PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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SUBJECT: BRIEFING ON RECRUITMENT PROCESS FOR PHYSICIANS AND NURSES IN PEI

COMMITTEE:

Hal Perry, MLA Tignish-Palmer Road [Chair]
Dr. Peter Bevan-Baker, Leader of the Third Party
Hon. Jordan Brown, Minister of Education, Early Learning and Culture
Kathleen Casey, MLA Charlottetown-Lewis Point
Colin LaVie, MLA Souris-Elmira [replaces Darlene Compton, MLA Belfast-Murray River]
Sidney MacEwen, MLA Morell-Mermaid
Hon. Chris Palmer, Minister of Economic Development and Tourism

COMMITTEE MEMBERS ABSENT:

Darlene Compton, MLA Belfast-Murray River

MEMBERS IN ATTENDANCE:

Brad Trivers, MLA Rustico-Emerald

GUESTS:

Department of Health and Wellness (Kevin Barnes, Rebecca Gill, Hon. Robert Mitchell)

STAFF:

Joey Jeffrey, Clerk Assistant (Director, Corporate Services)

Edited by Hansard

The Committee met at 1:30 p.m.

Chair (Perry): I'd like to welcome everyone to the Standing Committee on Health and Wellness today. I'm going to call this meeting to order. I'm going to start off with one replacement today and that's: Colin LaVie will be sitting in for Darlene Compton and we have another MLA sitting in today and it's Brad Trivers.

Everyone had an opportunity to view the agenda; can I have someone to adopt the agenda, please.

Mr. R. Brown: Moved.

Chair: Moved by Richard Brown.

Moving on to number (3) we have requested a briefing regarding the recruitment process for doctors and nurses here on Prince Edward Island and we do have presenters here today. I'll ask them if they want to come to the floor now.

Before we begin, I'd like to ask that each of you just – in the microphone for audio and Hansard purposes – state your name and your position, please.

Rebecca Gill: Hi, I'm Rebecca Gill; I'm the manager of Health Recruitment and Retention with the Province of Prince Edward Island with the Department of Health and Wellness.

Kevin Barnes: Kevin Barnes; director of Health Policy and Program with the Department of Health and Wellness.

Mr. Mitchell: Robert Mitchell; the Minister of Health and Wellness.

Chair: I want to thank each of you for coming in today.

I will ask that we hold all questions until the end of the briefing and then I will create a list at that time – or actually during that time – and questions will be asked.

You can begin.

Mr. Mitchell: Thank you, Mr. Chair.

I would like to thank yourself and all members of the committee for inviting us to be present here today. As my new role as Minister of Health and Wellness, it is great to be with you all today in my inaugural visit to the standing committee.

With me today is Rebecca and Kevin who are, I guess, the experts in the field of physician recruitment and retention on Prince Edward Island. Have been with the department a number of years and today they put together – I will call it – a very well put together presentation on where we are and where we're going as far as recruiting and retaining, both, those from the doctor professions and nurse professions on PEI.

With that, I'll turn it over to – I guess Kevin will lead the way first as part of the presentation.

Kevin Barnes: Thank you, minister, and thank you to the committee for having us here today and to the opportunity, as the minister has indicated, to speak to you on this issue.

We do have a short presentation (Indistinct) which we'll walk through and we're going to share the presentation duties between myself and Rebecca over the course of the next few slides.

Our purpose here today, really is in response to your request. We are here to provide an overview of the recruitment process for physicians and nursing positions within the Province of PEI. In the context of that, we will provide you with an update on the recruitment programs and initiatives that we have in place to support those functions.

A little bit about the health Recruitment and Retention Secretariat; just to give a little clarity. The secretariat actually is assigned to the Department of Health and Wellness, but it is responsible to support the workforce requirements of Health PEI and it really does so in three ways.

First and foremost, it provides health workforce analysis, including a review of occupational demand and supply; demographics, in origin, inform Health PEI of labour force requirements. In addition to that, recruitment and retention does undertake specific recruitment and retention

efforts on behalf of Health PEI to meet identified requirements for physicians, nurses and even some of the allied health professions, physiotherapists, lab technologists etc cetera. Focuses primarily on specific physician vacancies, but in the case of nurse practitioners or registered nurses; it's more of a general approach to the recruitment of those professionals, as well with respect to certain hard-to-recruit allied health professions. So they'll take a more targeted look at recruitment efforts in those areas.

Just to give a very high level overview of the physician recruitment process and kind of simplified it down here to sort of five key steps, but there are a number of elements that typically take place within each of those parts of the process.

In the terms of physician, first and foremost as I mentioned a moment ago, the Recruitment and Retention Secretariat does provide demographic and workforce analysis information to inform Health PEI of the needs, whether it be in the area of physicians, nurses or other professions. It does provide that sort of intelligence, or business intelligence information that will inform Health PEI relative to its workforce. In response, the Recruitment and Retention Secretariat will take direction from Health PEI in terms of specific vacancies or opportunities to pursue.

With respect to physicians as a posting of the vacancies, there's a specific website that's used for health recruitment, healthjobspei.ca. Those physician vacancies will be posted there.

In addition to that there are a number of professional websites, CareerBeacon, etc cetera, across the country that as well, those types of physician vacancies will become posted and advertised. Once we identify perspective candidates for physician opportunity, there is an interview process typically through a web or WebEx type of form. And subject to the outcome of that process we will have physicians come to the province for specific site visits.

In the interview process, the WebEx process, typically will involve physicians from the related area. So if it's in a particular specialty area, we would have physicians from that practice area participate in the interview process. So there is an involvement of Island physicians in that process. Likewise, if it's in a family physician practice, the medical director from the particular region again may sit in on that process so that there's some involvement of the medical community in that sort of interview process.

Again, if there's an interest through the WebEx process, there's a connection that looks to be favourable, we will do site visits with the perspective physician. Often times those site visits will focus on different facilities or locations in the province.

Again, if it's a family practice, we may look at different sites when the physician is here. If it's a specialty area, it's probably more focused where the specialty is actually provided here on PEI.

In the event that the recruitment involves a foreign trained physician, there is some work done really at this point in time to make sure that the credential match is one that will allow the physician to be licensed to practice here in the province. That typically involves consultation with the College of Physician and Surgeons relative to their training country of origin and the sort of past-practice that that physician may have.

Once there is an interest by the physician in coming here and the way has been cleared in terms of licensing, then we really start to discuss on a very specific level with the physician the actual opportunity. We do have some incentive programs, re-location assistance, which we can make available to facilitate the physicians move to the province. I will sort of walk through some of those incentive programs here momentarily.

That sort of gives you a high level view of the process as it relates to physicians.

In terms of nurses, it's a little more general in its approach in terms of the recruitment process, whereas the physicians are tied to specific opportunities or specific positions. Our approach around nursing recruitment is more general in nature and looks at addressing the overall needs of the province, whether it be for NPs or registered nurses.

Again, the process starts with a very similar sort of overview or intelligence type of process that applies with physicians. So the health Recruitment and Retention Secretariat would undertake a look at our existing workforce, the demographics, the attrition rate, for example, that is occurring within our nursing workforce. Again, inform Health PEI relative to those high level needs for nursing.

In a Recruitment and Retention Secretariat, as we're taking sort of a general approach, there is an ongoing relationship in connection with the PEI School of Nursing and the students that are enrolled in those programs at UPEI, really throughout the course of their education, find that many of our RN positions and certainly NP positions are sourced through UPEI. The Secretariat maintains a close connection with students throughout their time at UPEI to make sure there is an awareness and an understanding of the opportunities that the health system has to offer.

We do have some incentive programs again, which I'll speak to in a moment, relative to nursing students or nurse practitioners. Again, the process for recruitment and retention is really to connect with those students primarily at UPEI, but not exclusively, and make sure there is an understanding and awareness of what are the opportunities that are available in Health PEI for professional nursing practice.

We provide information to those students throughout their education. Recruitment and retention makes a number of site visits certainly in the third and fourth year of education at UPEI. Again, to make sure nursing students have an understanding of what is available here on PEI, and again, what are some of our support programs. Ultimately with those students, we will help them, essentially, with the navigation of the application process for jobs at Health PEI.

In terms of our incentive programs which I mentioned a moment ago, with respect to physician recruitment programs, we have a couple that are directly sponsored through health recruitment and retention; one of which is the Family Medicine Sponsorship Program. This program has been in existence for about four years now and we typically sponsor one medical student per year through this program. This is a sponsorship that takes place early in medical education and it could be in the med students' either second or third year of med school. It's very early on in their education. It provides, really a financial incentive over the course of their education, of either 80,000 or 110,000, depending on the year of education. What is given in return from the student is a commitment to practice in Prince Edward Island for a term of five years after graduation. In particular, there is a commitment to practice in the area of greatest need as identified by the province when that student comes out of school.

We actually have our first graduate, I guess, essentially of this program, starting practice later this year in July; that was just recently announced. Dr. Craig Malone will actually be starting, I believe, in Souris later on in the year. Again, that's securing the student fairly early on in medical education, supporting the student through that process and then securing his or her services for an extended period of time upon graduation.

The second program is a more general Return in Service Grant and this is typically for those physicians that have finished their education their practicing and they're looking for different opportunities or to move to the province. This will apply both in the case of family practice, as well as specialties. Again, a grant will give the 30,000 in the case of family practice, or 40,000 in the case of specialties is offered to physicians as an enticement for them to work in the province. In exchange for that, we secure a three-year return-in-service from the physician, so they commit to work for the province in that particular area for a three-year period.

Another program, I guess, and it's not specifically offered by health recruitment and retention, but another area where we have found a really close connection for physician recruitment is our Family Medical Residency Program. This program has been in existence for a number of years. It allows for the training of five medical residents here on PEI in family practice. We have found that process – and by virtue of having students come here and do the residency here, has been a very successful way to find physicians to fill vacancies in the province. Having the opportunity to train and work in

our facilities through the course of the residency, there is a connection that's made with those students to the system here. Often times we've had very good success in retaining those students after they've completed their residency to work here on PEI.

Just to kind of give you a little sense of that, if I kind of go back over the last few years – we've got five physicians in the program. In 2014, four of those five physicians actually stayed and continued on and practiced in the province after the residency program. The same in 2016, four of those stayed on. In 2017, three stayed on and in 2018, we're not quite complete yet, but we've already signed on two, again, to stay in the province after they've completed that residency program. So we've found that while that's not a specific recruitment program of health recruitment and retention, it's an important linkage that we have as a source of family doctors for Prince Edward Island.

Again, as I mentioned, there's also recruitment programs or incentive programs for nurses. Just to kind of give a little bit of an overview of what those are, in terms of, we have a Bachelor of Nursing Sponsorship Program. This is a program whereby we have about 18 sponsorships per year that are offered to students in their university training. We provide a grant of $4,800 towards the cost of their education and a commitment of two years employment in the system post-graduation. Again, we have a sort of an inroad into the health system for 18 students per year through the Bachelor of Nursing Program.

In addition to that and it's a very similar program, we have a new Graduate Employment Guaranteed Program for RNs. When it's fully operational, we expect an intake of about 30 to 40 nurses per year into that program. Same sort of arrangement, we offer those graduate nurses essentially two years full-time employment in the system post-graduation. It gives them an opportunity to work within various worksites across the province in various practice settings; the opportunity to make a connection with the health system and hopefully ultimately work into full-time employment.

In addition to that for students that are actually at UPEI in their second and third year of nursing practice, as well for LPNs, we do have summer employment programs. Again, even prior to graduation, we have the opportunity for nursing students to work in summer employment roles within the health system. Again, to introduce those nurses to the system prior to graduation; again, in hopes of sort of connecting with them and encouraging them to stay and work in PEI afterwards. Again, the size of that program; it's about 45 students per year work and get some benefits from the summer employment program.

Last but not least, we do have a Health Care Futures Program. This is a little earlier on in the educational process. We have a program which offers about 40 spots per summer. Again, this can be high school students or university students. It provides kind of a diverse range of summer employment opportunities in health care settings across the province. It can be long-term care, acute care, community practice settings. The idea being it's to engage students early on around the prospects of a career in the health care field, whether that be medical practice, nursing, or whatever the case may be. Again, it's intended to try and encourage some interest and some exposure to the health system to younger students.

I'm going to turn it over to Rebecca; we'll talk a little bit about sort of our approaches to the recruitment efforts.

Rebecca Gill: Thank you, Kevin.

As you can see here, is a list of some general promotion that the Recruitment and Retention Secretariat undertakes and we typically try to do unpaid promotion to begin. If you look through the list you'll see opportunities where we post our positions, either to the Public Service Commission's website, or as Kevin mentioned earlier, Health Jobs PEI for physician positions.

We also have maintained great contact with various associations, schools and networks where we can advertise our positions and really cast the net wide in terms of our recruitment efforts. We also ensure that there's regular and focused email correspondence that's sent to different members of associations that we're ensuring

we're getting the right information into the right hands at the right time.

The websites and career centre promotion, that's just an opportunity that exists currently in various areas where we're able to send our information and they're able to post it for us to ensure that the target audience of the students are aware of the opportunities that exist.

We do have quite a social media presence through, both Facebook and Twitter and so we do use both of those platforms as a way or a mechanism to inform and ensure that we have a large reach with our opportunities that exist. The follow-up and support that currently exists is generally on a daily basis, whether it be through email or a phone conversation, we have a lot of contact with our recruits in terms of process for hiring, walking them through application processes, showing them, pointing them in the right direction where the opportunities exist, putting them in contact with people in the health care system where they can ask questions. That is an ongoing process that we do, like you said, on a daily basis.

When we turn our efforts towards more of the pay, the targeted promotion, these are opportunities we have and have seen some great return in years past. Number one, the visits to medical schools and universities; that is something we do on a regular basis, both with Dalhousie University and Memorial University of Newfoundland. We go to those universities, meet with students in the physicians program, or whatever program it may be that we're targeting, and speak to them about the opportunities that exist in PEI and really create some of those great connections.

