self-identification.

We also have a number of people that seem to be moving to the community. I follow some social groups where it's all new people coming to Nova Scotia and I don't know what the numbers are overall in terms of population growth, but they're all coming from areas apparently where they've had physicians and they're like, hey, do I have to wait a couple of months to get a physician? And people are answering, a couple of months? Yeah, more like a couple of years. I think the shifting of population back to Nova Scotia, and maybe that's part of a COVID thing - that's going to influence the numbers, for sure.

In terms of gathering, it could be that as Nova Scotia Health has organized and they shift their organization a little bit, perhaps their gathering methods for those metrics are shifting as well, so maybe the numbers are more comprehensive than they were before. Because I don't work for Nova Scotia Health and I have no impact on their statistics, really, that's not something specifically that I could speak to.

We know our population is aging and we know that Nova Scotia doesn't necessarily have the healthiest population and so, as we mentioned before, people who may not have felt like they needed a physician may feel like they need one now. Sometimes access to

other things such as mental health services is tied to having a family physician, and we know that mental health issues are more of an issue given COVID-19. Perhaps there's more of an increase that way. People may be identifying as needing a physician not necessarily because of a physiological, medical necessity, but more as a mental health support as well. Those are probably the biggest impacts that I could see.

SUSAN LEBLANC: I just want to sneak in one last question. You said a good part of your time is dedicated to helping medical learners find housing, and a large part of the community navigator budget is also associated with this. Can you talk about the availability of housing in Yarmouth and what impact this has on businesses and employee recruitment and retention generally, as well as on the doctor piece of it?

REBECCA CASSIDY ROSE: In short, we work with students from here who are coming back to the community to do a week's rotation or one to four weeks rotation, depending on where they are, and they're already paying for living accommodations in Halifax, or wherever they're going to medical school. So, as a result, paying an Airbnb rate is out of their budget. They're just strapped as it is.

Having organizations like Coastal Financial Credit Union step forward and allowing us to have a co-operative project where we are able to run this - basically, the medical students are going to be able to stay there for free. We've had 16 to 18 medical students, I want to say, just since September who have had significant impacts on their housing costs and the fact that they can have reduced rates and then are going to have mostly free accommodations makes where Yarmouth sits in terms of their preference huge.

We're looking at a long-term investment pay of between four and eight years where they're then looking at residency, depending on where they are, and Yarmouth looks very good for them. Kerry, would you like to address employment issues?

KERRY MUISE: To answer your question in brief, housing is at a crisis level here. There's no housing available, and I know that's common in many communities. I have tenant apartments and I get calls every single day about people looking for availability. We are selling houses at a record speed, and a lot of those people are moving in from away, and just placing people who are selling their houses at a great profit and have nowhere to go. It's all flowing downhill.

That affects not just doctors but when we're bringing in - I have a lab tech renting from me, nurses - attracting any kind of medical professionals to the area. As a Chamber, we're aware that that's one of our major challenges right now, is housing. We're not alone in that. I know the government is aware of that, we've all heard these issues. Definitely a huge part of recruitment and retention is housing.

THE CHAIR: We'll move to the Liberal caucus. Mr. Glavine, please. We'll try Ms. DiCostanzo to start and we'll go back to Mr. Glavine.

RAFAH DICOSTANZO: I believe he's frozen, that's why. I did have a couple of questions, probably to Ms. Rose. Ms. Rose, I know that immigration and bringing doctors through immigration has been an amazing positive for us. My question is to you. How many doctors in the Western Region that you've worked with who have come from, I'm not sure if it's Australia, England - we have specific countries that we can accept doctors with the right certification - how do you deal with what they need? For me, I was a medical interpreter and I worked with a lot of doctors, and I found it's not their knowledge of medicine, it is our system that is difficult for them.

What do you offer, and how have you put any systems for them through - I know you said you had a lot of your doctors mentoring other doctors, and that is for the young ones and for the residents, but what are you doing for the immigrant doctors, and what they need in learning how our system works?

REBECCA CASSIDY ROSE: That's an integral part of what we're doing. Oftentimes, as I said before, retention begins with the very beginning of recruitment, and so as soon as I have a connection with a physician who's maybe considering the area, I'm already connecting with them. Sometimes we're having phone calls, sometimes they're emails. I'm learning about their kids, their spouses, their religion, specific housing requirements or financial requirements, according to whatever they hold to be important to them, and connecting them with other members of the community who have similar values, who have similar interests, who have children the same age, who decide to get together.

