

Standing Committee on
Social Development



Report on Healthcare Accountability and Sustainability

20th Northwest Territories Legislative Assembly

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

REPORT ON HEALTHCARE ACCOUNTABILITY AND SUSTAINABILITY

EXECUTIVE SUMMARY

The Standing Committee on Social Development (Committee) presents this *Report on Healthcare Accountability and Sustainability*, to provide the Government of the Northwest Territories (GNWT) with feedback received from experts in healthcare. Through this report, Committee aims to inform the GNWT and, beyond its release, intends to continue holding the Government accountable for adequately addressing the healthcare needs of residents and the pressures facing the healthcare system.

Committee received six presentations between October 2024 and March 2026. Witnesses and subject matter experts spoke about the recruitment and retention of healthcare workers and flexible employment models to help the Northwest Territories (NWT) achieve sustainable vacancy rates in healthcare staff. Experts also spoke of ways to improve upon the administrative workload and burden of healthcare staff in the Territory.

Committee learned of the importance of expanding the scope of practice for certain types of nurses in the Territory, and to invest in the use of Registered Psychiatric Nurses to support the NWT's mental health system. Committee highlighted nursing education programs that are needed in the Territory to support the nursing profession.

Committee analyzed the current structure and reform efforts for the NWT's healthcare system, and included sentiments on the initiative of Primary Healthcare Reform, Medical Travel Modernization, and the Small Community Model of Care. Committee examined the efficiency of healthcare spending in the Territory, one of the highest spending rates in healthcare in jurisdictions across Canada. With the pressures of population growth and an aging demographic in the Territory, identifying efficiencies in spending is crucial to further access to care.

Throughout its study, Committee identified gaps in key leadership initiatives such as the 2025-2028 People Strategy. Gaps in licensing and regulation were also examined, including in pan-Canadian licensure for physicians, the labour mobility of nurses and the regulation of allied health professionals.

The delivery of healthcare services in the Territory has struggled on numerous fronts in recent years, with examples such as the decline in healthcare staff across the country and continuous issues with poor coordination of medical travel and inadequate associated supports in northern and remote communities. Committee urges the GNWT to take timely and coordinated action to implement the 27 recommendations outlined in this report. These recommendations reflect the wishes of health care staff, experts and residents of the NWT to strengthen its healthcare system.

LIST OF RECOMMENDATIONS

Recommendation 1: The Standing Committee on Social Development recommends the Government of the Northwest Territories work directly with frontline healthcare staff to incorporate their knowledge and connection to social networks into the recruitment of healthcare professionals in the Northwest Territories healthcare system.

Recommendation 2: The Standing Committee on Social Development recommends the Government of the Northwest Territories investigate and report on the feasibility of increased incentives for healthcare workers in small communities, such as subsidized rental units and designated spots at childcare centres and day homes for healthcare workers.

Recommendation 3: The Standing Committee on Social Development recommends the Government of the Northwest Territories research, identify and address barriers – including those related to privacy within the *Health Information Act* and related to necessary higher technology upgrades – to support the timely implementation of technologies such as online booking, automated reminders for appointments, virtual care, remote ultrasound, and expanded use of artificial intelligence scribing across healthcare settings.

Recommendation 4: The Standing Committee on Social Development recommends the Government of the Northwest Territories ensure that procedures are in place for the implementation of new technologies in the healthcare system, including appropriately trained designated staff (or contracted locum practitioners) and clear processes for quick and effective application and execution.

Recommendation 5: The Standing Committee on Social Development recommends the Government of the Northwest Territories promote job sharing opportunities for healthcare professionals in the Northwest Territories, based off of Nunavut's model, as a strategy to increase the recruitment of healthcare professionals to the Territory.

Recommendation 6: The Standing Committee on Social Development recommends the Government of the Northwest Territories significantly increase investments into the

Northwest Territories Health and Social Services Authority for their work in providing on-the-job education training to Licensed Practical Nurses to further enhance the sustainability of the healthcare system and the autonomy of this type of nursing profession.

Recommendation 7: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with employers and Licensed Practical Nurses to promote awareness of their changed scope of practice, and work with employers to update job descriptions to ensure that they are reflective of the regulatory scope of practice in order to provide proper support to Licensed Practical Nurses.

Recommendation 8: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a targeted initiative to expand and support the integration of Nurse Practitioners in small communities to improve access to timely primary care services, including ensuring that Nurse Practitioners have continuous and reliable access to consultations with physicians.

Recommendation 9: The Standing Committee on Social Development recommends the Government of the Northwest Territories review current job descriptions within the health and social services system to see where Registered Psychiatric Nurses may be best utilized.

Recommendation 10: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into the feasibility of establishing Registered Psychiatric Nurse educational programs in the Northwest Territories that would meet the unique needs of our mental health system.

Recommendation 11: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into the feasibility of implementing programs to address key nursing education and professional development gaps such as nursing refresher programs, nurse practitioner programs, nursing bridging programs, registered psychiatric nursing programs, midwifery programs, and prescribing and diagnoses programs in the Northwest Territories.

Recommendation 12: The Standing Committee on Social Development recommends the Government of the Northwest Territories invest in the professional development of all nurses in the Northwest Territories, without reducing the allocated funding envelope for professional development for other health practitioners.