We do use, as Kevin mentioned earlier, some paid advertising through CareerBeacon and we're looking at a few other areas where we can get our jobs posted where there is a small fee but certainly has an opportunity for reach.

Again, the social media campaigns, there are paid promotions through that as well through Facebook and LinkedIn – and we've actually just undertaken the LinkedIn recruiter tool which was an investment for the province. It is a specific tool added on to the LinkedIn program but we have seen benefits. It actually allows us to really focus our recruitment to the right target audience. That's been a good addition to the recruitment composition.

We still do print and online advertising. We don't do as much print right now but there are a few select specific areas where we do go to and online advertising as well. We do purchase marketing spots for our physicians so that people are aware of what exists. We also attend various job fairs and career conferences just so that we can speak to students, tell them about the great opportunities that exist in the province and make strong links that we can follow up on after.

In terms of what success looks like for our province – but we speak specifically to physician recruitment – over the last number of years these are the number of hires that we've been able to confirm with the province. When you look at those numbers initially, you might think it is a large number to hire 25 physicians in 2017, but when you look at the attrition rate in terms of the number of doctors who've retired, who've left the province, we did have that number of vacancies, so we were able to attract to those. That is, in our essence, a successful story.

Right now, PEI currently has more physicians practicing than ever before. So our current number that we have is 225, and that is fluctuating on a daily basis. When we become aware of retirements and when we continue our recruitment efforts, we certainly are hoping to ensure that our complement is complete.

For nursing specifically, we talked a bit about the programs that we have in place and certainly they have had return on the investment for those programs, so we're able to secure 23 nurses through the new Graduate Employment Program in 2017, and 18 nurses through the sponsorship program. The year prior to that we had 19 through the new graduate program and 18 again, through our sponsorship program. It just speaks to the efforts that are being placed in those programs and also the ability that we are having as a province to retain our talent. We're looking forward to continue to build on that momentum.

Also, additionally, we do have nurse practitioners, of course, entering more and more practices. Currently there are 25 nurse practitioners who are practicing within Health PEI; again, more than ever before. Before too long, you'll seven more nurse practitioners positions being posted. So we are continuing to grow our complement there.

Recruitment doesn't come without challenges. When we speak to challenges we certainly want to speak to the responses that the department is currently looking at, working very closely with our partners at Health PEI. Demographics in general aging; that is no surprise. We do see an older – an aging workforce. What we're looking at in terms of how we respond to that is implementing some collaborative practice models.

So, looking at opportunities to have nurse practitioners working with family physicians to deliver care in the right areas, we're also looking at how we transition our physicians prior to their retirement and transitioning the new hires we have in as well. Succession planning and of course providing that right level of support to our new family physicians to ensure that they have success in their new roles. There is a bit of a committee underway right now that's looking at that process in and of itself to ensure that everything from communication right through to the orientation of those new hires is done properly and is done efficiently, so that is work that's ongoing as well.

A lot of doctors when we speak to them, or physicians or nurses for that matter, they do have a preference sometimes for urban practice, so we're looking at different incentives to have them work in the rural areas. Also, we're considering telehealth as an opportunity, whether that exists to have telehealth operations in certain areas of our province, it's something that we're also considering at this time.

When we speak to doctors – and we'll talk a little bit about that in a second – but when we hear back from some of our health care professionals there's a large emphasis on work life harmony or work life integration. So we're looking at how we brand ourselves as a province and what we offer as a province. What would attract people to come to PEI and want to live here, and more importantly, want to stay here. That's a large part of the work we're doing as well.

Also, we know spousal assistance is a key component in attracting and retaining strong medical professionals here – health professions. Working with partners in government and also in the community to establish strong support systems so that once we again get those professionals here, their spouses can be integrated into the work force and hopefully we have a larger opportunity to keep them.

In terms of how we focus our retention efforts, we did survey our physicians. We did that for a few reasons, but we more so, wanted to hear what it was that attracted them to Prince Edward Island in hopes of strengthening and understanding of that work, but also ensuring that we continue that good work forward. A lot of what we heard was around work life balance, work life integration, harmony, whatever we call it. The different opportunities that exist certainly are important; people have an interest in certain areas and so what opportunities exist for them was a big proponent of that. The Island environment – we speak to the life style – all of the great opportunities that exist here for residents of the Island, so that's a big piece. Also, we had a number of physicians who saw this as an opportunity to come home and so we were happy to facilitate that process as well.

I'm kind of jumping through this quickly. Did you have anything you wanted to add?

Kevin Barnes: No, I'm good.

Rebecca Gill: Okay, perfect.

In terms of our immediate priority – right now we are currently recruiting for 10 family physicians and we do have a need for family physicians primarily right now in the western end of the Island, so ongoing physician recruitment efforts exist there. We also have a need for a number of specialists which are listed there as well. Contact has been made and ongoing efforts are currently happening to try to attract individuals who have the right credentials and the right qualifications into these roles.

From a nursing perspective, nursing is ongoing. It's something that we constantly deal with. There are a number of hard-to-recruit-to nursing positions. Just based on the work that they do – it's specialized, let's say, in OR or in intensive care what not – we need the right balance of new graduate nurses who are coming right from university with experienced nurses who worked in their field or practiced for a number of years and can help support the proper level of health care to our Islanders. It is something we see on a regular basis.

Our nurse practitioners, as I mentioned as well, that is a growing area and we are continuing to recruit. We work very closely with UPEI for their program. Also, have to (Indistinct) in a few other areas that have nurse practitioners programs as well. We stay in contact with them and when our opportunities are ready to be posted we certainly work hard to ensure that we get the right candidates attracted to those positions.

That is in essence our presentation today. If anyone has any questions?

Chair: Thank you very much.

I'll now open the floor to questions. I do have a list that's being compiled at the moment. Just indicate to me and I'll put your name on the list and I will acknowledge when it's your time to speak.

First on the list we have Sidney MacEwen.

Mr. MacEwen: Thank you, Chair, and thank you Rebecca and Kevin and minister for coming in today.

I guess the first question I wrote: What's the budget for the – how long is the Secretariat office been in place for recruitment and retention and how has that budget gone over the years and what's it currently at?

Kevin Barnes: Perhaps I can speak to that.

The Secretariat has actually been in existence, since I believe, it's about 2009. It's been in existence nine to 10 years roughly. The budget for the Secretariat is in the neighbourhood of – I think 1.8 to $1.9 million for that. That would include the staff of the Secretariat but it would also include funding for some of the grant programs that we talked about, the return-in-service program and the Family Medicine Sponsorship Program, some of those student programs. Primarily that budget is probably more the grant line than other costs; but to give you a sense of the $1.85 million.

Mr. MacEwen: How many salaries are in that budget? How many staff?

Kevin Barnes: There are four positions within the Secretariat.

Mr. MacEwen: Four full-time?

Kevin Barnes: Yes.

Mr. MacEwen: In 2009 it was separated from Health PEI, correct, and brought back into the department?

Kevin Barnes: In 2010, actually, when it was formally in the department of health when government undertook the reorganization, Health PEI was created in 2010, and the Department of Health and Wellness was created. The recruitment Secretariat was essentially assigned to the Department of Health and Wellness at that point in time.

Mr. MacEwen: Has that been reviewed? You've been around that long, Kevin, and minister; you're fresh into the role. Has that been reviewed? What are the thoughts on that separation and has it been successful, do you feel?

Kevin Barnes: There has been consideration since 2010, of that location of the health recruitment within the Department of Health and Wellness. That's come up from time to time. We have had a look at: Is it properly placed? It is more in line with Health PEI?

There are, I guess, are benefits to having it at the department. It does – and as I mentioned earlier in the presentation – there's a fair bit of work that is undertaken at the secretariat that really focuses on understanding the workforce profile, the demographics, looking at supply and demand and those types of trends, and it's just more of sort of a policy side of the house which really does fit with the Department of Health and Wellness perspective.

Certainly, when you get into the individual recruitment of positions, as that does link closer to Health PEI, I think we're quite comfortable that that relationship and the protocols that are in place between Health PEI and health recruitment to make sure that there's clear communication around the recruitment priorities. I think it allows the model to work with health recruitment at a departmental level.

Mr. Mitchell: I think I'd like to take the opportunity to stress the collaboration between Health PEI and the retention part of our department is very open. It's very consistent and in my briefings since taking over the department, I know they work very well together to identify needs, both in numbers and in areas, where focuses should be spent.

I think that relationship is strong. It's been strong over the last number of years and we'll – in new ways, probably just because of the way things are, physicians trying to reach work/life balances, reduce panel sizes – I think that has to be maintained and both sides understand and realize that.

Mr. MacEwen: The reason I ask that about the Health PEI department of health thing is – and I'm fairly new into my role as the critic for health too, but it keeps coming up and, again, as it always does in past history with all the reorganizations in health. In simplistic terms, does the left hand know what the right hand is doing with Health PEI and the department?

I'll give you one example. There were a couple of members over there last fall. I know it's a little bit different. We met with the psychologist association of PEI and it really seemed like the ministers hadn't even been talking with them. Now, I don't know how that all shakes down recruitment wise, but they were saying: We know people that are from away that would like to come here. The ministers were saying: Well hook us up with them, let us know kind of thing.

To me, why isn't that conversation happening a long time before. How can you – can you assure me that with the associations – whether it's the medical society or the psychiatrists or all those ones you listed, up to date, what are we doing in touch with those people? Because there seemed to be a disconnect last fall there.

Kevin Barnes: In terms of the individual, sort of, specialty areas and those types of things? I think, hon. member, some of the things that are going on to ensure that there's clear communication is recruitment and retention works very closely with medical affairs at Health PEI and medical affairs has the overall sort of responsibility for the physician, physician practice, and the positions that are available within the province. There are really ongoing linkages and communications with medical affairs as a large group.

In addition to that, when there are identified specialty areas, practice areas where there are vacancies, there is a very close involvement – I think I mentioned it earlier in terms of the recruitment process – with members from or practitioners that are in that specialty area. So, as we're starting to recruit, say, for an anesthetist, we are actually working very closely with the anesthetist that, may be working say at the QEH or PCH, and so that there's an involvement of them as professionals within that process.

Sometimes we do get, through that process, people coming forward and saying: I have a colleague, or I have somebody that I know that I went to med school with that may have an interest. We build in that sort of feedback by having those practice areas specifically involved, essentially, in the recruitment efforts.

Mr. Mitchell: I think, if I might add as well Kevin, the slide that indicates this year we have 11 new hires and last year 25 new hires as well as the nurses; significant numbers up in the 50s. What's going on does work.

When you go out and recruit these professionals, retention is something that we continuously have to work on to make it the best environment that they could possibly work in and any other jurisdiction in the country or internationally, we want them to remain here. But, what's going on is working and it's working well. That slide that indicates how we've been doing over the last four or five years, year over year, we are seeing doctors come to Prince Edward Island.

Now having said that, we do have doctors that are retiring and obviously we had a couple of doctors retire in the west end of the Island that happened fairly quickly, that we're still trying to deal with that. The recruitment part is ongoing, working well. Retention is something we're continuing to work on, but retirements, we do need to focus on; on a plan, on a forward plan. Who do we have in the system that could retire or could be looking at retiring within the next two, four, five years to kind of develop that go-forward plan?

But, to get a good handle on that, that's where things are moving. To stress, is it working and is the collaboration part with Health PEI working? I think it's working well; I think the data kind of indicates that. But, we still have lots to do; no doubt about it.

Mr. MacEwen: I'm glad you talked about that, the focus on retention because obviously, with that chart, that's great. Throw up 25, but we could have lost 30 that year, right?

Mr. Mitchell: Absolutely; right. That's right (Indistinct)

Mr. MacEwen: That's the big thing. We can inflate the numbers and we can make it look good, but we could still be going down in total numbers – physicians, you've got it up kind of thing, or flat lining, too. So, I think that's important and I would suggest when we present, that is to present that real number, not just how many we've gained. Let's show is it plus one on the year? Is it plus two? If we could get that information back that would be great too.

As far as the 1.8 or 1.9 million, is any of that contracted out in the recruitment (Indistinct) as part of the budget of your budget? Is there any of that contracted out?

Kevin Barnes: There could be from time to time. We may use – and it would be a modest use of funds – we may use placement firms to assist with hard-to-recruit physician positions. The reliance on those firms is limited and they usually charge sort of a contingency fee. If they find somebody, we hire them; they'll charge us a fee.

Our expenditures on that in the run of a year wouldn't exceed 25,000. We rarely use those firms, so yeah. On occasion there is and that would be the nature of the expenditure, but as I say, our experience in recent years is that it's been very modest. We've sort of built our expertise more in-house and are kind of relying on that.

Mr. MacEwen: I don't have the numbers right on front of me of the divide between salaries and programs or offers kind of thing, but that's the most obvious question that I'm sure you guys get, and we get too, is why are we not throwing it out there to firms and is it modest because they're not seeing success? Or if it's, as you say it's based on success, if we do recruit someone successful to come to these people, why don't we have everybody out there, all recruitment firms? How are their success rates versus our own internal success rates?

Kevin Barnes: Our experience, hon. member, has been that – and we've used various recruitment firms over the years, our experience has been that our ability to recruit internally is stronger, typically, than the recruitment firms.

They certainly will have a roster of names, but when it gets down sort of the fit to PEI and the interest in coming to PEI, and the scale of recruitment that we might offer the firms in relation to other jurisdictions – we probably don't get as much, sort of, attention and focus from those firms. So, we found that it's hit and miss. We've had a few successes for sure, but I think we're comfortable that we've got a stronger approach through our own staff.

As the minister has indicated, we've had a number of hires over the past few years. I think that's indicative of the success that our team has really had in terms of recruiting physicians.