Maybe they make a special purchase of groceries from the city, or I'm going to the city and I'll call a few of them and I'm saying, I'll be at X grocery store on Saturday. Do you want to call in an order and I will take my coolers and I'll bring it down to you?

That's huge in terms of establishing them. Then they kind of take care of themselves to a certain extent, and in light of that comment, happy physicians recruit happy physicians. At one point, just before I started, I'm going to say six months before I started, we had a psychiatrist who was here from the U.K., and he came here for a site visit, and before he was back on the airplane in Halifax to go back to Ireland, he had already called his two buddies and said, this is where we need to be. This is where we need to be practising. This is the population that we need to serve, and this is where we want to be raising our families.

Now I have a fully stocked psychiatry department, and all those three families are here. That's fantastic. All I have to do is support as much as I can and make those connections, and then they continue to do that.

[10:15 a.m.]

In terms of trying to facilitate their connection with the community, sometimes I do very simple things like I go and look at a property, we do a little GoPro view of the property, and maybe when that physician comes here, I sit down with the physician, the landowner, and myself, and I say, guess what? This is the Nova Scotia tenancies agreement, because

maybe it's different here. I don't know. I go through that with them, and I ask all the extremely uncomfortable questions that nobody wants to ask, like what happens if she doesn't come fix whatever, and what happens if so-and-so doesn't pay their rent? I ask all those questions so that there's no grey zone, so everybody knows exactly what the parameters are, because within safe boundaries - just like medicine - within safe, established boundaries of practice, that makes people comfortable if they know exactly where they sit in terms of the regulations for, if you live on this side of the street you go to this school, if you live on this side of the street, you're going to go to that school. This is where your friend's kids go. All of those things, and promoting the safety of our communities and promoting the accessibility. Even though we may be considered regionally remote, there are usually physicians that are coming here from long distances. They're ready for the change, and they're ready for what we have to offer.

I do my best before they even get here to have a very good connection with them. Usually by the second exchange we're on a first-name basis - and how are the kids today, has she gotten her resume to the Western Regional Enterprise Network (WREN) representative here? The biggest issue, however, is immigration - trying to figure out where things are for them to navigate. That is extremely complicated. I just found out that we have a new position added locally. I believe it's a new position, a new person in the position at least, who will be an easy touch point for me to say, look, this is where this position says their application is. What does this mean? What are we looking at in terms of timelines?

Often we have physicians who think, okay, I'm going to be there in two months, and really, their applications are five or six months at least. That's a problem. I'm very optimistic that this new approach or new position will make my job a lot easier.

THE CHAIR: I apologize for any additional noise. I think they're mowing the lawn upstairs. Ms. DiCostanzo, please.

RAFAH DICOSTANZO: As a follow-up, is there maybe a connection between the present doctors and the new doctors who are immigrants, and sitting down maybe once a week to discuss how they deal with things, mainly because of the system, not the knowledge of the medicine itself? That's exactly what I found, that our system is very different to the system in England. Is there maybe a communication, a chat that they can be on and feel comfortable to ask questions? Has anybody approached or have the old doctors thought of this?

REBECCA CASSIDY ROSE: Yes, a number of our physicians, the families get together, the kids play together, the physicians are friends, the spouses become friends, sometimes they become co-workers. They do have those conversations. A lot of those conversations don't include me necessarily, because they are coping mechanisms and strategies and figuring it out amongst themselves. I think they know that they can communicate with me at any time. Most of them have my cell number and they're just texting back and forth sometimes.

They do support themselves in that way, but one of the things that I alluded to before is that I feel there is a gap in the system in terms of supporting international doctors. I think that there are a number of perceived biases within our community. Canada in general, rural Nova Scotia is no different. I think that there could be communication issues in terms of workplace documents, workplace expectations, how to navigate this system themselves, and at that point we look at community onboarding versus employment onboarding.

Employment onboarding is something that I have nothing to do with. Somebody coming to Canada from the United States, the U.K., Australia. It's literally the only part that I don't have any impact on at all. It would be great if there was something within the system that would allow the physicians to contact them and say look, I don't understand what this means in my onboarding package, or I don't understand what this means in terms of my contract requirements or whatever. There just seemed to be a gap in that, because I hear concerns and I hear questions, but there's really no place for me to take those questions or concerns to, so I always refer them back to their Nova Scotia Health Authority recruiting consultant, to Doctors Nova Scotia, the Department of Health and Wellness, the Nova Scotia College of Physicians and Surgeons.