Recommendation 13: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into potential changes to the healthcare delivery framework in the Northwest Territories, including governance and

reporting structures, with potential changes to be based on the three governance structure principles outlined in this report.

Recommendation 14: The Standing Committee on Social Development recommends the Government of the Northwest Territories immediately re-assign the initiative of organizing team-based care for frontline healthcare workers to the Medical Director to ensure there is a clear point-person to take over the details of this initiative.

Recommendation 15: The Standing Committee on Social Development recommends the Government of the Northwest Territories develop, in consultation with the Standing Committee on Social Development, and publicly report on, a plan for how team-based care will be operate in small community health centres and health cabins.

Recommendation 16: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Government of Canada to share or transfer some decision-making power of the Non-Insured Health Benefits Program to Yellowknife, including establishing a physical office for Non-Insured Health Benefits in the North.

Recommendation 17: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a bursary program for Indigenous residents of small communities and a funding program with the purpose of incentivizing residents of small communities in the Northwest Territories to pursue nursing education programs.

Recommendation 18: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a marketing strategy targeting the recruitment of Indigenous residents into healthcare fields and healthcare education programs by showcasing success stories of Northern Indigenous healthcare practitioners working in the health field.

Recommendation 19: The Standing Committee on Social Development recommends the Government of the Northwest Territories staff patient advocate positions in each small community of the Northwest Territories.

Recommendation 20: The Standing Committee on Social Development recommends the Government of the Northwest Territories demonstrate that the work of the Healthcare Systems Sustainability Unit and the Public Administrator of the Northwest Territories Health and Social Services Authority is being informed by the experiences and input of frontline health practitioners to better understand where to find efficiencies in the healthcare system, such as with medical travel, and with every decision being made and reported upon, that it notes the input that has informed the decision.

Recommendation 21: The Standing Committee on Social Development recommends the Government of the Northwest Territories publicly release how many dollars can be saved by eliminating non-core services, including a break down per program/service area.

Recommendation 22: The Standing Committee on Social Development recommends the Government of the Northwest Territories publicly release the methodology used by the Healthcare Systems Sustainability Unit for the evaluation of the seven program/service areas identified for initial sustainability efforts, and how they will gain an understanding of each program/service area.

Recommendation 23: The Standing Committee on Social Development recommends the Government of the Northwest Territories demonstrate costing and milestones of the 2025-2028 People Strategy and commit to an independent analysis of its results.

Recommendation 24: The Standing Committee on Social Development recommends the Government of the Northwest Territories prioritize the work of advancing a pan-Canadian licensure at the national level as well as work with the Yukon Government and the Government of Nunavut to establish the tri-territorial licensing model.

Recommendation 25: The Standing Committee on Social Development recommends the Government of the Northwest Territories establish a scholarship or bursary (similar to British Columbia) that Internationally Educated Nurses can access in the Northwest Territories to support the cost of their Inspire assessment program with a condition that they work a certain number of years in the Northwest Territories healthcare system upon receiving the scholarship or bursary.

Recommendation 26: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the College and Association of Nurses in the Northwest Territories and Nunavut to ensure cultural training programs are afforded to Internationally Educated Nurses as well as cultural competencies for nurses across the board.

Recommendation 27: The Standing Committee on Social Development recommends the Government of the Northwest Territories research a regulatory model based on British Columbia's *Health Professional Occupation Act* with the aim of creating an arms-length regulator that encompasses a group of allied health professionals in the Northwest Territories and report on their findings.

Recommendation 28: The Standing Committee on Social Development recommends the Government of the Northwest Territories provide a response to this report within 120 days.

INTRODUCTION AND BACKGROUND

Starting in October 2024, the Standing Committee on Social Development (Committee) undertook a study on healthcare accountability and sustainability to understand how healthcare in the Northwest Territories (NWT) can become sustainable and accountable to improving the quality of care, quality of life, and wellbeing of residents and healthcare staff.

Challenges within healthcare systems in the 21st century have become increasingly complex, with COVID-19 only exacerbating the many problems faced by healthcare systems. Committee identified this study as a priority because of issues with NWT's healthcare system that have been continuously highlighted and brought forward by residents and healthcare staff. For the purposes of this study, Committee has defined sustainability as "systems sustainability", and more specifically addressing systems challenges and dynamics through a systems thinking approach. Additionally, Committee has identified accountability as when a governing body is in a position to mandate providers or organizations to meet certain enforceable goals and objectives. Accountability can also mean that an organization is being evaluated on its performance or behaviour related to something for which it is responsible.

Committee understands that issues and solutions within NWT's healthcare system have and are continuing to evolve. Committee believes health care sustainability is a complex issue that will not be solved in the life of the 20th Assembly. Achieving and maintaining strategies for healthcare sustainability in the Territory should remain a years-long, intentional pursuit by the Government of the Northwest Territories (GNWT). Acknowledging this journey, Committee presents this report, but will continue to hold the GNWT to account on the issue of healthcare sustainability and accountability in the NWT. This issue is crucial to the health and wellbeing of all NWT residents.

ACKNOWLEDGEMENTS

The Standing Committee on Social Development acknowledges the challenges that residents face in light of a struggling healthcare system. Please be kind to yourselves as you read through this report, and note that areas may be triggering to some.