Mr. Mitchell: I think, too, the availability of many platforms now for reaching out with the advancement of technology aids the process of being able to do a lot of it in-house as well. I think in years past you may have had to rely more on a recruiter because you didn't have all of those access points to reach out to others, and that's what they're using as well today. I wouldn't say primarily, but very readily.

Between the two, it's a good fit. It's a good match, and it's been very successful.

Chair: Colin LaVie.

Mr. LaVie: Thanks, Chair.

Thanks, Rebecca and Kevin, and minister, for giving us a briefing. I know the minister was up to Souris hospital and had a tour and was hit with a lot of questions and hopefully he will –

Mr. MacEwen: Address them.

Mr. LaVie: Address them, yes.

You say we have 225 doctors on PEI right now; family physicians?

Kevin Barnes: No, that would be the entire complement, specialists and family physicians.

Mr. LaVie: Oh, that's specialists, too. How many of them are family physicians?

Kevin Barnes: I don't have the exact number, hon. member. I'm thinking it's somewhere in the neighbourhood of about 110, but I can bring –

Mr. LaVie: A hundred and ten.

Kevin Barnes: – that number back.

Mr. LaVie: And how many family physicians do we need to bring PEI up to the full complement?

Kevin Barnes: I think, as we showed earlier here, we are currently recruiting for – I believe it's 10 family practice physicians, and essentially those would be the vacancies, hon. member, that exist, and so filling those would sort of bring it up to the full complement.

Mr. Mitchell: And seven NPs –

Kevin Barnes: And seven NPs, yes.

Mr. Mitchell: – in collaboration with those.

Mr. LaVie: So 120 is the full complement that it'd take for PEI to be up; so 10 more and we're at a full complement and that would give everybody on Prince Edward Island a family physician?

Kevin Barnes: That would provide full complement of family physicians, yeah.

Mr. LaVie: So you have 25 nurse practitioners?

Kevin Barnes: Yeah.

Mr. LaVie: And these nurse practitioners, do they got to work with a family physician?

Kevin Barnes: Yeah, currently there is a requirement that NPs work in what's called a collaborating practice with a physician. So essentially, that ensures that they have a relationship with a family physician that allows for a referral, essentially, of patients that have higher acuity needs, those types of things, so there is that sort of linkage or process for NPs to work in that –

Mr. LaVie: So when the NP works with a family physician, is that – where is the family physician? Is he in Charlottetown, is he in Kings County, is he in Prince County, or –

Kevin Barnes: Yeah, they have various locations. It would be – and I'm not sure we have the actual breakdown of the 25, but essentially it would be working in family physician offices.

I'll give you an example, hon. member. In Cornwall, for example, we have a family physician that replaced Dr. Stewart back in the fall, the former fee-for-service physician. That doctor came, he started to practice on a salary basis, and in order to be able to address the full patient load that Dr. Stewart had, we added an NP into that office – so basically working in that practice, in the collaborating way, with the physician.

Mr. LaVie: So a nurse practitioner could work with a doctor from Cornwall, in Cornwall.

Kevin Barnes: Yeah.

Mr. Mitchell: Yeah.

Kevin Barnes: Absolutely, yeah.

Mr. LaVie: If 120 family physicians – within the next 10 years, how many is due to retire?

Kevin Barnes: I'll have a peek here. We've done a little bit of – and of course, it will depend, obviously, on a number of things – but we have done some work on that. Our expectation as we look ahead – and we haven't done 10 years, or I don't have 10 years available – we are looking at in the neighbourhood of about 12 family physicians over the next four years.

Mr. LaVie: Twelve in the next four years.

Kevin Barnes: As I look ahead to 2019, 2020 and beyond.

Mr. LaVie: How many retired in the last four years?

Kevin Barnes: I don't have the exact number of who's retired in the last four years. We have had a significant amount in this past year, whether they'd be retiring or sort of moving to other areas of practice.

We've had some, for example, that have left family practice, gone to work with either VAC or WCB or other practices like that. I'm just having a quick look here.

Okay – 11, actually.

Mr. LaVie: Oh, 11?

Kevin Barnes: Yeah.

Mr. LaVie: When a doctor decides he wants to practice, a family physician in Prince Edward Island, who decides where the doctor goes, whether it's Kings, Queens, Prince? Who decides?

Kevin Barnes: Well, I –

Mr. Mitchell: You can go ahead.

Kevin Barnes: Basically, physicians are hired to specific opportunities that are here in the province. When we're recruiting and looking at physicians that are available for recruit, they are identified as to where those physician vacancies are. So of the 10 that we have mentioned earlier, they're primarily in either, sort of East Prince or West Prince area right now. So those vacancies exist in those regions or areas. Physicians that are coming to work here are aware, and are coming in sort of response to those particular opportunities. So they don't have an opportunity to go and work in Kings County if they're seeking a position that is posted for West Prince, for example.

Mr. LaVie: So if they don't want to practice in West Prince, where those two positions are needed or whatever's needed, what happens then?

Kevin Barnes: Again, we would focus our hires, whether that be a salaried physician or a fee-for-service, we would focus our hires on where the opportunities and where the needs are.

Chair: Jordan Brown.

Mr. J. Brown: Thank you very much, Chair.

A couple of things, Chair, that I have been wondering about: I'll start off, perhaps, first, with what I'm going to call kind of impediments to hiring. Part of this might be my perception, so I'll ask the questions and I don't even know to what extent you folks will be able to answer them, but I know from having friends and family members and that that are physicians that there is a significant kind of hurdle to jump over when you move from one jurisdiction, even within Canada, to another.

I'm not sure whether it's our place to get too far into this, but I know probably 15 years ago within law societies across the country we had looked at this and basically, there was an overwhelming feeling at the time that those kind of hurdles wouldn't stand up to a charter challenge if the – in this case – college attempted to enforce them, I'm curious as to whether that discussion's ever been had at the college level here on Prince Edward Island.

Kevin Barnes: There certainly has been discussion with the college relative to getting some clarity and understanding as to what their expectations are for licensing. I know there have been cases in the past where it has been a bit challenging to get physicians licensed, or perhaps the process is one that's a little burdensome on the

physician, time-consuming and all of those types of things.

I think certainly there has been discussions in the past from the department with the college around how we can make that process more transparent, more timely in terms of physicians, particularly those that are coming from other jurisdictions within the country; and certainly, there's a different sort of consideration for foreign-trained, but certainly from within the country we've advocated and had discussions with the college on various occasions designed to really make sure that that process is as responsive and as consistent and transparent as the case may be.

I know certainly there's discussions on a regional level, as well, as to whether a regional model for, a regional sort of college model might be something that would be a consideration. I think we've got a ways to go there in getting some acceptance with the various jurisdictions around that, but I certainly recognize, minister, that there are challenges and there have been in the past, and we've advocated with the college around making that process certainly much more open and continue to do so.

Mr. Mitchell: If I might comment as well, minister: as recently as last week in other discussions, some of what you have just suggested there came to light as well in conversations. I think as a new minister coming in recently, I think it certainly would be doing my due diligence to have those discussions with the college, to look at regional scan as Kevin mentioned, what's going on in our region in regards to other colleges; in fact, in other areas in other jurisdictions of Canada, to see where we lie in the essence of qualifications, transparency going forward as far as what qualifications should be in place.

I think my commitment would be to undertake the beginning of that process to determine if there's some other process that would make it more streamlined, more applicable to somebody coming from anywhere that has comparable training. Your question is timely, it's just a few days ago that I had it presented and agreed that it was something that I would dive into and see if we could get a better feeling for and what ways could we expand on that to make it better, I guess.

Mr. J. Brown: There's a couple of other pieces of that I'm kind of curious about, and that I might say, king of bugged me over time, another would be the kind of fee/insurance piece of it; probably particularly related back to locums. It wouldn't necessarily be confined to that. It will be my understanding that if a physician was to want to come practice say for six months on Prince Edward Island, or for two weeks or six days or whatever it might be, they'd still pay the full fee here to come and practice whether they have insurance in their own jurisdiction or whether they don't.

Again, I'd say that would be another piece of it that as a lawyer in a self-regulating industry would totally baffle me, where you're effectively insured twice and basically you have a group that's causing you to pay a second fee – I'm not going to get into the reasons why I might think that might be – but I'm not sure that they would necessarily hold water if you got right down to the context of it.

I'm wondering whether anybody has raised those sorts of issues with the college here on Prince Edward Island or the medical society.

Kevin Barnes: To your point minister, yes, we have found and had some frustrations with that process in the past. It has been raised with the college and it is primarily the college that we're referring to here and we have expressed concerns that creates barriers to locums coming here. To date, we've not had a success, in I guess, changing that fee structure, changing that practice, but certainly there has been concern raised around the barriers that that presents, yes, point was taken.

Mr. J. Brown: I do have more questions here but on a different subject, so I'll maybe throw that at you.

Chair: Sure, we'll move on to the list again and we move to Kathleen Casey.

Ms. Casey: Thank you, Mr. Chair. Thank you for your presentation.

We all know that doctor recruitment is not a unique challenge to Prince Edward Island

and we've been hearing that throughout your presentation. How many Island students are currently in medical school?

Kevin Barnes: We'd have to check that, hon. member. I don't know the exact number at this point in time but we could bring that back.

Ms. Casey: Thanks. Would you also have how many are doing their residency right now, if they're doing them in Canada or in the United States?

Kevin Barnes: As well, we could get that information.

Ms. Casey: The reason I'm asking that question is you did a presentation on the Family Medicine Sponsorship Program and that you only sponsor one student and I thought why wouldn't you sponsor more students. I think your investment in – it's not a lot of dollars in the whole context of trying to have more doctors in Prince Edward Island – if you upped your number with the ratio that you have now in medical school, I'm thinking one is: why choose just one. If you subsidized or helped out more students they'd be more apt to come this way.

Kevin Barnes: I take your point, hon. member. The Family Medicine Sponsorship Program as I may have mentioned through the presentation is a relatively new program, where in the sense that it's about four or five years old. It really has started essentially as a pilot project to understand how subsidizing students early on in their education, how that would actually sort of work through the system and how we could secure resources for particular placements at the back end.

We're just getting to the point where the very first student is coming out of that program; Dr. Craig Malone is starting later this year. I think we're sort of seeing – I guess we wanted to take the time before we made a significant investment in that program recognizing that we had to have other incentive programs and other ways to encourage physicians to come to PEI.

Essentially, I think if we introduced that as a pilot, certainly if we find good success with that, there's a lot of uptake on that that the physicians are prepared to work the five year return-in-service, which is a little lengthy compared to other commitments. I think we could see an expansion of that program in the future. So subject to sort of our experience with the first few students coming through (Indistinct)

Mr. Mitchell: I think it's important too, to mention hon. member there, that as a package that's one piece, we're also involved in five seats as far as you know. We're also involved with the internships here. We're touching on 10 or 12, basically at the end of the day; it's not just focusing on one. But that could – your point is well taken, that's something that maybe could be moved forward, looked upon as successful now that we're sending a doctor to Souris that came through that program. So certainly, it's something maybe we could reassess it and say: Is it time to make it bigger.

Ms. Casey: Just back to that program, is there a competition for that program? How does a potential medical student apply for that program? Then, if you have one doctor who's successfully coming out of the pilot program – so you're saying after five years, it would make sense to me that you would have a new student come in each year so that you would have – after five years you would have data. Instead of having data for one person in five years, there's data coming out every year and they would have more experience in the five years.

I'm just thinking: Is there competition for that?

Kevin Barnes: The process is, there is in fact, a competitive process and students are sort of made aware of the opportunity early in their medical education. There is an application process. There is a requirement, I believe, for a written submission to go with the application. There is a preference given to PEI applicants, those that have a home here on PEI. So yes, we do have sort of a criteria by which we would evaluate and assess the applications that are made for that program on a year-to-year basis.

Ms. Casey: Thank you.

I'm going into – I've always been an advocate for internationally trained doctors. I have a lot of them who live in my neighbourhood and who are quite frustrated

with the process through the College of Physicians and Surgeons. For the last, I guess, 11 years, this is something that's been kind of a passion of mine and I've been following closely any time there's improvement in programs to recruit internationally trained doctors.

Just this week, Nova Scotia, I don't know if you're aware, but Nova Scotia, their minister of immigration has just introduced a new stream in their new Provincial Nominee Program to make the immigration process easier for internationally trained physicians. They are aiming their recruitment process at doctors from the United Kingdom, Ireland and the United States because they have training equivalencies similar to those of the college of physicians in Canada.

The minister, in her article, the immigration minister in Nova Scotia, said they could process an immigration applicant from somebody who's already has a job offer in five to 10 days. I know doctors in Nova Scotia are fully in support of this program and it's just another tool to allow for the recruitment process to be easier to increase your doctor complement.

Is this something – are you aware of what happened just this week in Nova Scotia? And is this something that you might be asking our minister responsible for immigration to follow suit?

Kevin Barnes: We certainly are aware of the measures that have been taken in Nova Scotia. Interestingly enough, minister, we have been targeting the UK and particularly Ireland, as well, for the last few years in terms of physicians. We've had two to three hires from Ireland in the past couple of years. We've been very fortunate to be able to attract those physicians; and as you say, the training equivalencies are quite comparable to the Canadian environment.

We still have a little bit of a requirement from a college perspective for supervision for the first few weeks of the individual's practice on PEI, which is a little bit of – we'd like to see some changes to that particular piece, but we are focused on that particular market certainly as a source of physicians. In terms of means to sort of move those forward in a faster way, we're most interested, I think, in what's gone on in Nova Scotia and we'll have a look at that.

Ms. Casey: Thank you.