Somehow, with all of those organizations, there still seems to be a little bit of a gap. I'm not sure how to address that, and I'm very positive that that is above my pay grade, unfortunately.

RAFAH DICOSTANZO: I have another question, but I'm going to let my colleague, Honourable Leo Glavine, ask his. We have less than 10 minutes, and then if he has leftover time, I have my other question.

THE CHAIR: Mr. Glavine, please. It looks like he just conked out again.

RAFAH DICOSTANZO: Okay, I can ask mine until we get him back in. Technology - and he is in the office here, at caucus office, so I don't know why - I'm having no problems, so I'm very lucky.

I'm also wondering about internet service and the huge investment our government has made in getting internet to the rural areas. How has that affected you? Where do you see it? Has it improved so far? Are the doctors complaining about it? Has it been a hindrance for you in recruiting doctors?

KERRY MUISE: Internet service is definitely an issue in rural areas. Within our town.

THE CHAIR: In HRM.

KERRY MUISE: Yes. It looks like it's an issue for Minister Glavine, too. Within the town, it's not such an issue, but a lot of our residents live in rural areas. You can live

on a lake five minutes away and be to the hospital in no time down here because we live in a beautiful area, but it has definitely been a struggle. I know there is some new infrastructure coming. The faster it comes, the better, and that doesn't just apply to medical recruitment; that applies to people moving into the area, too. It's a concern for businesses setting up.

Internet access is very important. The sooner we get a really good structure here, the better. It's a key, for sure.

THE CHAIR: Ms. Rose, did you have anything you wanted to add there?

REBECCA CASSIDY ROSE: I just wanted to add that as a number of our physicians come here and they need to quarantine, with internet they're able to work from their homes, and they're able to get a lot of their documents sorted out ahead of time, whereas before, we would be going to those offices ourselves. We have a physician who moved here last year to do some very specific educational requirements of one of his children. He works from here and his family lives in another community, just because that's essential for his family's well-being. He is still able to service my community, even though a couple of days a week, he's not living here, and he can do that because of the internet.

One of the number one questions when I have people coming here for locums or new physicians moving here, sometimes the biggest question is not are you within 10-15 minutes for on-call time, it's what's the internet like there? Sometimes it's an issue. We know there are new initiatives like Ms. Muise had mentioned, and so the faster that gets going, the better. In the meantime, it's important. Very important.

THE CHAIR: Mr. Glavine, do you want to give it a shot here?

HON. LEO GLAVINE: I want to thank everybody for understanding my technical dilemmas here this morning. I am at the caucus office, and back in the Valley, I have the smallest provider maybe in Nova Scotia, but it's absolutely trustworthy.

Anyway, as I move along, I want to first thank Rebecca and Kerry for their outstanding work, and in many ways, you've been on the vanguard of re-establishing community engagement for recruitment and retention. For the most part, the old days have passed, and that is a doctor who spent 30, 35, 40 years in a community, large practice, and often was able to recruit their successor - that now is going to be really the past. The ongoing work that you have established in Yarmouth will be supported by the provincial government. We know that hands-on touch that you're able to give to recruitment is now an essential component and certainly will be even more so in the future.

I know many young doctors who see perhaps three or four careers within their M.D. life, so this is why this community engagement is absolutely critical. I am wondering, at this stage - you have some great experience. You've brought up some terrific ideas as well as challenging us in your comments this morning. What do you see for your area in perhaps

going back to recruiting seminars, contact, especially with the U.K. - what do you see now in the post-COVID world, especially to get GPs into Yarmouth and area?

REBECCA CASSIDY ROSE: Thank you for that question and for your comment of support. It all comes down to retention. The pre-COVID and post-COVID reality is, especially with worldwide shortages, we cannot afford to not support our physicians, to make them try to fit into our mould of what we expect for medical services delivery. We need to be able to adapt to the changing desires of new physicians. They don't want to have a family practice of 3,000 or 4,000 patients. They don't want that. They want a little bit of hospitalist duty. They want a little bit of emergency time. They want variation, because they understand it prevents burnout for them.