PUBLIC ENGAGEMENT

Between October 2024 to March 2026, Committee engaged the public to inform Committee's project. Committee sent ten (10) targeted engagement letters to

researchers, non-profit and charitable organizations, and healthcare staff. Committee received presentations from:

- Northwest Territories Medical Association
- The Society of Rural Physicians of Canada
- The College and Association of Nurses in the Northwest Territories and Nunavut
- Lisa Little Consulting
- Honourable R.J. Simpson and Honourable Lesa Semmler
- Yellowknife Seniors Society
- Northwest Territories Seniors Society

The presentations are included in Appendix A.

Committee extends its appreciation to all individuals and organization for contributing feedback at public meetings. Committee recognizes that there is a lot of work to be done to improve our healthcare system, and thanks organizations for taking the time to provide their valuable insight.

Committee categorized the content of the public comments received into seven themes:

- Workforce sustainability
- Healthcare system structure and reform
- Fiscal and operational sustainability
- Leadership and governance
- Licensing and regulation

WORKFORCE SUSTAINABILITY

1. Recruitment and retention of healthcare workers

During its public engagement, Committee heard a strong emphasis on stabilizing the territorial healthcare workforce. Moreover, the need to implement innovative recruitment and retention strategies for healthcare professionals in the Northwest Territories was clearly identified and consistently raised by stakeholders. This is especially important considering the increasing demand for healthcare professionals across the country, as Canadian jurisdictions compete for healthcare staff. Committee recognizes broad consensus among healthcare staff, residents, and the GNWT that achieving a stable healthcare system with happy and satisfied healthcare staff is a clear priority for the Territory.

Committee heard from a key stakeholder, the NWT Medical Association (NWTMA) on April 25, 2025. Referring to the summer of 2025, the NWTMA highlighted that the NWT was reaching a “crisis point” in retaining primary healthcare staff. Referencing a recent survey they conducted and sent to physicians across the NWT, the statistics are concerning:

We have a 49% vacancy rate in primary care physicians in the NWT and a 42% vacancy rate in specialist physicians in the NWT. 63.9% of colleagues have considered leaving in the past year and 11% actually have ended their contracts.

Northwest Territories Medical Association

As of December 31 2025, the vacancy rate for physicians in the NWT was 62%. Committee believes these statistics are significantly contributing to a crisis in our healthcare system, and most importantly affecting the Territory’s healthcare staff. Another key stakeholder that Committee met with, the College and Association of Nurses in the Northwest Territories and Nunavut (CANNN), described sentiments regarding retention:

Recently, we asked nurses what they want, what would entice them to be recruited or retained in our health care system. The highest scoring responses were competitive compensation, workload and staffing levels, and work-life balance.

Megan Wood, College and Association of Nurses in the Northwest Territories and Nunavut

As of June 2025, the vacancy rate for front line registered nurses in the territory was 27%, with communities outside Yellowknife struggling with higher vacancies than in the capital.

Committee believes there should be a clear focus on the retention of nurses in the Territory, especially because Community Health Nurses (CHNs) are often described as the “backbone of care in small communities”. Stakeholder Lisa Little noted to Committee, when speaking of the recruitment and retention of nurses: “The best recruitment strategy is an effective retention strategy”. Committee wholeheartedly believes in this sentiment, thinks it is applicable to all healthcare staff, and urges that an innovative marketing strategy be created to entice healthcare workers to the Territory. Committee acknowledges that Practice NWT, under the Northwest Territories Health and Social Services Authority (NTHSSA), is the attraction and recruitment banner for health and social services professionals for the entire Northwest Territories Health and Social Services system, with a primary role to attract health and social services professionals, including allied health professionals, midwives, nurses, physicians, and social workers to

employment opportunities available in the NWT¹. Nurses are also being recruited through the Health Recruitment Unit through the Department of Finance, aimed at strengthening staffing in nursing, social work, and allied health professions across the NWT².

Recognizing PracticeNWT's aim and mandate, Committee is interested in seeing unique and innovative recruitment strategies to be further developed by PracticeNWT to help build our healthcare system. These strategies should include using current healthcare workers as the best recruitment tools. Moreover, using strategies such as word of mouth and empowering practitioners to contact their social networks, employed healthcare workers in the Territory have the tools to showcase that the NWT is a unique and exciting place to build a career. Committee presents the following recommendation in an effort to promote this different method of recruitment:

Recommendation 1: The Standing Committee on Social Development recommends the Government of the Northwest Territories work directly with frontline healthcare staff to incorporate their knowledge and connection to social networks into the recruitment of healthcare professionals into the Northwest Territories healthcare system.

In terms of creating a welcoming environment for healthcare workers in the NWT, Committee would also like to note that communities in the NWT have a large part to play in providing a welcoming environment for healthcare workers. Furthermore, to entice more healthcare workers to small communities, there needs to be an increased investment in elements that allow healthcare workers to stay in communities such as subsidized rental units and designated spots at childcare centres and day homes for healthcare workers. Committee believes these types of investments are crucial to the recruitment and retention of healthcare workers in small communities and presents the following:

Recommendation 2: The Standing Committee on Social Development recommends the Government of the Northwest Territories investigate and report on the feasibility of increased incentives for healthcare workers in small communities to the Standing Committee on Social Development, such as subsidized rental units and designated spots at childcare centres and day homes for healthcare workers.