Another kind of passion of mine, and you've all followed it, and I was quite pleased that in the last session of the Legislature, legislation was passed to pave the way for midwifery in the province. I'm wondering if you can – I know I've been talking to a midwife who's now practicing in Nova Scotia who owns a home and lives part-time in Prince Edward Island, who practiced for, I think, seven years in Ontario and now is practicing in Nova Scotia.

I'm wondering where it stands with the province with regards to midwives. When will they be starting and when will we be opening the door to midwifery on Prince Edward Island? There's a lot of interest. Young people moving to the province, you talk about spousal support, when we're recruiting people or people are coming back to the province, and they've had children in other provinces through a midwife and now they come to PEI and that service is not available. So can you enlighten me as to when we may have our first midwife in Prince Edward Island?

Kevin Barnes: It's not necessarily sort of in what we've been prepared to speak to today, hon. member, but I think I can probably give you a little bit of feedback on where the department is relative to that process.

As you're aware, the registered health professions act has been tabled in the House. We expect that act to be proclaimed later on this calendar year. There will need to be the development of regulations to go with that, both general regulations to go with the act but also profession-specific regulations. So, it is going to follow a model very similar to the regulated health professions, whereby each profession that is under the registered health professions act will have a specific set of regulations that guides their practice.

First step in the process would be proclamation of the act and the creation of general regulations, and we're expecting that's probably later this calendar year. From there, there will be an application process. We have, I believe, a number of professions who have expressed interest

already. I know midwives certainly have expressed interest in becoming a registered health profession. There are a number of others as well.

So we will go through a process once those general regulations and the act are proclaimed, to assess and to start the process of bringing those various professions in under the registered health professions act, develop with them specific regulations to their practice.

I don't have a specific timeline for where midwives fit in that, but just to kind of give you a sense, the process will first and foremost involve proclamation of the act and the general regs, and then an intake process for those professions that come with that and development of regulations that go with that. Midwives certainly would be one of those professions.

Ms. Casey: My final question is the experienced midwife that I've been speaking with would be very happy to consult or help you out, or would be willing to collaborate with the province in setting up the midwifery program, and I'm able to pass on that name to you.

Kevin Barnes: Sure.

Ms. Casey: She's willing to do that.

Mr. Mitchell: That'd be great.

Kevin Barnes: Thank you.

Mr. Mitchell: Thank you.

Ms. Casey: Thank you.

Chair: You're welcome.

Next on the list we have Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

Firstly, I want to thank the hon. member for her question. Having also been in conversation with, I suspect, the same woman, there was obviously delight last year when the registered professions act was passed, and now frustration because it's taking time to be proclaimed and for the regulations and for the registrar to be put in place, etc cetera. Thank you for asking that.

I also want to reference a comment made by another hon. member, Colin LaVie, who asked about the full complement. You mentioned that with 10 more physicians we will have a full complement. I want to know – and it wasn't exactly made clear to me in the question or the answer – whether, when we have a full complement, 120 physicians here on Prince Edward Island, will that mean that every single Islander has access to a family physician? Are they the same thing?

Unidentified Voice: Good question.

Mr. Mitchell: I'll take a crack at that, hon. member.

I think what's important to consider here, like we're talking 10 doctors, we're talking seven new NPs to work collaboratively with doctors that are either some of the new 10 or some that are existing. As was discussed earlier with our new physicians it's about striking work-life balance. It's about striking a client panel size that they can work with to maintain the other parts of life that they need to be with their family.

I guess the short answer to your question, that's hard to define today. We do know we have a patient registry. We do know that we will have doctors retiring. We do know that we'll have identified up to 12 in the next five years. So for me to sit here today and tell you that every Islander would have a doctor, I would not be able to do that. I think what's important to indicate, that we understand there are Islanders that do not have a doctor. We understand that the registry is a significant number based on various reasons, but we are working towards providing quality health care for every Islander when they need it.

Obviously some of these doctors, when they come, depend – it's whether they're fee-for-service or salary, they get to determine that through the master agreement, of course, right? So to specifically say who's going to pick up what numbers, it's hard to do, but we know we have challenges there. We're working with them. They're what keep all of these people up at night. There's no question about that. So we'll continue to do our absolute best to control those numbers and provide the best possible health care we can.

Dr. Bevan-Baker: I appreciate your answer, minister, and I'm still not quite sure where we stand. Of course, this is a moving target. We have physicians leaving, we have physicians coming, we have an increasing population here on the Island, so I understand that it's very difficult to match supply and demand perfectly. It's just not going to happen.

You brought up the patient registry there, and there's some question as to exactly what that number is. CBC reported a few weeks ago it was 8,000; a previous report not very long before, there was 5,000. So I'm interested whether you have an accurate fix on that.

I realize there are many people, many Islanders out there who do not have a family doctor, who just don't register, so this is not the full number; but I'm wondering, firstly, what that number is – as far as you're aware, the most accurate number you can give us – and if there is a review underway of that patient registry whole process? If so, where is that? Can you give us an update?

Mr. Mitchell: That's one of the first questions, obviously, hon. member; I asked when I took my chair just a few weeks ago. I think the number currently hovers around 9,000. Is that a good number? Certainly not. Is it a number we're pleased with? Absolutely not.

There are a few mitigating factors, like down east our complement is shorted down there by two doctors, of course, so the panel that existed before is now sitting on a registry in those numbers. We have some possible similar situations in the west where some have left the current panel of the two doctors and have gone onto the waiting list; and quite frankly, our immigrant population, we have a lot of people moving to Prince Edward Island which will be a part of that number as well.

So, is it a number we're proud of? Absolutely not. Is it a number that we're trying to work with? It definitely is. As I said earlier, that's what keeps these folks awake at night trying to get out and do their job, to get the proper doctors here, to fill all the requirements that we need to get those numbers down to a level of zero, hopefully, at some point in time.

It is a challenge. My time in nearly 11 years here, there was a significant number on the list and there still is. That's ever changing because some leave, some come, and it's a number that we definitely have to work with. It is what it is and we're trying to do our best to get it reduced.

Dr. Bevan-Baker: I think we're all aware of the complexity of what you've just described, but the second – I know I asked a couple of questions in my last go. The second part was whether there's a review of this sort of general agreement that this patient registry is not functioning very efficiently or effectively.

Is there a review of the patient registry process underway, and if so, where are we with that?

Mr. Mitchell: I don't have an answer to that question specifically. It's something that maybe we could take a look at. With the identifying 10 physicians, the family practice part of it, with the assistance of NPs; that could take up to 2,500 or so per arrangement there. I mean there are opportunities before us to greatly reduce that, but that's not to say that we shouldn't take a firm look at that.

I'd have to verify this, but I think there was an effort last year to kind of determine − actually, physically call everybody to say: Are you still there and do you still need a doctor? I'd have to confirm that to be absolute certain on that, hon. member. But, I think if it hasn't been done, I'm not suggesting that we shouldn't take a run at that again as well.

Dr. Bevan-Baker: Modern trends in providing frontline, primary medical care have changed a lot in the last little while, and sort of gold standard appears to be moving towards primary care model of collaborative care. You mentioned in your presentation collaborative care, but it didn't extend beyond the partnership between the general practitioner and his or her nurse practitioner.

I'm wondering whether this idea that we have to funnel all patients through a family physician, through a general practitioner, rather than this more collaborative primary care model which has been adopted in many

other places, whether there is a concerted effort within Health PEI to adopt that sort of model, and if so where are we with that?

Kevin Barnes: I think, hon. member, in terms of the collaborating practices, and we did speak on that a little earlier in terms of physician and collaborating practice with an NP. I guess I'll speak to it from the concept of access to the nurse practitioner.

In the case of a physician and a nurse practitioner working together in a collaborative practice, there is the ability for the NP to see patients essentially on a direct basis. So, there's not a requirement for those patients to filter through or be seen by the physician first. They can be referred directly to the NP. The NP, within his or her scope of practice, then does have to maintain and refer those patients to the physician when it's beyond the scope of practice when the complexity of the matter presents itself.

We do have NPs, and I'll give the example of Cornwall just because I know him personally. We do have a practice, for example, in Cornwall where you can go and see the NP directly without having a, sort of, referral or any interface with the physician. So, that is actually happening in that context right now. Again, we would have that happening in various sites across the province.

As we start to look at other health professions beyond physicians and nurses, certainly the primary health centres that Health PEI have, there is access to other services at those facilities right now; the dietitians, the physio, occupational therapy – those types of things and they do happen as well. But again, certain things do sort of link back to a medical practitioner, whether it be NP or the physician. That sort of is still kind of a core of the practice.

Dr. Bevan-Baker: I'd like to talk about a specific situation in my district in the South Shore. We lost a doctor recently in Crapaud who moved to Cornwall, perhaps the same clinic you're talking about. That's great for Cornwall, but it certainly leaves local access to a large number of my constituents, and constituents from neighbouring districts as well, without access to local care.

There's been a very active effort within the community to work with government on alleviating that problem. They have raised money. The South Shore health and wellness incorporated have made a huge effort and they are promoting the idea of a primary health care clinic, which again goes beyond just a doctor and a nurse. It involves a much more holistic approach to care, preventative models, promotion of health, testing being done and using mental health professionals. For example, nurse practitioners absolutely, nurses, physiotherapists – all of those people within a clinic in the rural setting.

I want to ask a general question, first of all. Is there a vision within Health PEI to provide that sort of primary health care clinic in order to provide frontline medical services to rural Islanders?

Mr. Mitchell: Thanks for the question, hon. member.

I guess I'm going to address it in a couple of ways. I am fully aware of the situation you talked about in the Crapaud area. I have had the opportunity to sit down and talk to many of those community folks that you speak of, and our discussions went very well from my perspective.

When you look at the situation that you find themselves in today, that's a community that's had a doctor for – I think it was over 100 years that a doctor has been in that –

Dr. Bevan-Baker: Yeah, since 1847.

Mr. Mitchell: − yes, in the heart of that community.

I appreciate that and I understand that, from many different lenses, and some of them are from the chair I used to sit in as well, right, and how important that is to building and strengthening communities.

The situation they find themselves in with the doctor – they came and deciding that's not exactly where you want to do practice at, but within the regions as we spoke to, he was in that particular region, allowed him to pick that practice up and move it down the road to another area. That's well within the contractual business that we do with him.

Having said that all, though, I have spoke to the community and in the second part of your question with providing medical services within rural PEI, we currently are working with nurse practitioners now within Kinkora and Borden, and another rural community which is leaving my mind at the moment.

I would certainly like to look at ways that we can support that area and obviously they had suggested to me a nurse practitioner would a good fit for them at this point in time and it's something that I continue to work with them. We've identified nurse practitioners that we will be putting in the system.

As has been alluded to today, our primary pressure point is in the west, but based on history and based on need, and based on other aspects of it, I indicated to them fully that it would be something I will give my full commitment to and will continue to. I know I have an email to respond to as we speak, but I have a little more work to do, so until I get to that level, I will respond when I know a little bit more that I can do a little bit more.

But, I'm fully understanding of where they are and what their needs are and I'm looking to work with them on that. But we do have a program now of NPs that are working in rural Prince Edward Island and this is another good, potential fit and we'll see if we can get to a good outcome, I guess, is what I'm looking for.

I hope that answers your question.

Dr. Bevan-Baker: Yeah, I'll ask specifically about what else might be able to be done because the South Shore health and wellness incorporated have been very proactive on this and they've created a situation where they themselves have set up walk-in clinics. They're prepared to provide the space for a new doctor/nurse practitioner, whatever primary health care centre, and even to stock that with the equipment and supplies required.

They would like to have a closer collaborative arrangement with the department, and something just as simple as giving email contact and information to SSWHI, the group there, for potential candidates; people who are coming. Is that something – they are willing to do the work to be even more proactive than they are if you would be willing to give them that sort of information. Is there a possibility of that happening?

Mr. Mitchell: I think there's a very good possibility of that happening. We've already had meetings. I suggested to them when I get to a point where I can sit down and bring them up to speed of where we are today, I will definitely do that. I think that process is already in the works, hon. member, and I will continue to meet with them and –

Dr. Bevan-Baker: – just as simple as giving email contact information to SSWHI, the group there, for potential candidates, people who are coming. Is that something – I mean, they are willing to do the work, to be even more proactive than they are, if you would be willing to give them that sort of information. Is there a possibility of that happening?

Mr. Mitchell: I think there's a very good possibility of that happening. We've already had meetings. I've suggested to them when I get to the point where I can sit down and bring them up to speed of where we are today, I will definitely do that. So I think that process is already in the works, hon. member, and I will continue to meet with them and bring them up to speed; but as we hear today, there are processes in place and that's the process we're looking to aid the situation in Crapaud.

I don't have it solved today, so I'm asking for their patience, of course. Certainly it is top of mind for me, top of mind for the department, that there was – they had something there that was working well for them and they don't have it anymore, and because it's been there for such a significant amount of time, it's kind of entrenched in the community and I can appreciate that. As I said, there are other reasons why that should continue, and I'm trying to find ways to help them with that to continue.

Chair: Hon. members, we have two presentations today, so we allotted an hour for each one and we actually articulated that part coming in here today, so they would be prepared for a presentation of 20-25 minutes and then field questions for the next half

hour to 40 minutes. We've extended this – I've kind of done it as the Chair, took it on my own, but I didn't ask, and I'll ask now, if our presenters mind fielding a few more questions.

Kevin Barnes: Sure.

Mr. Mitchell: I'm here all day.

Chair: We do appreciate it. We have a lot of interest in it and it's an engaging conversation, so we do appreciate that.

However, I want to remind members, if you could please keep your preambles to a minimum. I still am halfway through the list, so we'll work through it. Peter, do you have another question?

Dr. Bevan-Baker: I do, Chair.

Chair: Jordan, sorry.