I really think that the post-COVID reality, in having our province seated well in terms of the worldwide shortage, is all in retention. Happy doctors will recruit happy doctors, and if we support them and we adapt what we expect in terms of our idea of the family doctor in the country - if we can adapt that to what they are able to give us - different generations have different values in terms of their lifestyle and we need to adjust and retain who we have coming. I think that will help with our recruitment overall but it is key, number one for me.

LEO GLAVINE: My next question is looking at the local area. You do now, of course, have residents who are a wonderful boost both in the ongoing medical work required by Yarmouth Regional Hospital, but also providing an opportunity to look at Yarmouth and western Nova Scotia as a potential site for their careers.

I'm wondering if you have looked at students from western Nova Scotia that are in medical school and create a liaison and tie with possibly attracting them back to the area. I know in your neighbouring community of Clare this, in fact, has been an extremely successful way of recruitment, so I'm wondering if you could comment on any overtures made in that direction.

[10:30 a.m.]

REBECCA CASSIDY ROSE: As soon as I hear of somebody whose student has applied for medical school, whether they've got in or not or they're in high school and they're looking at medical sciences as a career, I am in touch with them. We have a student whom I've been in touch with, actually, since the beginning of my position here, and they just got accepted to Sherbrooke Medical School this September. I sent off a handwritten card that said, hey, congratulations, this is fantastic, here's a little bit of money to help with your textbooks, and know that your community supports you and encourages you and that we are proud of you.

I took the residents from the family medicine program to Clare for a maple syrup boil this past weekend with the lead physician there, Dr. Michelle Dow. They do a fantastic job of being in touch with their community medical students that are going away and I'm

hoping that in time the same kind of relationships that I've been establishing in this community will begin paying off as well. The Northern Ontario School of Medicine often has little articles there in terms of rural physicians. Rural physicians are almost a subspecialty in themselves and that rural doctors are happy.

The happiest rural doctors are actually brought up from rural areas, and so I really take that to heart and I feel like that's extremely valuable and hopefully within a few more years, we'll start to see some of the students that I've been in touch with from junior high and high school starting to come through and coming back here.

THE CHAIR: We're going to move into the second round of questioning. The Progressive Conservative Party will have three minutes. Ms. Adams will start us off and the Liberal and NDP caucuses will each have two minutes apiece to give our guests some time to wrap things up. Ms. Adams, please.

BARBARA ADAMS: I was sent a message saying that we had 11 minutes, so I'm not sure what happened there.

Anyway, Kerry and Rebecca, I just wanted to start off by thanking you so much. I can see how much this weighs on your soul and how much you are putting into this and so we know that the outcome is not a reflection of how hard you are working. God knows what it would be like if you weren't there, so thank you very, very much.

I know that we have 300 fewer physicians listed with the NSHA this year than we did last year, according to the Nova Scotia Health By The Numbers 2019-20 report. Doctors Nova Scotia told us at a committee meeting that on their survey, the number of Nova Scotians saying they don't have a family doctor is 12 per cent now, compared to seven per cent five years ago.

Given all of the work that you're doing, I'm wondering two things. One is, this grant came through the Department of Communities, Culture and Heritage. I've never understood why this isn't a permanent position and why you need to get a grant to do this job. I'm seeing you nod, so I'm assuming that that's your - this should be a permanent position with the Department of Health and Wellness. You shouldn't have to apply to it and have communities competing against each other.

My question for you is: What is the anticipated retirement rate in your community that you know of now? If you're already at 13.6 per cent, what's the anticipated retirement rate that you see coming?

REBECCA CASSIDY ROSE: Thank you for acknowledging the need for this kind of position to continue. Off the top of my head, I can think of four to five physicians who are probably looking at retiring within the next five years. They are all well-established physicians with large practices and to say that doesn't concern me would be completely false. It absolutely does.

You had mentioned 12 per cent - my region's at 13.9 per cent. When I look at 13.9 per cent plus, those retirements are extremely concerning - and those are anywhere from Barrington to Clare, so Barrington, Pubnico, Yarmouth, and Clare. Especially because, as I mentioned earlier, the newer physicians coming in like to have more variety within their job scope, which is fantastic. However it means that we need to look at full-time equivalencies and say, okay, for each physician that's retiring, maybe what we're looking at is replacing that person with two physicians - or maybe even more, depending on what their caseload is like.