The Society of Rural Physicians of Canada (SRPC) also brought forward the reality that the NWT faces unique challenges in healthcare delivery, as do many rural and remote areas across Canada. They highlighted that this includes the significant importance of family physicians in regions outside of urban regions (such as the NWT), as they provide the majority of health services to residents. While family physicians are extremely important in the NWT, Committee would also like to point out the reality of remote regions of the North, in that most communities rely heavily on CHNs to operate their health cabins

and centres. This creates an added layer of complexity for access to care in small and remote communities in the Territory.

As noted by a stakeholder, a common phenomenon post-COVID has been nurse burnout, with rates greater than 80% in Canada. According to a 2025 study, some contributing factors of nurse burnout may include elements such as role conflict, negative emotions, moral distress, stress, and workplace advancement. Emotional exhaustion was the most common among nurses working during the COVID-19 pandemic³. Committee notes that aspects of nurse burnout may look different in Northern setting, including isolation and large workloads. Presenters urged employers to invest in workforce mental health and professional development which may promote lower vacancy rates in positions. Chronic workforce shortages, retention struggles and gaps in local training are elements that significantly impact healthcare sustainability in rural and remote communities, and will be further discussed in the following sections.

2. Improving administrative burden and use of virtual tools

Committee believes there must be strategies implemented to improve upon the large workload and administration burden of all staff in healthcare fields. From the NWT Medical Association, Committee received the recommendation that Artificial Intelligence (AI) could be used to improve the large workload of medical staff. Committee notes that privacy issues with the *Health Information Act* have been previously emphasized by the GNWT as a barrier to introducing new technologies such as AI into healthcare settings. That being said, the GNWT launched an AI Scribe one-year pilot in January 2026 in select primary care and community health settings across the NWT. This newly introduced Mika AI Scribe tool drafts clinical notes during patient visits. This pilot is included as part of the GNWT's work to modernize health services and improve patient experience through responsible use of digital tools⁴.

The GNWT noted to Committee that other areas of investigation to help streamline workload and administration include the areas of online booking, virtual care, and remote ultrasound technologies. The Department of Health and Social Services (DHSS) and the HSS Authorities are looking at immediate and longer-term investments needed in new technologies that can help enable better care, minimize medical travel, improve access and reduce the administration burden on the system.

It is important to note that streamlining the use of higher technology tools in the healthcare system can help with administrative burden as well offer ways for the healthcare system to be more accessible, timely, and cost-efficient (such as the use of remote ultrasound and virtual care). For example, Committee acknowledges that the implementation of

virtual care technologies should not be a singular approach, and encourages that virtual care be implemented in a combined approach with the in-person work of nurses and doctors in communities. Committee believes that in-person relationships with healthcare professionals is paramount and should not be fully replaced by virtual care appointments in all cases.

To further implement technologies and strategies to address administrative burden in the NWT’s healthcare system, Committee believes that more urgent research should be conducted by the Department of Health and Social Services to meaningfully address any barriers, including those within the *Health Information Act* and with the implementation of more advanced technology. In addition, the implementation of new technologies should be adequately staffed and resourced for maximum effectiveness and speedy implementation. For example, Committee is concerned that while the technology to implement virtual appointments is available, there has been little to no clear organization around how or who is booking virtual care appointments, and who will be the practitioners offering care remotely, based on what kinds of contracts or scheduled arrangements.

Committee therefore presents the following recommendations:

Recommendation 3: The Standing Committee on Social Development recommends the Government of the Northwest Territories research, identify and address barriers - including those related to privacy within the *Health Information Act* and related to necessary higher technology upgrades – to support the timely implementation of technologies such as online booking, automated reminders for appointments, virtual care, remote ultrasound, and expanded use of artificial intelligence scribing across healthcare settings.

Recommendation 4: The Standing Committee on Social Development recommends the Government of the Northwest Territories ensure that procedures are in place for the implementation of new technologies in the healthcare system, including appropriately trained designated staff (or contracted locum practitioners) and clear processes for quick and effective application and execution.

3. Flexible employment models

Committee heard the emphasis on adopting and promoting flexible employment models for healthcare staff in the NWT, in particular for nurses. CANNN shared an anecdote regarding the Government of Nunavut implementing job-share positions, in particular using a “fly-in fly-out model” which allows nurses to rotate through positions every few months. They note that this has become a popular option.

Committee understands that flexible employment models for healthcare staff in the Territory may currently be decided on a one-to-one basis with staff and the Healthcare Recruitment Unit or the Department of Finance. That being said, it is Committee's belief that more intentional use and advertising of flexible employment models should be shared as a strategy for recruitment of nurses to the Territory. By explicitly sharing and promoting flexible work models such as Nunavut's job-sharing approach, this could be another key perk to enticing nurses to work in the NWT:

Recommendation 5: The Standing Committee on Social Development recommends the Government of the Northwest Territories promote job sharing opportunities for healthcare professionals in the Northwest Territories, based off of Nunavut's model, as a strategy to increase the recruitment of healthcare professionals to the Territory.

4. Expanding scopes of practice

The College and Association of Nurses in the Northwest Territories and Nunavut (CANNN) has the legislated responsibility, through the NWT's *Nurses Professions Act*, to set the professional scope of practice for registered nurses, registered nurse practitioners, and licensed practical nurses.