Mr. J. Brown: Just on the scheduling (Indistinct), I wonder if we might – I know I have a few more questions here. I suspect other members probably do, too. I wonder if we might consider dismissing the second group and continuing on to finish out this presentation. I'm just cognizant of the fact that we're holding these people here and whether we're going to, in fact, get to them and expect to have them done today.

Chair: Well, I think what we'd have to do is, first of all, ask our next presenters if they're willing to stay, and secondly, have unanimous consent to extend this particular meeting. So with that said, I will – I'm sorry to speak from outside the rail – but would our presenters have any problem with a delay in presenting today, or would you prefer to come back another date?

Unidentified Voice: I can stay.

Chair: Okay, great.

So now I'm going to ask our committee members if we have unanimous consent with the possibility – we're not at 3:30 yet, but with the possibility of extending our time here today.

Mr. MacEwen: Chair?

Chair: Sidney.

Mr. MacEwen: I don't think there's a set time (Indistinct) meeting. It's usually open.

Chair: In our request, we did give them a time –

Mr. MacEwen: Our request to our presenters.

Chair: Yes, and we give them a timeframe that we're working within. So generally, when we book, today we had them booked in for each approximately an hour. So in consideration of their time, I want to make sure that they are okay, that they don't have any other commitments, that they can sit here today and field these questions because we do have a lot of interest in this.

Mr. MacEwen: Chair –

Chair: So now they've already stated that they don't mind staying. I'm just asking if you want to stay.

Mr. MacEwen: Chair?

Chair: Yes.

Mr. MacEwen: Yeah, I really want to stay.

Chair: Okay.

Mr. MacEwen: Why don't we invite our current presenters back again, because as the minister said over there, he's got questions; we've all got multiple, multiple topics.

Chair: Yeah.

Mr. MacEwen: It's pretty interesting. We could ask our presenters if they'd like to come back and bring in our second presenters now.

Chair: I'm going to pose another question to the floor, though, and that is: Do I have unanimous consent to ask our next presenters if they would – we'll continue with this one – and if our next presenters will come back at another time.

Some Hon. Members: Yes. (Indistinct)

Chair: Do I have unanimous consent?

Some Hon. Members: (Indistinct)

Ms. Casey: Yes.

Chair: So with that said, I'm really sorry that you came in today, but I do appreciate that you came, and we will be in touch with you and reschedule as soon as possible.

Unidentified Voice: Sure.

Chair: Okay, thank you.

Mr. R. Brown: We'll be able to go to the national pharmacare program (Indistinct) –

Chair: With that said, we're going to move on.

Peter Bevan-Baker, you have another question? Peter, you have the floor.

Dr. Bevan-Baker: Thank you, Chair.

Our office made a request last fall to your department for information into the Physician Resource Planning Committee, their work, what their scope of – what their terms of reference were, how they determined physician allotment and a whole bunch of questions and we never heard back, so I'm using this opportunity to ask those questions again.

What are the terms of reference for the Physician Resource Planning Committee? Are minutes from those committee meetings public? Is the report from that committee available to the public? I'd be interested to know.

Kevin Barnes: Hon. member, actually I'm aware of the request that came to our offices. I believe – and there may have been a subsequent request – I'm aware of one that came in probably a month or so ago.

Dr. Bevan-Baker: We did follow up again.

Kevin Barnes: I wasn't aware of the one sort of prior to that. We are working on a written response to that request, hon. member, just so you know; but in the interim, I can speak to some of the questions that you've raised.

The Physician Resource Planning Committee is a committee that is really set out in the *Health Services Payment Act*. The terms of reference of that committee really are well set out in the act itself. I don't have them here, but I'll sort of paraphrase as best I can the role of that committee; but as I say, if you were to look at the act, you could see that they're sort of fairly clearly laid out within the act.

The role of the Physician Resource Planning Committee is essentially an advisory committee providing advice to the minister with respect to the physician complement. What the committee will do is consider requests for changes to the physician complement, whether that be increases or decreases, but typically increases. The committee will undertake essentially a clinical review of the merits of the request for a change to the complement.

So that committee, to kind of back it up, is actually a committee of eight, with representation from the medical society – the four members from the medical society on that committee, two representatives from Health PEI on the committee and two representatives appointed by the minister from the department. So, it's a balanced committee between, essentially, physicians and health care administrators.

The committee, as I say, does take into consideration requests for changes to the physician complement. Those requests typically come from specific practice areas within medical practice, so it may be a request from anesthesiology, it may be a request from family practice in a certain region of the province, etc cetera, to consider an increase in the complement, and the Physician Resource Planning Committee takes an evidence-based review of the need and validity for that request.

We look at clinical evidence. We would look at patient demand, referral practices, all of those types of things, and ultimately make a recommendation to the minister on that request. So it's sort of a recommending or advisory body that sort of speaks to the request. From there, the minister makes a decision as to his support, or whether he wants additional information and he can essentially present it as a recommendation to the minister.

In essence, the terms of reference of the committee, to kind of really paraphrase it, is to give consideration to those requests or

identify requests for a change to the physician complement, and to provide advice with respect to those requests.

Dr. Bevan-Baker: Thank you, Chair. You've been very generous.

The second part of my question was: Are the minutes of those committee meetings available to the public, and is the report itself, recommendations from them?

Kevin Barnes: The recommendations of the committee are simply correspondence to the minister, and I'm not sure. I don't think in the past that they have been made public, and certainly I don't believe the minutes of the committee has been made public, not that necessarily we've had a request for that, essentially. As it stands, I don't believe they're public documents; but again, I'm not sure that there has ever been a request for them.

Dr. Bevan-Baker: It just strikes me as this is important information that affects thousands of Islanders' lives, so I would certainly hope and expect it would be available to the public.

I do have other questions, but I know you've been more than generous, Chair.

Chair: Thank you.

Next we have Richard Brown.

Mr. R. Brown: Maybe we could send Sid to the physician recruitment committee or whatever it is and get those minutes.

Bachelor of Nursing, you said there's a $4,800 grant?

Kevin Barnes: Yes.

Mr. R. Brown: And are they also allowed to get the George Coles stuff – bursaries?

Kevin Barnes: Yes.

Mr. R. Brown: So it's about $14,200?

Kevin Barnes: That's right.

Mr. R. Brown: Okay, so we should be communicating that to a lot of young people out there because UPEI school of nursing does a great job.
What is the national benchmark for patients per doctor, family doctor?

Kevin Barnes: It will vary, minister, and it varies according to the nature of the practice, I guess, quite frankly whether it's a fee-for-service practice or whether it is a salaried practice. It also varies according to where the physician is relative to his or her entry to practice − if he or she is fairly new in to medical practice versus, whether he or she is pretty well established.

We've done a lot of work, I guess, locally in identifying – we had a panel size committee, Health PEI a few years back, where we looked at what's an appropriate panel size and, essentially, the number that is typically used for a salaried physician once they're up to sort of full scope is about 1,500 patients.

Mr. R. Brown: In 1993 or 1994, back then some federal people came up with a brilliant idea that if we reduce the number of seats in medical schools we'd reduce the cost to health care. Quite obviously that person didn't take economics 101 with supply/demand (Indistinct) and I'm just wondering today if – how many new seats are there in schools across Canada? Have we increased the number of seats in universities and colleges across Canada?

Kevin Barnes: I don't have an exact number for you, minister, but I do know that the number of training seats available for physicians has increased over the last 10 years. I actually sit on a committee for health workforce which is a federal/provincial committee. I could bring back to this committee sort of the trends in medical seat, training seats, if you would like.

Mr. R. Brown: Yeah.

Kevin Barnes: I just don't have it with me, but I do know there has been an increase, certainly, across the country.

Mr. R. Brown: I'm hoping the seats have increased to the population increases in Canada, because I hope Canada is not depending on foreign doctors because we're too cheap to make seats available in the schools.

Kevin Barnes: I believe, minister, and I'm subject to correction for sure, but I believe the rate of increase in the number of seats has outstripped the rate of increase in population.

Mr. R. Brown: Okay.

Just one more question. Nurse practitioners – I've been fighting for nurse practitioners since 2000, and I think they provide a great service. I know we're not allowed to do a preamble, but –

Chair: No, you can do a preamble.

Mr. R. Brown: Okay, that's a (Indistinct)

Chair: Just keep it to a minimum.

Mr. R. Brown: Okay –

Ms. Casey: (Indistinct)

Mr. R. Brown: So, a nurse practitioner; is there a way to say: Okay, I'm a nurse. I work hard nursing and then I go onto my nurse practitioner. I spend another two years nurse practitioning and I get my nurse practitioning done and I work a couple of years in that. Is there a way to speed up the medical school? Do they still have to do the four years or can they say: Look, these are my experiences. I've got two years of nurse practitioner done. Is there an accelerated program to family doctors? I'm talking about a family doctor, family physician, in terms of a nurse practitioner saying: Okay, I can go to Dal medical school and I can get into an accelerated program to be a doctor?

I think nurse practitioners are well educated, very well educated. The nurses are well educated and I think with some experience under their belt, there should be a fast track to being a medical doctor. I may be shot for that.

Kevin Barnes: No, it's a good point, minister. I don't know exactly what sort of equivalency say, Dal med school would recognize for a fully trained NP. Again, we can bring that information back; quite happy to do so.

I certainly would expect that medical schools would recognize credentials and provide exemptions based on prior training, so I would expect that that's the case. How much of an acceleration it is, minister, I don't know. But, I –

Mr. Mitchell: I believe nursing schools recognize other credentials of, like for instance, LPNs or something like that, so I'm assuming, but we can confirm that for you.

Kevin Barnes: Yeah, happy to do so.

Mr. R. Brown: One more question.

Chair: Richard Brown.

Mr. R. Brown: Thank you, sir.

Medical records; it's always been a bone of contention with me. It's the continuation of care, and with the number of locums coming in and doctors leaving and going – we had a doctor up in O'Leary or Tyne Valley left and the medical records belonged to the son, which I totally disagree with, because the son is not a medical doctor and for him to have medical records of individuals is totally wrong, and I stand to be corrected.

Is there a way that we can – when a doctor leaves and they're leaving and they're leaving their records, is there some sort of system we can set up in Health PEI to say: Look, you're leaving, we'll take your records to Health PEI with the registry; their names would be on the registry. The next doctor that picks up these patients, then we will pull those files and give them to the doctor, instead of the doctor starting all over again with the medical records.

We've got to come up with a better system than medical records being owned by the doctor first and being allowed to be inherited or put in a Will. I think that's totally wrong. We have to come up with a system that says: Okay, this doctor is leaving. There's no replacement doctor. We take the records. We take them to Health PEI. The people are on the registry. When they get off the registry, we'll send the records to the new doctor and then that way, I think, the continuation of care would be a lot better and a lot faster than starting over again.

Kevin Barnes: I appreciate what you're saying, minister.

I think that challenge is really specific to our fee-for-service practitioners. The issue doesn't exist with a salaried physician who would be an employee, obviously, of Health PEI. If a salaried physician were to leave, the medical records that were part of his or her practice would be in the custody and care of Health PEI as the employer, and they would move on to the succeeding physician.

It is an issue certainly in fee-for-service practices, and we're not alone in the country in that issue of the custody and the transfer of medical records. There are requirements in terms of the *Medical Act* and the responsibility for fee-for-service practitioners and the care and custody of medical records and all their responsibilities that go with that. The *Health Information Act* has sort of reinforced the responsibilities of physicians for records.

I think what often happens and what people find challenging with the practice transition is when there's some expectation of a reimbursement or a charge for the transfer of records from one physician to the other. I think people struggle with that whole concept to have the records – pay to have the records transferred to a new physician. Again, we're not alone in the country in terms of that challenge when it comes to fee-for-service practitioners.

The charge is not for the record itself. It's for, really, the reproduction and the duplication and the actual movement of the documentation, but nevertheless it's still a charge to the patient at the end of the day. We don't have an easy answer to that. Fee-for-service practitioners are independent contractors. They have that record as part of their business and they have a responsibility to keep it confidential and secure. The transition piece does and can present some challenges.

We fully appreciate that and we, again, we're not alone on that issue across the country. We do need to find a better way to allow for those transitions to happen.

Mr. R. Brown: Just one more question.

If someone goes to – they can't get to see their doctor so they go to a walk-in clinic; does that record get transferred back to their primary doctor?

Kevin Barnes: Yeah, information that's recorded at a walk-in clinic – if a test is ordered, if a prescription is provided, that does get referred back to your family physician.

Mr. R. Brown: Thank you.

Chair: Just on that, I have a question.

What happens if you at the present time do not have a family doctor but you have a specialist? So, when those specialists send a report, where do they send the report and where does it go?

Mr. R. Brown: Good point.

Kevin Barnes: That's a good point, Chair.

Chair: That is an actual reality. There are patients out there that go to a specialist for a particular reason, see the specialist but they don't have a family doctor. What happens to that report or that record?

Kevin Barnes: We'll have to bring that information back, Chair.

Chair: I would appreciate that.

Kevin Barnes: Yeah, absolutely.

Chair: Thank you.

Next on the list we have Chris Palmer.

Mr. Palmer: Thank you, Chair.

Thank you very much for the presentation.

My question is around nursing, and I'll give you a flurry of questions all at once, and you can kind of ask them or answer them on your way through; but it's around nursing vacancies, retirement forecasts, and seats at the UPEI school of nursing.

The ultimate question that I have going through those is, if we need a lot more nurses, can we just double or triple the class sizes, or can we add more seats to UPEI? So if you can kind of run us through those, that'll be my only question.

Kevin Barnes: Sure, no problem.

We actually, at health recruitment and retention, we do maintain a nursing projection model. So we do take a look at the data. We look at the profile of the nurses that are currently working in the system, the age of those nurses, and we do, on a year-to-year basis, sort of project what's the attrition, what's the need for new nurses in the system.