Those are questions and applications and acknowledgements which are not within my job scope, so I hope that Nova Scotia Health Authority and the Department of Health and Wellness are looking at those. Part of the need to have a consistent individual representing the community means that I can go to my recruiting people and say, you know what, that's great that we've got three new family physicians from our graduating class that are going to be staying here, but don't forget this is coming up, this is coming up, this is coming up. It's important to have a representative from the communities to continue to remind and continue to put those efforts forward.

Kerry, would you like to address the funding?

THE CHAIR: If I may, we're going to move on to the NDP caucus and then we're going to set aside some time for you folks to close up, so you can come back to that if you'd like.

Ms. Coombes, please.

KENDRA COOMBES: Thank you, Mr. Chair. A brief scan of the Code Critical campaign in the past day or so - #CodeCritical released by our paramedics union - reveals a dozen or so Code Criticals in Yarmouth in the last week. Can you talk about the impact of the EHS challenges and its impact on recruitment?

REBECCA CASSIDY ROSE: To a certain extent, I can't actually comment on that, unfortunately - it's outside my scope. I would venture to say that the emergency physicians that we have here are probably in the best position they have been in in a very long time. I know that they are looking forward to the announced emergency department renovation that we're supposed to be getting here, and that that will have an impact on flow and availability for the emergency department to respond to the needs of EHS.

Over and above that, there are so many details within my scope it's not even something that I personally have a lot of impact with, so I can't adequately address that question. I'm sorry.

KENDRA COOMBES: We were talking just a little bit ago about doctors that are training out of province. I know there are limitations to local residencies for doctors who

are being trained out of province. Can you tell us what's being done to remove the barriers for those out-of-province doctors?

REBECCA CASSIDY ROSE: Technically, those are all questions for the College of Physicians and Surgeons because they deal with licensing issues. I know that in terms of locums and in terms of the students being able to do their residencies here, obviously with COVID-19, we're having those restrictions around quarantine and workplace isolations or work isolation.

I do have to say that if I had my dream world that would make my job so much easier, it would be to have some form of Atlantic physician licensing. The fact that we have to scramble in Nova Scotia and P.E.I. and New Brunswick and Newfoundland and Labrador for physicians who all value rural practice - I think it would be great if I had a full-time practice in P.E.I. and I wanted to come over and work in Nova Scotia a little bit. It's a quick drive. It's a great way to cement the Atlantic provinces provincially and nationally in terms of the family medicine and the medical supply crisis overall. I would love to see that. If I had any impact, that's what it would be.

THE CHAIR: Thank you for that. We'll move on to the Liberal caucus and Mr. Horne with a couple of minutes here, please.

BILL HORNE: I'll just make the short questions, I guess. I think you mentioned earlier, Ms. Rose, about having seven other community people working on similar issues as you are. I'm just wondering if you have any interaction with these other community navigators and I'm wondering if it's helpful for you.

REBECCA CASSIDY ROSE: We have, actually, an enormous amount of contact. When I was hired, I reached out and found out about two - one in Lunenburg and one in Pictou - and we basically created our own network or our own working group. None of us are mandated to work with each other but we all have an excellent working relationship. We understand that what works in Pictou might not work in Yarmouth, but there are some things that will.

We work very collaboratively. We do not say, oh, I'm not going to give Annapolis Valley any information because they might take our doctors. The reality is, to work with retention, you want the community and the physician to have the best fit possible. Somebody may not like living next to the ocean, or somebody may really like living in the Valley or living in the Highlands of Cape Breton.

Because most of our jobs are very organic in their development, depending on the needs of the community, we can shorten the learning curve for each other and really place the province overall in a much better position because we work well together and because we can say, oh, you're doing a locum there - let me connect you with somebody who's going to help you with housing, or let me connect you with somebody that can show you the area.

It’s all about that great fit, and it’s an excellent working group that is extremely supportive and very development-oriented.

THE CHAIR: Thank you, Ms. Rose. Folks, that’s all the time we have for questions for today. I wanted to leave some time for our guests to summarize anything that they felt needed to be revisited during the meeting and perhaps add some closing remarks.

Ms. Rose, why don’t you kick us off, please?

REBECCA CASSIDY ROSE: Thank you very much. In closing, I would just like to thank you all for including the Yarmouth region partnership in this conversation. We value the partnerships that support us in our efforts to strengthen our communities and Nova Scotia’s position as a welcoming and accessible place for physicians to practise.

The ever-desirable work-life balance we all seem to be chasing is attainable for physicians in Nova Scotia, and a collaborative approach between government and various agencies can strengthen the marketability of Nova Scotia on the worldwide physician market. Community engagement is critical, but in terms of building retention rates, I would love to see continued success and momentum.