In their presentation to Committee, CANNN noted many key aspects related to expanding the scope of practice for Licensed Practical Nurses (LPNs) in the Territory. Being that the regulator is responsible for determining scope of practice frameworks, in November 2024, CANNN released a new and adopted scope of practice for LPNs. The new regulatory scope of practice enables LPNs to work to their full potential within legislative boundaries. It supports the enhancement of their skills and competencies, provided they receive appropriate education, training and support. This scope of practice framework offers a structured and reflective approach to ensuring safe, competent, and authorized nursing care. It also provides guidance to healthcare professionals, educators, employers and the public in determining whether an activity is within the scope of practice of the profession⁵.

As noted by CANNN, historically, the scope of practice for LPNs has been very prescriptive, outlining specific tasks that LPNs could execute. CANNN made it clear to Committee: There is room for the profession of LPNs to grow in the Territory. To successfully retain and recruit LPNs to the North, LPNs need to know they are able to work to the ceiling of their scope of practice while also having the supports to do. To facilitate supports and investments for LPNs in the North, Committee presents the following recommendation:

Recommendation 6: The Standing Committee on Social Development recommends the Government of the Northwest Territories significantly increase investments into the Northwest

Territories Health and Social Services Authority for their work in providing on-the-job education training to Licensed Practical Nurses to further enhance the sustainability of the healthcare system and the autonomy of this type of nursing profession.

CANNN also noted to Committee the layers of scope of practice, these include (1) the regulatory and legislative scope of practice; (2) the employer scope of practice; and (3) the scope of practice of the individual. They highlight that there is progress to be made by employers in addressing the expanded regulatory scope of practice for LPNs within job descriptions. It is for this reason that Committee presents the following recommendation, in an effort to continue to expand the profession:

Recommendation 7: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with employers and Licensed Practical Nurses to promote awareness of their changed scope of practice, and work with employers to update job descriptions to ensure that they are reflective of the regulatory scope of practice in order to provide proper support to Licensed Practical Nurses.

CANNN also described to Committee two additional types of nurses: Registered Nurse Authorized Prescribers and Registered Psychiatric Nurse Authorized Prescribers. They emphasized that right now, the NWT and Nunavut do not have any of those licensure types, and that they are in the process of implementing a jurisdictional scan to understand how other jurisdictions have implemented this type of licensure and the requirements they need to have to be able to diagnose, prescribe and treat.

The utilization of Nurse Practitioners was also brought forward by CANNN, specifically that a 2022 report by the Canadian Nurses Association found that jurisdictions that were utilizing Nurse Practitioners experienced improved patient outcomes, shorter wait times, and cost efficiencies due to decreased dependency on physician services. They recommended that the Territory continue to expand and support the integration of Nurse Practitioners, especially in rural and remote communities, to improve access to timely primary care services and reduce system reliance on locum physicians.

Recognizing how valuable Nurse Practitioners are for NWT's healthcare system, Committee recommends the following:

Recommendation 8: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a targeted initiative to expand and support the integration of Nurse Practitioners in small communities to improve access to timely primary care services, including ensuring that Nurse Practitioners have continuous and reliable access to consultations with physicians.

5. Utilization of Registered Psychiatric Nurses

Being the largest group of healthcare workers in Canada, Canadian nurses hold a vital role in addressing mental health needs⁶. During their briefing, CANNN brought forward a striking statistic to Committee: There are less than 40 Registered Psychiatric Nurses (RPNs) employed in the NWT and Nunavut combined, and less than 5 of these professionals are being utilized in the NWT. RPNs are health care professionals who provide holistic, client-centered care for clients with complex psychosocial, mental health and addictions, and physical needs. They often work both autonomously and in collaboration with their clients and health care team members, and utilize bio-psycho-social and spiritual models for a holistic approach to care. In 2024, 5,901 RPNs were employed in Canada, although this number does not include the three northern territories. Canada is seeing a stable annual growth rate for RPNs, with most being employed on a full-time basis⁷.

Research analysis regarding the use of psychiatric nurses in Canada has found that there are inconsistencies in psychiatric nursing education in Canada, and limitations for Canadian nurse practitioners to advance the role of the psychiatric mental health nurse practitioners⁶. Committee notes that there is a shortage of research studies that look at how the current nursing workforce specifically address improved accessibility to mental health care. Following the declaration of a public health crisis in September 2015, the Government of Nunavut initiated major changes to its mental health and suicide prevention strategies. One of the shared commitments was to strengthen mental health services, including developing and publishing standards for Community Psychiatric Nurses practicing in Nunavut and including Inuit-specific adaptations⁸.

CANNN made it clear to Committee: “If we can fully utilize these nurses in the Territory, we can advance the Territory’s goals for mental health and addictions recovery.” CANNN also noted that this nursing role is a highly sought after profession across Canada, while being also highly utilized in southern jurisdictions.

Committee believes that the use of Registered Psychiatric Nurses can be of huge benefit to our healthcare and mental health system and therefore presents the following two recommendations:

<p>Recommendation 9: The Standing Committee on Social Development recommends the Government of the Northwest Territories review current job descriptions within the health and social services system to see where Registered Psychiatric Nurses may be best utilized.</p>

Recommendation 10: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into the feasibility of establishing Registered Psychiatric Nurse educational programs in the Northwest Territories that would meet the unique needs of our mental health system.