Roughly speaking, minister, there's about a 5% attrition rate, or that's kind of been the recent history. It'll change from time to time, but roughly about 5% of that number of nurses turns over. Now roughly, it's about 1,100 nursing positions in the system, so 55, 60 per year is kind of the number that we work with as attrition.

What we have access to from the University of Prince Edward Island reasonably approximates that. It doesn't always. We have in the neighbourhood, typically from UPEI, of about 60, 65 grads per year coming out of the school of nursing. A good number of those grads would be new nurses, will come in to work in Health PEI through some of the programs that we talked about. Certainly not all; we have some graduates of UPEI that have come here for their education from other jurisdictions and they want to go home. We have others that want to leave the Island, see the world for a while before they settle.

Our experiences would probably, in the neighbourhood roughly on a year-to-year basis, probably 45 to 55 grads from UPEI will enter practice into the system, so we're almost at an equilibrium there in terms of what we have leaving and what we can recruit from UPEI in terms of nursing, so we have almost an equilibrium there.

Having said that, one of the challenges that we find, and it's an issue that Rebecca raised earlier, is not all our demands for nursing are the new grads. We need a mix of nurses coming into the system or opportunities to present themselves in specialized areas, critical care, intensive care, those types of things. That's where sometimes our recruitment efforts need to go beyond UPEI to be very targeted in terms of bringing the practitioners in to sort of fit those particular needs.

But relative to the university, new entry to grads and sort of what the attrition rate is in nurses, there's pretty much an equilibrium, give or take a few. Our challenges sort of come more from those specialty areas, and that's kind of where we have to reach out.

Mr. Palmer: One more question. That's good. So I think what I heard you say, Kevin, was for entry or new graduates –

Kevin Barnes: Yeah.

Mr. Palmer: – our UPEI school of nursing is able to give us as many of those as we can handle in the system.

Kevin Barnes: Yeah.

Mr. Palmer: So then it's really about trying to find experienced nurses in other places.

Kevin Barnes: Yeah.

Mr. Palmer: So –

Mr. Mitchell: It's the hard-to-recruit areas that they're out working every day –

Mr. Palmer: Right, right.

Mr. Mitchell: – trying to find the experience piece.

Mr. Palmer: Right, so that's really the focus piece is having those experience –

Mr. Mitchell: Yeah.

Mr. Palmer: – because the investment that we made in that school of nursing has kind of solved the problems that we had on the – I don't know if it's called the entry level or whatever that –

Kevin Barnes: Yeah, the new grads.

Mr. Palmer: – the new graduate side, okay.

So then that's a piece of the focus that you have inside of your department, which is – or inside your group, which is to find those hard-to-find. So how many of those hard-to-find – is that, like, 20 of those a year you're looking for, roughly?

Kevin Barnes: Roughly about –

Mr. Palmer: I know it's an estimate.

Rebecca Gill: Yeah. It's an ongoing issue, as I mentioned earlier, and so we would work very closely with our partners at the Public Service Commission to ensure we're posting those jobs as soon as the vacancies, that we become aware of them.

At any given time, if you look on the website right now, there are nursing positions that are open. It just fluctuates based on where the need exists and how the vacancies come about; but it is an ongoing need, so at any given time, 5-10 positions we'd probably be recruiting for. It just depends on the time of year and where the changes are.

Mr. Palmer: This will be my last one, for sure. What about the intake into UPEI? Do they have full complement or – I don't know if that's the right word. Are the classes full every year because we're doing, I suppose, a really good job of forecasting to tell people: Listen, if you want to be a nurse in PEI and you go through the training, there's pretty high likelihood that you'll have a job coming out.

Kevin Barnes: Yeah.

Mr. Palmer: So UPEI is filled every year? Is there any empty seats, I guess? Do you know that?

Kevin Barnes: I'm not sure that there are empty seats at UPEI. It's filled in the sense that it provides the graduates necessary to meet our needs, and I know certainly the school would have students from, as I say, other jurisdictions or who'd go elsewhere, so I believe the number of students in the run of a year out there, I believe it's 70 but that may vary a little bit. I think between sort of the demand that we would have for graduates and sort of those others that are coming from other areas or going to other areas, I believe the school does sort of turn over about 65 to 70 students per year, roughly.

Mr. Palmer: Okay, that's great.

Thank you.

Chair: Thank you.

Brad Trivers.

Mr. Trivers: Thank you, Chair and thank you, presenters.

You mentioned work-life balance a number of times during your presentation, referenced it, and I was curious about the flexibility that you have when you're negotiating contracts with doctors. Are they able to choose whether they're going to be salaried or fee-for-service? Are they able to choose the number of patients they take on? Are they able to choose what patients they pull off the registry? Can they look at the registry and pick and choose the ones that they want?

These sorts of things that – sometimes, you know, the balance between how much time they spend with their own patients, how much time they have to spend on-call or at clinics or ER, teaching committees, how much time they're allowed to spend on professional growth, these sort of things. I know there's a lot of questions all in one there, but I was hoping you can comment on all those areas.

Kevin Barnes: Sure. Certainly, hon. member.

In response to the first question, certainly under the Master Agreement new physicians do have the opportunity to choose the modality of pay. So they can choose a salaried position, they can choose a fee-for-service position as well. They have that choice coming in.

I think in response to kind of the interest of work-life balance, what we're finding is a lot of newer docs certainly are looking at a salaried model. There's definitely more of an interest for the salary model, because it does provide sort of more predictability in your work week. You do have a requirement for the 37.5 hours, essentially, but you do sort of have a more defined work week than perhaps a fee-for-service physician might have.

Certainly, there's as well, expectation of a panel size that would go with a position, and as I mentioned earlier, typically for a salaried position that would be a panel size of 1,500. Now again, if you're a new grad coming out and maybe you're doing some

ER work or something like that, there may be some adjustment to that to recognize that; but presuming you're up to speed and you're comfortable in the practice, a panel size of about 1,500 is the typical.

The panel size is a mix of patients, and so no, there's not a choice, the physician doesn't have a choice of picking the patients that he or she wants from the list. Panels are typically assigned with an appropriate mix or a representative mix of patients: younger patients, older patients, chronic disease, those types of things, so that there's a balance from physician to physician in terms of types of patients that he or she is seeing.

You can't achieve perfect balance, but it certainly is taken into account in terms of the patients that are assigned. They're not all the easy patients and they're not all the really difficult, challenging patients either. There's kind of a mix in there.

Mr. Trivers: Thanks for that answer; that helps a lot. I know that there's a lot of people on the registry. They've been on there and they wonder, you know: How come I'm not being assigned to a doctor, my brother was over there. So thank you for that.

My next question: You mentioned telehealth, and this is something that I've been intrigued by since at least 2011. Now a lot of people think telehealth is the 1-800 number you call to get advice, but I was wondering if you could describe what telehealth means when you're recruiting and how doctors are responding to the idea of telehealth. Is this something they want to provide, they like, that they're open to?

Kevin Barnes: This is fairly new, hon. member, for us to be looking at and I guess we are trying to essentially respond to the interest of physicians and how to balance their interest relative to the needs of the population.

Our work to date has probably been more in the specialty areas. So, we've used telehealth in the context of sort of some of the specialties like radiology, like psychiatry for example, on a couple of occasions. We haven't to date had a full expansion into family practice with respect to telehealth. We're exploring what's involved in doing that.

There are some barriers, I guess, right now to that in a family practice setting on PEI. There is a requirement right now, for example, for prescriptions to be signed by a physician. So essentially, if you're doing telehealth there are some limits on what a doctor can do, if he or she can't write a script that you can take to the pharmacy and fill. We're trying to address how do we look at telehealth in the context of that sort of very practical reality. How do you serve a patient and be able to provide a full service consultation in a family practice setting?

We're just starting down that road. Our experience, as I say earlier, is probably more tied to some of the specialty areas, but it is something that I think we're going to be looking at more specifically.

Mr. Mitchell: If I might add a couple of points as well, Brad.

This is an item of discussion and it is early discussions, early days with advancement in telehealth. I think − and I'm sure others would agree − it's going to take a bit of a cultural shift, not only by physicians and those in the medical field, but by Islanders too, to say: This is a system that I want to embrace; I can fully trust.

Early discussions would be, as Kevin mentioned, as far as prescriptions you need the doctor by your side to (Indistinct), but there are probably identified tangible pieces that it could address, such as consultations, whether it's in the mental health area or others; therapy pieces to see how people are doing. There are a lot of opportunities here, but I think it's going to take a little more discussion as far as – in some regards too, in the conversations I had, it's like: Does the doctor need to be on PEI or can it be another province, or even in the States or somewhere like that? Or should it be the doctors in O'Leary talking to a patient in Montague?

These are things that are just early days of discussion on, but I think it's something that we should take a really good look at. But also, get everybody's say on it; the medical professionals, Islanders, to say, get some buy-in at that level as well because I think with today's, as the slide said, our aging

population and challenges that we're going to see based on that, these are all things that we really need to give that full look at and see if it's something that we can aid the best possible outcome for health of our Islanders here.

Chair: Next we have Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

I've got a few here so I'll try and rifle through them.

Where are we at with the psychiatrist complement?

Mr. Mitchell: Just last week we have four new psychiatrists. That gets us back up to full complement of 15, I believe is the number.

Mr. MacEwen: Is it fair to say that 15 should be higher? Like, now that we're at 15 –

Mr. Mitchell: I know we're pretty excited to get back to the 15 (Indistinct)

Mr. MacEwen: I understand that, but I – when I've talked to the people in that area, 15 was never a realistic number anyway and I know you're going to keep recruiting that type of thing, but is that the next step?

Mr. Mitchell: We are – we'll continue to work in that area.

Dr. Heather Keizer plays a big role when it comes to determining how many professionals we need in that area and whether it's psychiatrists or the psychologists, all the way through; counsellors or whatever is needed there. There's a big, wide focus on that right now, Sidney, and we want to continue working on that but the four that we have are very highly-qualified – a wide range of experience is going to provide great stability that was lacking for a number of months here. It's a pretty good day and a pretty good announcement that we were able to do that last week.

As we move forward on some announcements that were also made last week, we have now some experience in areas like the mental health mobile crisis unit. A couple of those individuals bring a fairly good experience to that. So when we design that going forward, now we have expertise right in-house that can be a very big part of how that architecture moves forward.

Mr. MacEwen: Yes, thank you.

I've seen the promotional videos. It's great news.

Do the international psychiatrists that come – and I understand that the four that we've just hired are international – do they require supervision for a period of time?

Mr. Mitchell: They do.

Mr. MacEwen: Does that take up time away from other psychiatrists?

Mr. Mitchell: I would say – Rebecca probably could answer that – but I know they do require a timeframe of supervision, which will be held under Dr. Keizer.

Rebecca, you can address that a little closer.

Rebecca Gill: Same understanding as you, minister.

There is a requirement and it would just depend on the individual and perhaps the experience that they've had to date, and that's determined through the college of physicians at the time, yeah, physicians and surgeons.

Mr. MacEwen: If it was someone already in Canada, they don't need that supervision? Is that correct?

Mr. Mitchell: I think it is in Canada. There are other international doctors in other areas of specialty who come in and they have to follow the same – they do. It works out. They stay. They remain and they get their full certification and off they go. I would predict that will be the case with these four psychiatrists as well, that they will do what they need to do based under the college and meet the criteria, and move out and provide great service to Islanders.

Mr. MacEwen: Thank you.

A couple of local situations, Chair.

You've talked about the pressing need in west prince. I understand a physician has been moved from Tyne Valley to Alberton and that physician is not available for family medicine, and the nurse practitioner are booked for March. So, anybody now is being told walk-in clinics or the ER.

What are we doing right now to rectify that situation in Tyne Valley right now?

Mr. Mitchell: I know there's a fairly heavy recruitment focus going on for West Prince. Rebecca can probably indicate just the focus that's on that.

Mr. MacEwen: (Indistinct)

Mr. Mitchell: I certainly understand that there is a (Indistinct) -

Mr. MacEwen: And the reason why they're taken from one spot or directed to go from one spot to the other, or is that a personal decision?

Rebecca Gill: (Indistinct) Kevin (Indistinct)

Kevin Barnes: Sure.

I believe, hon. member, the requirement for the physician in question – I think as a result of vacancies at the Western Hospital, I believe. The physician from Tyne Valley is essentially there to provide the in-patient rounds at Western Hospital. I think there's been a need for a physician – identified need for a physician to provide rounds on an in-patient basis at that facility.

It isn't necessarily a personal choice. I think it's where the need of the system is and we need somebody by virtue of the vacancies to do that pretty essential piece of work on a day-to-day basis. I think that physician, as well, he's working on a part-time basis now working back to, I think, a fuller scope of practice and I think he had his own period of time where he was working at less than full complement. I think he's working back towards that now so I think that's kind of complicated things a little bit. But in essence, I think it's a response to the need for in-patient rounds at Alberton.

Mr. MacEwen: The nurse practitioner that comes to Morell for half a day a week now, I understand, is consistently overwhelmed. Are we going to move to a full day or multiple day nurse practitioner in that area?

Mr. Mitchell: Those are things that we'll assess ongoingly. I don't have the data, to be honest with you, Sidney, on just how that's working out. Morell was the other community that I couldn't think of earlier; I do apologize for that.

Mr. MacEwen: I shouted it out, but you didn't hear me.

Mr. Mitchell: Okay, I do apologize.

These are things that we are fully in support of. I believe we are seeing great uptake on, and we will continue to reassess that and see if there's improvements that are needed, or changes that are needed. It's something that we see great merit, that's why they were initiated and then we'll build on them if they need building or we'll adjust if adjustments need to occur as well. I think that's an important thing that we have to look at.

Mr. MacEwen: Physicians that are from PEI but are practicing elsewhere now; we've heard about people that are in med school and Kathleen had brought up that program, I think there's – I've heard 41 med students out there right now. I've also heard that the program that you were talking about doesn't quite fit their needs.