I believe that this requires support in a number of ways, such as stabilized funding, acknowledged pathways created to allow community navigators to be recognized as a key tool for Nova Scotia Health Authority, the Department of Health and Wellness, Nova Scotia Immigration, and Doctors Nova Scotia, to name a few. Also, to maybe open the discussion of a standardized Atlantic physician licensing.

So I look forward to placing our community at the forefront for physicians looking for the benefits of rural medicine practice, and I’m interested and available to have any future contacts either with any of you individually or on this platform. Thank you very much.

THE CHAIR: Thank you, Ms. Rose. Ms. Muise, did you want to add anything?

KERRY MUISE: Sure. I just wanted to comment on one thing there, the grant funding that we get from the Department of Communities, Culture and Heritage. Ms. Adams, you had suggested that perhaps it should be a government position, but I just want to emphasize how well this works as a community position that has a grant from the government.

When you attach it to an agency in the community, all the stigma of a government job or a civil servant job kind of falls away and the person can be very organic in the community and use other assets. It’s a wonderful grant to get, but I don’t want to see this become a government position. Also, every community that’s had a navigator has attached their navigator to a different organization, so it’s whatever organization is working best in that community can have this position. For us, it happens to be the Chamber of Commerce.

If you want to know how you can help, when someone calls you about helping with an immigration issue, please help us. Help your community navigator or your recruiter. Get that prospective doctor through the immigration system. Our local MLAs and our MPs have helped us with this on numerous occasions. It's so much more effective if you pick up the phone and make the call.

I can't emphasize enough that an Atlantic bubble would be phenomenal - maybe even a Canadian licensing system. If we could move physicians across this country at the drop of a hat to get to them to locum and other places, hands down Nova Scotia is going to get some recruitment out of that, and never be afraid to pay for it.

[10:45 a.m.]

Doctors are just like us. They love things for free. If you pay for that licensing, it's not very expensive, but to them it's a lot of money when they have to license in every single province to be able to locum.

If Nova Scotia says we'll pay the Nova Scotia College of Physicians and Surgeons for your licensing fee if you'll license here, then we can get them in as locums at the drop of a hat. It makes it easy for them to move around. Those are just some little things.

I think if there's one thing to take away, we need more positions opened up. The more full-time equivalency physicians we have, the easier it is to recruit. It reduces workload. Our new doctors want life-work balance just like the rest of us. I'm sorry, I know MLAs don't have that - you never will - but they want life-work balance, and it makes for a happier physician who will stay in the community longer when they have life-work balance.

We're not going to see physicians who want to work 70 hours a week anymore, and that's got to become a reality, so more full-time equivalency positions are a must. I want to thank you very much for listening and taking into account the information that we've gleaned so far. Thank you.

THE CHAIR: Thank you both for taking the time to be with us today. On behalf of the committee, we want to pat you on the back for the work that you're doing. Ms. Muise, best of luck with your new chair position down at the local chamber.

KERRY MUISE: Thank you.

THE CHAIR: If you would like, you can join us for the remaining few moments of our committee meeting, where we'll conduct some committee business, but you're more than welcome to depart.

We'll quickly move back in this case to the agenda item that we were discussing related to the correspondence between the Chair and Mr. LeBlanc. Do we want to continue that conversation at this point in time? Mr. LeBlanc.

COLTON LEBLANC: Just a couple of points of clarification. I shouldn't have to send a text or a telegraph or anything to anyone other than communicate with the clerk. That's how, since I've been a member of this committee, is to direct my correspondence through to the Clerk, and then there it be shared with the members. That's just a point of clarification.

Typically, when I see urgent on correspondence or in correspondence, whether it be myself or my staff, it's flagged. The reasons to explain why this particular issue wasn't brought up at the last Health Committee meeting was a sequence of events have taken place after the Health Committee meeting. The ongoing Code Criticals, the escalation of public outcry, Nova Scotians reaching out to at least MLAs in our caucus, expressing their frustration and anger that government had not acted on this file. Now we know that government had the Fitch report that we've long called for that Liberals in this committee have voted down after an Opposition motion.