6. Funding for healthcare education and training programs

Any nursing education opportunities provided in the NWT are approved by CANNN. The reason for this approval is to ensure that programs meet national standards for students.

CANNN is hearing that there are gaps when nurses can't get the training they need in the Territory. It was noted that this is due to no fault of educators but primarily due to a lack of resources. There are many training programs that would be beneficial to offer nurses in the North, and it was emphasized that many nurses are having to travel to Southern jurisdictions to do online or bridging programs, re-entry to practice, or prescriptive authority certifications.

CANNN suggested that the fact that students are being required to travel south for training is a detriment, and funding educational programs and institutions to deliver and support nurses in getting additional training would make a significant long-term impact on our health system. They provided a list of program gaps in the Territory, including:

- Nursing refresher programs
- Nurse Practitioner programs
- Nursing Bridging programs
- Registered Psychiatric Nursing programs
- Midwifery programs
- Prescribing and Diagnoses programs

Recommendation 11: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into the feasibility of implementing programs to address key nursing education and professional development gaps such as nursing refresher programs, nurse practitioner programs, nursing bridging programs, registered psychiatric nursing programs, midwifery programs, and prescribing and diagnoses programs in the Northwest Territories.

The SRRC spoke about investing in training for healthcare providers as essential for addressing the evolving needs in rural communities, and that access to training has also been shown to improve retention of family physicians.

Of note, in collaboration with the Nunavut Tunggavik Incorporated and the Institute of Circumpolar Health Research, CANNN will be undertaking a research project to explore Indigenous Nursing students' experiences writing their licensing exams. This research will aid in understanding this unique recruitment and retention issue impacting northern nursing practices. They recognize that there are Indigenous community members that are having difficulty passing their exams but who have completed their Bachelor of Science or LPN programs – recognizing that this workforce is not being fully utilized due to barriers with completing licensing exams.

Committee believes that investing in the professional development of all nurses in the Territory is crucial to their retention, including the training they need to fulfill their licensing requirements. Committee therefore recommends the following:

Recommendation 12: The Standing Committee on Social Development recommends the Government of the Northwest Territories invest in the professional development of all nurses in the Northwest Territories, without reducing the allocated funding envelope for professional development for other health practitioners.

HEALTHCARE SYSTEM STRUCTURE AND REFORM

7. Healthcare system structure in the NWT

The current healthcare system structure in the NWT includes three health authorities; the Northwest Territories Health and Social Services Authority, the Hay River Health and Social Services Authority and the Tłı̄ch̄q Community Services Agency. In August 2016, the NTHSSA was established as one of the three health and social services authorities in the NWT and serves the Beaufort-Delta, Sahtu, Dehcho, Yellowknife, and Fort Smith regions. The NTHSSA is also responsible for the operation of the Stanton Territorial Hospital Foundation⁹.

Throughout its study, Committee underwent an analysis of the current structure of healthcare delivery in the Territory, including looking at other delivery models in other Canadian jurisdictions. As a result of this analysis, Committee has concerns regarding the effectiveness of the current healthcare system structure in the NWT. Moreover, Committee has identified three principles for governance structure change in the Territory:

1. Increased ability for the Minister of Health to fix what is going wrong in the health authority;
2. Increase regional input to identify and suggest solutions for what is working and not working;

3. Policy being directly informed by front line staff experiences and realities.

In light of these principles, Committee recommends the following:

Recommendation 13: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct research into potential changes to the healthcare delivery framework in the Northwest Territories, including governance and reporting structures, with potential changes to be based on the three governance structure principles outlined in this report.

8. Primary Healthcare Reform

On April 30, 2025¹⁰, Committee received a briefing on the Primary Healthcare Reform, a mandate item of the 20th Assembly, which seeks to redesign primary healthcare delivery across all regions of the NWT. This work originated approximately ten years ago, following direction from Standing Committee, with the objectives of improving Indigenous health outcomes, enhancing system responsiveness to Indigenous clients, and integrating traditional health practices into primary care.

As noted in the Department of HSS' presentation, "primary healthcare is the foundation of our system". The presentation also outlined key contextual realities in the NWT. In 2023, access to a regular healthcare provider among residents aged 18 and older was 59%, significantly below the national average of 84%. This disparity is further contextualized by the fact that 65% of Indigenous residents in the NWT live in small communities, where healthcare is primarily delivered through a nurse-led model. The NWT has the highest per capita health expenditures in Canada, yet it continues to experience comparatively poorer health outcomes than the rest of Canada. According to the Department, these factors have collectively underscored the need for, and informed the initiation of, Primary Healthcare Reform.

The Department emphasized that the current model of primary care is not working, and transitioning to a team-based care approach has been a global trend. NWT's Primary Healthcare Reform is based off Alaska's Healthcare Transformation Project. This Project focuses on three goals for the state of Alaska: reducing the per capita cost of care, enhancing healthcare delivery, and improving population health.