Two questions, Chair. One: What are we doing to contact practicing physicians from PEI elsewhere? Ones that are already practicing just to say: Hey have you thought about coming home? Consistently, that seems like an obvious one, but consistently I keep hearing back from people that would say: No, no one has actually ever reached out. I understand that's a little trickier process and maybe it's poaching and I'm not sure what the rules are around that. But people want to come back to PEI.

Mr. Mitchell: I think those are discussions that Rebecca and probably Kevin are working on. Rebecca, you can talk to that but I know that's her plan is speak to all of those Islanders. The best chance of retaining Islanders to work on the Island in the urban or rural centres (Indistinct) on PEI, that's what brings them home initially.

Rebecca, I think will focus on any Islander that's identified that's in med school anywhere will be getting a call.

Mr. MacEwen: Thank you.

But this has been here since 2010, and why are we just planning to search them further now? Has that been ongoing?

Kevin Barnes: Hon. member, I can speak to that. We have, on occasion, over the past number of years touched base with – we're well aware of who's gone through – in particularly the local schools, maybe not as much other schools, but certainly Dal and MUN, we're well aware of who's gone through those schools that have a home on the Island.

We certainly – through the process of their medical education – I know that's not the nature of the question you're asking, but certainly the process of the medical education, we would have stayed very connected with them, made sure they were well aware of what's happening or what was available on PEI. Should they make a decision to do something else and go somewhere else? We absolutely retain the names of those individuals and periodically we'll reach out to them when there are vacancies in their area of specialty. Many of those would be family docs as opposed to specialists, but not all, some of them wanted a specialist as well. We do do that from time to time, reach out.

The other thing I mentioned earlier on as a connection and it isn't necessarily based on a PEI resident, but we certainly work with practitioners that we have here on the Island that are working in a specialty area that have colleagues and friends that went through medical school with them that are practicing elsewhere. We will engage, as I say, if they're working in a particularly specialty area, will engage the physician practitioners in the recruitment process and part of that process maybe for one of those physicians to reach out to former colleagues or friends or folks that he or she may know elsewhere in the country. They aren't necessarily Islanders, but certainly have a connection to PEI through that sort of collegial type of role as well.

Mr. MacEwen: I would encourage strongly we don't do that periodically. We make that part of our annual thing. We're not pestering them but they should know, they should know about this, they should know that there's being a new school built in that area, they should know about that stuff. I think that's – it's one that we always hear that it's frustrating to say: Well, actually no one has been contacting me. Even though we know we got the big budget and we're trying to do our best, kind of thing.

Mr. Mitchell: I think that's fair that we can maybe work on doing better.

Mr. MacEwen: I'll go back to the private practice as well and you say it's a very minor thing. But if we were engaging those firms to do that on top of the good work that we're already doing that the minister says, I don't see a problem. Why aren't we doing that in conjunction? I can't imagine there's that abundance of people that we're fighting over there, it's about doing that individual work to seek out. Rather than tying up Rebecca's (Indistinct) time, we have head hunters out there looking individually for those hard cases to track down that: it's Sidney's sister-in-law is in Australia and is looking to come back, or something like that.

My last question Chair and it goes back again to what Kathleen talked about, that program and how we keep talking about the one success story we have coming to Souris. But we have young doctors originally from PEI that are entering the system that certainly didn't do that. Are we meeting with them and engaging with them? They obviously decided not to do that type of program. It's got significant resources behind it.

Are we talking with them in their first year and after three years and after five years to say: Dr. so-and-so, what could we have done better? How can we keep you here in 10 years time? Perhaps starting to have kids, are we doing an interview with them quickly to say: Oh, wait, you're actually thinking about leaving because of a school situation or because about something in that community. That first five years, are we getting a review from them?

Kevin Barnes: To answer your question and I believe I understand what you're asking. Certainly with the residency program, those five that are doing the residency here on PEI, we maintain contact with them throughout the residency program. As I mentioned earlier, we have had pretty strong success in retaining those physicians in practice in PEI after they finished their residency.

We do know, as well, for those that we don't, we understand or we have some information as to why they chose not to. So, we do have that discussion – find my list here – but essentially, some of those have chosen to pursuit specialties, so they've just moved on to a specialty area.

One student has decided to kind of see the country and do locum work – we do have some information with respect to why they've chosen not to stay. Back to your point, we do kind of keep them on file and in mind for the future. I think we do do that, we do the exit interview, so to speak, and we know why those residents aren't staying.

I think I mentioned earlier as well, Rebecca's team certainly does a lot of contact with PEI students at the two medical schools that we have; Memorial and Dal. We are at those schools meeting with PEI-specific students on a regular basis. I think, in fact next week, you folks are going to Memorial. So, we do actually make sure that when PEI students are at those schools they're getting regular contact from recruitment and retention so they are aware of what's happening here, what are the opportunities. Even before they're into the residency they try and make sure they know there's opportunity here.

Mr. MacEwen: Thank you.

Chair: Thank you, Sidney.

Colin LaVie.

Mr. LaVie: Thank you, Chair.

Actually, that was my line of questions that Sidney was just asking.

When you're talking to these students in the residency are you're talking to these students through the university or directly to the students?

Rebecca Gill: (Indistinct)

Mr. Mitchell: Sure, no, you go ahead.

Rebecca Gill: As Kevin mentioned, we are going to Memorial University in Newfoundland next week and we have meetings set up with students, but we do work with the universities to facilitate those discussions. They are aware of our presence and we do have just very good ties with them, same with Dalhousie. We'll be on campus, on university site meeting with these students, both current and the residents as well, and also, maybe some family members as well. We do have those ties very well built already.

Mr. LaVie: Just like the member said, I have quite a few residents up home that are in the residencies going for a doctor, a family physician. When I speak to them they said: We were never ever approached. We were never ever spoken to. Is there miscommunication here?

Kevin Barnes: I'm sorry, hon. member, would these be students that are actually at Dal or MUN, or would these be –

Mr. LaVie: Yeah.

Kevin Barnes: – just for clarity, yeah.

Mr. LaVie: They said there were never ever approached.

Kevin Barnes: Okay. I think, as Rebecca mentioned, our practice is to reach out through the university to students at those universities, make them aware of when we're going to be on site and make sure that's conveyed and advertised. If it's not reaching individual students I'm not sure why and we can follow up on that particular piece.

But we do, as I say, make regular visits to those schools. We communicate that in advance through the school for those students that we have contact information. We make sure that they're aware that we're coming. Whether somebody may not choose to come and see us, I'm not quite sure, but we do try and make sure that those visits are

as productive and useful for us, but also for the students as possible.

If they're folks that we're missing in that process we'd be absolutely interested in finding out why and who they might be –

Mr. LaVie: For sure.

Chair: Colin, do you have another question?

Mr. LaVie: Yes.

Chair: Colin LaVie.

Mr. LaVie: Thanks, Chair.

The national average for a family physician is 1,500 patients, correct? Give or take.

Kevin Barnes: Give or take. I would say you'll find some variation from jurisdiction to jurisdiction. We've done some work here on PEI hon. member. We had a working group established at Health PEI and that's the number for PEI circumstances, we believe is an appropriate bench mark for a salaried position.

Mr. LaVie: Montague hospital district has around 16,000 people for nine family physicians. Souris Hospital district has approximately 7,000 people and three family physicians, so there's still people there with no doctor. As the Premier promised in 2015 for four physicians, are you looking at four physicians for Souris Hospital?

Kevin Barnes: I think, hon. member, we mentioned a little earlier on today that Dr. Craig Malone will be starting –

Mr. LaVie: Just for three years.

Kevin Barnes: Yeah, in July, I believe it is.

Mr. Mitchell: In my discussions on the day that we were together in your hospital and in the Montague region as well, a full complement of eight, there's some shared work that goes on within the whole Kings County complement of eight. To your point of specifically the number, that can – the flow can go either way depending on the need or the requirement. I believe, in my discussions that day, there's a significant amount of care that comes from Montague to Souris and vice versa. But with the two new doctors that are willing to do the same work, it's determined that the needs of both areas would be well suited now under the full complement of eight.

Mr. LaVie: So, these roughly 2,000 – 2,500 people will have no family physician, they'll just have somebody coming in on days that doctors are off.

Mr. Mitchell: I don't have the number of specific in your region without a family doctor, so I'd have to investigate that, Colin, and determine if that's one of the identified – if that's identified or not, I guess, at this point in time.

Mr. LaVie: Find out for April.

Mr. Mitchell: (Indistinct)

Chair: Next on our list we have Jordan Brown.

Mr. J. Brown: Thanks, Chair.

I might say that Colin LaVie took my questions but that's all right; I'll just build on them. I was going back to where Sidney MacEwen was anyway.

I'm going to start out though on the resident matching piece, as much by asking – maybe what I'll do actually is give you a little illustration and this was probably one of the most frustrating situations I have come across yet, as a Prince Edward Islander and was probably part of the reason why I got in to politics, too.

One of my buddies growing up, lived right across the street from us, went to an out-of-country medical school. When he was going through medical school he was strongly pushed by probably your predecessors – been going back now roughly 10 years – basically to come back to Prince Edward Island. In fact, he would say he was given assurances that if he matched for Prince Edward Island he would find himself in a position where he would be able to go through residency and walk right into an open position.

The frustrating part of it was, this is somebody who is very community-minded had always been very involved in athletics,

was a coach, had kids, had a family, bought a house here on Prince Edward Island on the strength of this talk, then went through the matching program. At that point in time and I think it's still the case – there was one matching seat for out-of-country residence through Dal to Prince Edward Island, as determined by Dalhousie, really.

Anyway, so he matched, he only matched for Prince Edward Island; he did not match anywhere else; which was probably one of the worst mistakes he has made in his life. After that, he came to realize that there was a student – I think from Ontario, originally – that matched for that position as well. Through the jigs and the reels the Ontario student ended up in that position here on Prince Edward Island. You can probably see where this is going. But this particular individual is now practicing in the US, after having been recruitment directly there and into a contract probably not that much different than Dr. Malone. The individual from Ontario left right after he was done of his residency.

Unidentified Voice: (Indistinct)

Mr. J. Brown: And yeah, ouch, is a big – I will say from what I know, we've done pretty good at getting Prince Edward Island residents through the residency program since then. I'll preference this by saying I used to do recruitment from my law firm and I can tell you your success rate probably is cut to about 25% when you start taking folks from off Prince Edward Island on to Prince Edward Island.

I'm just wondering where we are with the residency piece right now. Do we have the ability to indicate that we want Prince Edward Island students as a priority to somebody from a different place coming through that program?

Kevin Barnes: We do have the ability to indicate our preferences. Having said that, the CaRMS matching process continues and that can be a frustrating process for students. It's more on a sort of a national level as opposed to a local level. Our main influence and direct – the outcome of that process is somewhat limited. Again, we can express our preferences and we can try and seek PEI students who have process. We're not always successful. Again, it is a bit of a sort of a musical chairs type of process. It's probably the best analogy I've ever heard described for it.

While we can kind of indicate our preferences there's no guarantee we're going to get PEI students. As much as we would like and for the very reasons that you have indicated, minister, our success in retaining those students down the road is much higher if they have a connection to PEI.

We would share some frustration with that process. Again, we can influence it, but we can't ultimately sort of control the outcome, I guess, quite frankly.

Mr. J. Brown: Do we have the ability to go outside of that process, whether it be directly through Dalhousie and say we take residents, kind of, that we would pick –

Mr. Mitchell: Pick and choose individually.

Mr. J. Brown: – or do we have to go through that CaRMS process?

Kevin Barnes: There is a provision to go outside the matching process. It would come essentially, I guess, at a cost over and above what we currently have for our residency program. Again, you'd do that at a cost, I guess.

Mr. J. Brown: I would echo both Colin LaVie and Sidney MacEwen's comments in relation to the at-school contact. For what it's worth, I can kind of let you know what I used to do when I was doing recruiting work and the context is pretty similar, so I doubt that it's that much different.

Before the students would head off even for their first year, we would make sure that we had a contact with everyone of them personally. We would invite them to come in, in our case, and do a tour of our law firms and we'd take them either to lunch or supper, or whatever. We'd have a pretty good connection established with them.

I think a big piece of that, more so, just identifying where they are, is you can kind of start to get in their ear about what you might like to see. To Colin's point, you might be able to say to them: Look, we need a family doctor and wherever. We need an

anesthesiologist in Summerside. It might dawn on them there that there was something there that they weren't thinking of. But we never found great success in leaving it up to the schools to make these contacts because they will have every recruiter in their ear trying to do that and it never really works out that well.

Then when we go over the other thing that we would do, would be we'd reach out to them, because we have their contact information and say: We're coming, do you want to go for some drinks or do you want to go for some appetizers or whatever. And then you make the contact again, and you keep, just to Sidney's point, following up on that whether it be with a phone call or whatever and they're home next summer and all that kind of stuff to see where they are.

The secondary part of it, too, is that through those folks that come back, they will have and they will know – and I could give you a good example, my brother's (Indistinct) doctor here. We had a position here for an ortho surgeon, and so he alerted two of his buddies that had specialties in those areas, and sure enough, one of them ended up moving here.

Likewise, I can think of that situation repeating itself two or three different times over the course of the last couple of years. You know, kind of where you have that sales pitch already done for one, it's easy to multiply that out and have them do the work, but we have to work that and we have to have that relationship with the physicians and with the medical students as we go through.

Just back to the initial point about how many people are in the office there or whatever, well, I'd be quite happy to pay an extra couple of people in the office if it meant that we could get 10 more doctors out around the province in spots where we need them or whatever.

So I'll just kind of say all that. I don't know where we are right now with all that stuff, and we covered some of that ground, but I think we have a big interest in ensuring that we have more.