They had that report for 14 months. The report was in the hands of government in October 2019, and then in December 2020, they finally started negotiations with the operating company. It's the series of events that brought forward the reason for bringing it to this committee that's ultimately responsible to discuss the access and delivery of health care. For me and for my caucus, it is and it was a priority and emergency issue, and that's why we chose this mechanism to discuss it, because frankly, for the last year we haven't had any democratic process through our Province House, and finally through the resumption of committees to debate concerns that matter the most to Nova Scotians.

With that being said, I'm looking forward to going back to the House and hopefully for a successful session. Thank you.

THE CHAIR: Is there any further discussion on that from any other committee members? Hearing none, we will move forward. We received some correspondence from our friend Samantha Hodder at the Nova Scotia Health Authority related to the provincial mental health crisis line and contacts with the police in response to a request for information made at our February 9th meeting. Is there any discussion on that item?

Hearing none, an additional letter from our Minister of Health and Wellness related to telephone access for opting out of the human organ and tissue donation program in response to a motion we passed at our previous meeting on February 9th. Is there any discussion on that particular area? Ms. Adams.

BARBARA ADAMS: I'm thinking that one of the things that we were interested in was how many people had opted out of the program and I don't see that we got a response to that particular question.

THE CHAIR: If my memory serves me correctly, I think we were going to allow a gap of time for that data to be populated and then we can revisit that. If the committee members want to be definitive about setting a timeline to revisit that, then we can explore that perhaps as an option, but I believe that's part of the discussion that we had, if I'm not mistaken. Ms. Kavanagh is nodding her head yes. Ms. Adams, do you want to jump in there?

BARBARA ADAMS: We had written a letter on February 18th. What I would like to suggest or make a motion that we write to the department and give them a specific date. I don't want to leave this open-ended - I'd like to know. This is March. The program started in January. Can we write to the department and say, for example, in May 2021 that they provide us with the information as to how many Nova Scotians have opted out? I'd like to make that a motion.

THE CHAIR: We're discussing the four-month period. Does anybody want to discuss that? Mr. LeBlanc.

COLTON LEBLANC: I second the motion.

THE CHAIR: The motion on the table is for a four-month report on the opt-out side of the human organ and tissue donation program.

All those in favour? Contrary minded? Thank you.

The motion is carried.

That's all I have on my agenda for today. I appreciate everyone's co-operation and willingness to be prompt and efficient today. I did try to leave us some time, acknowledging that we're all prepping for the House this afternoon at 1:00 p.m. We have a few moments remaining. Is there any further committee business?

BARBARA ADAMS: In speaking with Ms. Kavanagh yesterday, was there a question about the speakers for the next committee meeting? Was there anything that needed to be discussed about that?

JUDY KAVANAGH: Not at this time. I've been talking to them about the meeting and they asked for more specifics about the topic because they weren't sure whether the two members that the committee wanted to invite were the appropriate people to speak. I said to them, this is the committee's decision to make. If you want to request that you not appear at the meeting or that somebody else appear instead, let the committee know and it will be up to the committee to decide. Please try to do so in time for today's meeting because it's always better to make these decisions in a public meeting than by email poll after the fact.

I haven't heard anything from them. I don't think that there is anything the committee needs to do about it at this point.

BARBARA ADAMS: For the record, our caucus had responded to the question about details. We explained that the people that we requested were the ones that we wanted to talk to because of their role with human resources and planning. Of course, in the absence of a more up-to-date NSHA organizational chart, if there was somebody else who might be more appropriate, we don't have access to that information. Unless there is a good reason for them not to be there, we would like them to attend. If somebody else would like to attend and they want to suggest adding someone, we would be open to that, but we certainly do want the people that we had suggested and had voted to have attend, we would like them to attend.

JUDY KAVANAGH: I passed those comments on to them and I did say what you've just said. I told them that if they want to bring other colleagues along, they're welcome to, up to a reasonable limit.

THE CHAIR: Thank you, Ms. Kavanagh. We'll leave that piece in your very capable hands.

Mr. LeBlanc raised his hand there, I see.

COLTON LEBLANC: A quick question - when's our next agenda-setting meeting?

JUDY KAVANAGH: If everything goes according to schedule, it should be in May. We have just the one topic left on our current agenda, and that's the one that I'm setting up for April.

THE CHAIR: Excellent. Is there any further discussion or committee business?

Seeing no hands and hearing no voices, we'll adjourn today's meeting and we'll see you all this afternoon. Thanks, everybody. I appreciate your time.

[The committee adjourned at 10:56 a.m.]