In May of 2025, the GNWT released the *Honouring the Voices of Indigenous Peoples* report, which include 13 Actions for Change to improve the care experience of Indigenous residents of the NWT. The report draws from Indigenous residents' lived experiences and identified actions enabling the HSS system to strengthen Indigenous perspectives and leadership in the system. The actions for change in this report focus on clinical health

services in the NWT, and the goal of the report is to be used to inform HSS public policy decision makers with the power to make change¹¹. Committee urges the GNWT to take action in implementing the recommendations housed in this report. In addition to these recommendations and efforts, Committee heard from the SRPC of the importance of offering cultural and language-specific programs and virtual services to help mitigate challenges in the healthcare system.

It is also important to note that the NWTMA emphasized in its presentation to Committee that there was little to no consultation of physicians before the rearrangement of primary care teams was implemented in 2023/2024. It is Committee's understanding that patients and practitioners thought that the move to team-based care was what Primary Healthcare Reform was referring to, and subsequently this may be the root of confusion. Whereas, the Department of Health and Social Services may believe that Primary Healthcare Reform refers to a larger project with the rearrangement of teams in the frontline as a minor operational detail of said project. The NWTMA highlighted many frustrations with the newer amalgamation of teams, including navigating team dynamics, scheduling time off, and managing new larger administrative workloads per physician.

The rearrangement to team-based care in 2023/2024 was not the start of team-based care but it is important to note that the NTHSSA has been attempting to implement some form of team-based care for a number of years. That being said, Committee is of the view that the work of the Department of Health and Social Services in Primary Healthcare Reform is extremely disconnected from the realities of the frontline, and the implementation of team-based care as a subsection of Primary Healthcare Reform lacked clear steps for roles and procedures, and coordination with front-line workers. Committee is concerned that practitioners feel that this rearrangement has not improved access to care at the front-line level. Committee believes that the Department needs clear guidance for how significant changes (such as a move to team-based care) will impact the frontline and on-the-ground logistics, prior to making decisions for healthcare workers. It is for this reason that Committee presents the following two recommendations in an effort to streamline team-based care for frontline healthcare workers in the Territory:

Recommendation 14: The Standing Committee on Social Development recommends the Government of the Northwest Territories immediately re-assign the initiative of organizing team-based care for frontline healthcare workers to the Medical Director to ensure there is a clear point-person to take over the details of this initiative.

Recommendation 15: The Standing Committee on Social Development recommends the Government of the Northwest Territories develop, in consultation with the Standing Committee on Social Development, and publicly report on, a plan for how team-based care will be operate in small community health centres and health cabins.

9. Medical Travel Modernization

Medical Travel Modernization is one of three pillars of the Minister of Health and Social Services' 2023-2027 Mandate. Their work is to modernize the medical travel process to make it easier to understand and navigate the system. Part of this work includes incorporating medical travel into the Extended Health Benefits (EHB) policy.

Committee has heard from many constituents regarding their struggles with medical travels, which is further elaborated in a 2026 article from Cabin Radio depicting issues with medical travel and access to care¹². The Yellowknife Seniors Society and NWT Seniors Society, when presenting to Committee, described the struggles that seniors undergo when traveling for appointments, and urged the GNWT to implement virtual care systems so that unnecessary travel can be avoided. They also noted the issues with being approved for non-medical escorts, which is crucial for seniors to feel supported.

Committee is of the view that medical travel in the Territory is one of the primary drivers of higher healthcare spending, and finding efficiencies would drastically improve healthcare fiscal sustainability in the North. In fact, according to the 2024-2025 report on Medical Travel Services, there was a net spend of almost \$16M from the GNWT. The report highlights that the total number of medical travel cases rose from 17,478 to 23,004 cases in the past three years¹³.

To help streamline conversations and collaboration of medical travel appointments as well as costs, Committee recommends transferring some decision-making power from the Non-Insured Health Benefits (NIHB) office located in Ottawa, to the GNWT or the NTHSSA:

Recommendation 16: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Government of Canada to share or transfer some decision-making power of the Non-Insured Health Benefits Program to Yellowknife, including establishing a physical office for Non-Insured Health Benefits in the North.

10. Small Community Model of Care Review

The Department of Health and Social Services is working with all three Health and Social Services Authorities to redesign how care is delivered in small and remote communities of the NWT. It is noted by the Minister in her 2023-2027 Mandate that this Review is not part of Primary Health Care Reform, but it is closely aligned.

The goals of the Small Community Model of Care Review are as follows:

- Find flexible and sustainable ways to deliver health services when Community Health Nurses (CHNs) are in short supply;
- Strengthen supports for CHNs, who are the backbone of care in small communities, providing 24/7 primary, public health, and emergency care.
- Reduce the dependence on a single staff type by safely integrating other professionals, such as Licensed Practical Nurses and Paramedics.
- Lay the groundwork for a stronger, more resilient model that ensures access to care across the NWT¹⁴.

When asked about their perspective on the use of paramedics in small communities, CANNN noted that while paramedics can help nurses in communities with workload and enhance team-based care, there is also a risk in role substitution and delegation. Committee shares this concern with CANNN. On the other hand, paramedics could have an added benefit if there was a strong emphasis on a more team-based approach to the delivery of care in communities. The success of the integration of paramedics into small community care would depend on the continuity of care, and clear delineation of roles. If the same allied health workers visit the same community continuously, then paramedics could potentially add value to remote healthcare teams. CANNN also contemplated whether addressing chronic nurse vacancies by bringing in paramedics would reduce the sense of urgency in finding new ways to recruit and retain more nurses in these roles, which is also a key concern of Committee. Committee would like to make clear that paramedics cannot replace the work of CHNs, and believes that paramedics could add to healthcare teams especially in the areas of acute and emergency care, and medical transport. Paramedics in small communities cannot be a safe substitute when CHN positions remain vacant.