The other piece of it worth mentioning, too, a lot of the medical students when they're coming back here, they would often bring a spouse from medical school –

Unidentified Voice: (Indistinct) indeed.

Mr. J. Brown: – or a nurse or whatever with them, so that's the extent that we can prioritize that. We all saw the article about the Nova Scotia town that's having people coming to babysit, and we sit here and we laugh, but honest to God, I can tell you my brother's here, just had a young child. It's huge for him to be back here with our parents here and her parents actually might move back to Prince Edward Island as well.

The ortho surgeon that I just mentioned, they had parents come to PEI to help care for the children. I can name another doctor right now that had parents actually move to Prince Edward Island to care for their kids. All that stuff matters when we're looking at it, and to whatever extent, we can put programming together to help with that, I think that's a leg up you're going to get on somebody else.

Mr. Mitchell: And to your point, minister, what you're saying is totally accurate. I had some conversations the other day, and yes, the physicians themselves feel they have a big part to play in recruiting professionals that they already know, and to help us sell Prince Edward Island. So that part is for certain, that they know they have a part to play in here.

I guess when we're talking about the number of Islanders attending medical school; it's not significantly large, right? Let's face it. We don't have a lot of Islanders going off to school, so our numbers is manageable that we can get out and reach them and have those conversations with them, take them to dinner if we need to do. It's a very manageable thing, and if we're not doing the best job in the world on it, we'll have to improve that, and we have the people in place to do that and do it well. So we'll continue to work on that.

But I think there's multi areas, just like you said, and thank you for flipping that clip off to me which quickly I sent off to Rebecca as well – and you know what? You're right.

We can laugh about things like that, but they –

Unidentified Voice: It works.

Mr. Mitchell: – make the difference of having people come.

Currently, we have some dual doctor spouses now that are looking to come to Prince Edward Island. A couple for sure, so these things – each thing builds on the other, on the next, right? So take advantage of everyone where we can, and we'll take criticism when we get criticism. If we're not doing the best job of it, we'll try to do better and get them out there. It's not a large number, but we should be able to manage it. We should be able to go and see them, and we should be able to get them back to PEI.

Mr. J. Brown: This is the last question that I have.

I'm wondering, too, on the – you mentioned return-in-service grants of 30 to 40 thousand to go work in other parts of the province that are underserved at this point in time. I'm wondering if we do anything with our existing complement to kind of incent them to go take shifts or do locums or whatever in other areas.

Again, I'll pick on my brother. He was up to Western Hospital there for a few emergency room shifts in the last month, and I was saying to him, frankly: Why would you do that? It's two hours either way. And he said: They're underserved and I feel there's a need, so I go do it.

Mr. R. Brown: Browns (Indistinct)

Mr. J. Brown: Great people, great people.

Unidentified Voice: Yeah.

Mr. J. Brown: But you know, when I was sitting there thinking that, I'm thinking to myself: We could at least offer to pay the fellow to drive the two ways if they're going to go do that, or do whatever to –

Unidentified Voice: It's a long way.
Mr. J. Brown: – to incent them to go to those different spots for periods of time.

So I guess we – do we do that (Indistinct) –

Mr. Mitchell: To your point – and you know what? – there's a lot in medical professionals that, you know, they're in it for providing that service of health care to Islanders, and they don't always think about I should be compensated for my travel or all parts and pieces of it. They just do it, because morally it's the right thing for them to do because that's the career they picked and chose and are working towards.

So I guess, you know, if – I haven't had anyone suggest that to me except for you today, but if that's a takeaway from here, we'll have a look at that; and if that makes it easier to do that, because let's face it, we have situations there. We can have a situation at anytime anywhere where a doctor's not able to perform their service in an ER and all of a sudden, boom, the call goes out and most of the time, 99.9% of the time, they pick up the charge because that's what their career and their DNA says for them to do. If there's little things there that would make it even better, tell them bring them on and we'll look at them.

Unidentified Voice: (Indistinct)

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

You mentioned, a long time ago at the beginning of the presentation, about why doctors come here. You'd done a survey on that. I don't remember all of them but it was the lifestyle balance and it was coming home to PEI and it was the environment of Prince Edward Island, I don't remember them all.

But I'm wondering whether Jordan's story about the lost opportunity to have a doctor who is clearly committed to our community, that tragedy when the resident came here and then left, do you ever do exit interviews with physicians, doctors who are leaving and ask them: Why did you leave? Sometimes that can be even more useful information as to why you came here.

Kevin Barnes: Actually, that is done, hon. member. It's typically done by Health PEI, medical affairs. When we do have practitioners leave the province, there is a process which medical affairs will undertake

to get some feedback from the physician as to why they're leaving. So we do collect that information.

It's varied. I don't have a summary of it here today, but it varies from other, more attractive prospects elsewhere to stuff like the lifestyle and place that they want to be; but we do collect that information, certainly, hon. member.

Dr. Bevan-Baker: I mentioned earlier about the concerns of the South Shore residents and the loss of the Crapaud doctor and I'm not going to go over that again, Chair, but there's not only a concern about lack of access to local services. It's also a concern about what impact this is going to have on their community when you lose essential services, like medical services, educational, retail, recreational. Then your community can start to wither and die.

I'm wondering – I mean, rural development is a big push of this government, and I'm wondering whether there has been any collaboration or any talk at all with the Minister of Rural and Regional Development. Do you sit down with them, is there any collaboration going on there? Because it strikes me that there's a very close connection here.

Mr. Mitchell: Well, it's – again, hon. member, it's fairly timely that you bring that up; but obviously, since I took my chair, I think it was seven weeks ago this very week, it's been a bombarding of information. I have not had the opportunity to sit down the minister of rural development, but in some conversations today we're looking at doing that to determine some opportunities, I guess, if they do exist.

I'm not going to suggest today that we have the crystal ball to solve all the problems here, but certainly to begin conversations to say: What have you collected for information and what can we work together on? I think when we talk about rural PEI and we talk about the nurse practitioners program that's out there now, certainly we need to strengthen in a lot of communities what's going on today.

If two ministries coming together can help that, we're going to have those conversations, yeah. But, we haven't had them as of yet, but I can predict that we'll be doing that very soon.

Dr. Bevan-Baker: Thank you. Very pleased to hear that, minister.

Final question and it costs an awful lot of money to run the health care system. It costs an awful lot of money for every doctor who is here and I wonder whether we ever look at the outcomes of our health care system. For example, the WHO definition of health is a state of complete physical, mental, and social wellbeing. Not just the absence of disease or infirmity; it's about positive health.

I'm wondering whether we use any metrics here – because surely the outcome – the purpose of the health care system is healthier Islanders. That's what we should have. I'm wondering whether we're measuring that. What performance metrics are out there that gauge the effectiveness of our system? Are Islanders healthy for all these hundreds of millions of dollars that we spend every day? Can you give us indication on that?

Kevin Barnes: There is – and I don't have the information here, hon. member, but I know from Health PEI perspective there are a number of metrics that they do monitor that would speak to that. There's likely a broader suite of measures that we could look at.

Things like average lifespan is one that is looked at. Looking at incidents of certain chronic diseases per rate of population is another area that they monitor; readmissions to hospital. There's a number of those types of pieces, and some of those are more acute-care hospital-based than probably the broader health of the population. I think things like average lifespan and those types of things are measures that kind of speak to that broader issue that you've raised.

There are also a number of indicators; things like income, employment and all those types of things which are kind of in that ballpark as well, which perhaps we aren't necessarily collecting as a total package. To say there is some measurement of that; is it probably where it should be, or is it as holistic a picture as we would like given the general determinants of health? Probably not, but I

think effort is certainly underway at Health PEI to try and do more of that type of work.

I'm happy to bring back information that they may be collecting, hon. member, to share with you relative to their benchmarks.

Dr. Bevan-Baker: Okay.

Mr. Mitchell: I would agree with that.

I think there's a fair amount of data being collected, but that doesn't mean that you capture everything that's on the go, Peter. As part of an announcement that we made last week, assessment tools are a part of that to be able to actually measure that those new dollars are good value.

I guess there is work going on. There is data being collected. Whether at the end of the day you can say: Oh, we'll reach saturation where the money we're spending will equalize out there. I don't know if we'll ever be able to determine that with our aging population, with chronic disease worsening. We have a lot of challenges before us.

I think if it would be acceptable, we could probably figure out some of those data pieces and get them out in some form or way that makes good sense. The work that they're doing, trying to establish things about it may not mean so much to us on the floor of this Legislature, but we could kind of create it in a way that does probably. It would take some time.

Dr. Bevan-Baker: Sorry, can I have one –

Chair: Sure, yeah.

Dr. Bevan-Baker: I know I said three, Chair, but this is a follow-up to that.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: I know that Health PEI has to provide the federal government with certain outcomes and certain metrics in order to get the transfer payments for health care, without which we would be in a mess.
Mr. Mitchell: Right.

Dr. Bevan-Baker: I know that there are some data that are kept, but specifically I want to ask about mental health; whether there is tracking in Health PEI on, for example, number of hospital admissions, emergency situations, anxiety or depression in school-aged children, suicide attempts or completed suicides. Are those sorts of statistics kept on file and what do they tell us about the general mental health of Islanders over the last 10 years, for example?

Mr. Mitchell: I don't know if everything that you just referenced there are, but a lot of them are. I don't really know how to get that back over here. We can probably figure out what's available and bring them back, but not everything that you referenced would be, but a lot of what you reference would be.

Dr. Bevan-Baker: Okay.

I'd really appreciate that, minister.

Thank you.

Chair: Thank you.

I have a question too and it's more of a local question for me, and it's regarding the recruitment of health care specialists in the west. I do understand that your department has challenges and that you're exhausting all your efforts, and you are considering all your options, but to those individuals who presently don't have a family doctor, what are their options?

Kevin Barnes: The options really available to those that do not have a family doctor, certainly, walk-in clinics is, and again, not the best solution, but certainly a walk-in clinic type of service is available to those that don't have physicians. That would probably be the primary response. Where the circumstances warrant, they are emergency visits, but again that's not something we want to encourage without there really being a need for that.

Walk-in clinics, I think, Mr. Chair, would be sort of the primary piece.

Chair: Is there anything else that the department can do in the interim to help alleviate some of those pressures put on those walk-in clinics?

Mr. Mitchell: There's the concerted effort of recruiting doctors for that area. Depending on how things go, there may be

opportunity for a locum, but you've got to – it's the same process to go out and identify and bring them here, and get them in place and do the work that needs to be done. You still have to – the role of the hospitals or the in-patient care has to be maintained.

So, there's a lot of moving parts in the thing, but obviously it's a focus of ours at the moment. We know that there's a – I don't even have the number of patients right now between the two panel sizes that are waiting for primary care professionals to come and take over their needs, but it's a focus and we're trying to work with it to get it as quickly as we can. If locums are a possibility, that could fit a short-term bill, but we're looking at all the avenues.

Chair: Which will lead to my next question.

Can you – or suggestion – and I do, as I said, I do believe you're doing everything you possibly can to alleviate this problem and give, not only west prince, but all Islanders, access to a family doctor. In the interim, can you assure me that today or tomorrow when you go back to your office that you will look at a possibility of a locum to help in the West Prince area at this time, or the possibility of an additional nurse practitioner?

Kevin Barnes: Certainly, Mr. Chair, we would have a look at that.

I believe, just on the point of nurse practitioners, I believe there are plans underway for an additional two nurse practitioners in western PEI the first of April. We're working towards that. Now, we don't have necessarily names for that right now, but we do have two new positions for the west as NPs, and we could and would have a look at locums as a potential solution for the physician vacancies.

Chair: Okay, great. That's great news and great uptake.

With that, my list has been exhausted. I want to thank each of you for coming in here today. It was a very, as I said earlier, very engaging conversation. There was a lot of interest in it and you did a great job fielding many, many questions. With that, on behalf of the committee, thank you very much.

Kevin Barnes: Thank you.

Mr. Mitchell: Thanks for having us.

Kevin Barnes: Thanks.

Chair: We'll take a two minute break and come back and finish the agenda.

[Recess]

Chair: Call the meeting back to order.

Next on our agenda is number (5) which is consideration of the letter sent by Sidney MacEwen dated November 17th to invite Rotary Club of Montague to present to this committee. The floor is now open for discussion.

Sidney, perhaps you want to –

Mr. MacEwen: Yeah, just to enlighten on the letter a bit, I was talking with members of the Rotary Club. As many of you know, they do that lottery and they donate half the money to certain charities or groups around down east, all over Kings County for that matter, each week. They do see a lot of the need, a lot of the health need in that area, and they would kind of like to come in and talk about what they do and what they see, and what they see as needs and priorities for health services in that area. So I said I'd bring that request forward.

Chair: Is there any other discussion on it?

Do you want to put a motion out?

Mr. MacEwen: I put a motion that we invite the Rotary Club of Montague to present to the health committee.

Chair: All those in favour, signify by saying: 'aye'.

Some hon. Members: Aye!

Chair: Contrary, 'nay'.

Okay, that motion is carried.
Mr. MacEwen: Thank you, Chair.

Chair: Our clerk will send out a letter to the Rotary Club and ask them for their availability, and then we'll circulate that time later on.

Mr. MacEwen: Thank you.

Chair: Thank you, Sidney.

Next, new business: So in new business, I want to talk first about the presenters that we had today that (Indistinct) on the Catastrophic Drug Program. Just in conversation here, to myself and then the clerk also had, it looks like they are available for March 13th. We will confirm that, and we will circulate that with each one of you when that is confirmed. So we're looking at March 13th for the next meeting to have presenters come in on the Catastrophic Drug Program.

Mr. R. Brown: Great.

Chair: Is there any other new business?

Ms. Casey: Motion for adjournment?

Chair: Called by Kathleen, thank you guys very much.

The Committee adjourned