Committee would also like to note that, given integrating paramedics into small communities is a goal of the Small Community Model of Care Review, it is urgent and essential that the GNWT prioritize regulating paramedicine in the NWT. Committee further discusses regulating allied health professionals in section 20 of this report.

Another key concern regarding primary care in small communities was highlighted by the NWTMA, specifically about the NWT's increasingly thin and fragile healthcare staffing situation, including physicians. They emphasized that when resources are reallocated on short notice to accommodate workforce vacancies and shortages, the areas that get more impacted are physician visits to the smaller communities, which are often missed or postponed. Committee believes that more investments to recruit CHNs and Nurse Practitioners in small communities is crucial to support a system that is already struggling to keep up with increasing healthcare demand. Committee is of the view that recruiting residents of small communities to pursue education in healthcare

fields is crucial, and in particular, Committee sees value in showing success stories of Northern Indigenous healthcare practitioners to show Indigenous residents what is possible.

Committee therefore recommends:

Recommendation 17: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a bursary program for Indigenous residents of small communities and a funding program with the purpose of incentivizing residents of small communities in the Northwest Territories to pursue nursing education programs.

Recommendation 18: The Standing Committee on Social Development recommends the Government of the Northwest Territories create a marketing strategy targeting the recruitment of Indigenous residents into healthcare fields and healthcare education programs by showcasing success stories of Northern Indigenous healthcare practitioners working in the health field.

Recommendation 19: The Standing Committee on Social Development recommends the Government of the Northwest Territories staff patient advocate positions in each small community of the Northwest Territories.

FISCAL AND OPERATIONAL SUSTAINABILITY

11. Efficiency of healthcare spending

Ultimately, investing in the people who are delivering healthcare – from clerks to physios to rad techs – is the most efficient way to cut down locum costs, cut down on medical travel, and create a system delivering culturally sensitive and high-quality care.

Northwest Territories Medical Association

The NWTMA noted that bringing in locum doctors is incredibly inefficient from a healthcare expenditure standpoint. Although, this is partly because there has been difficulty in retaining permanent staff. They highlighted that the locum pay in the NWT is not competitive with the rest of Canada, and urges the GNWT to quickly reconcile this issue so that core services are not disrupted, such as the emergency room at Stanton Territorial Hospital, and to prevent burnout among staff. More specifically, the NWTMA's ask were to:

- Implement emergency measures including a new locum contract to keep the Emergency Room open over the summer of 2025¹.
- Think longer term, and focus on local contract physicians, nurses and other frontline healthcare providers, and;
- Halt implementation of new initiatives with a focus of forced growth on the initiatives already in place.

The NWTMA notes that the reality is that staffing is increasingly thin and fragile, and there is a lack of redundancy in positions to ensure time-off and safe rest periods. They noted that they are so short-staffed that even if you denied every physician's leave for a month, they still could not fill their own schedule. This leaves no buffer in the system to absorb unexpected events.

We can't really get over the fact that we need to fund healthcare more.

Northwest Territories Medical Association

The NWTMA, in an effort to explain the complexity of healthcare spending in the NWT from their perspective, provided the following example:

Let's say we have a local specialist physician. For example, we have no orthopedic surgeon in town for that day. A patient comes in from outside Yellowknife with a hip fracture. They get to Yellowknife, hoping (being told) that that's where they're going to be treated. Their family is not on their medevac flight, they have to come on their own flight. Their last stop is Yellowknife, but now, we don't have a specialist in Yellowknife to take care of this hip fracture. We now have to reallocate all of that funding to medical travel down to Edmonton, to a new specialist. Their family gets to Yellowknife. Their loved one is no longer in Yellowknife. They, too, now have to get a flight to Edmonton. So, ultimately, this one day of physician vacation is costing the NWT tens of thousands of dollars.

Northwest Territories Medical Association

This example is a clear indication of the complexity of Northern healthcare systems, and the need to evaluate this intricate and convoluted web of cost. The Healthcare System Sustainability Unit (HSSU), a project born out of the 19th Legislative Assembly, is an exercise dedicated to defining core health and social services and highlighting opportunities to improve efficiencies while also taking into account financial sustainability

¹ The NTHSSA [increased locum rates in April 2025](#), and [implemented a temporary shift bidding system](#) aimed at strengthening physician coverage in the Emergency Department at Staton Territorial Hospital.

and constraints. In 2008, eight health authorities across the NWT were amalgamated into the Northwest Territories Health and Social Services Authority (NTHSSA). In a briefing to Committee, the Premier noted that it is crucial to follow the progress on that amalgamation and ensure it is happening appropriately, hence the creation of the specific Unit within the Department of Executive and Indigenous Affairs. The HSSU is a focused effort on efficiencies and fiscal sustainability of NWT's healthcare system.

During a briefing with the Minister of Health and Social Services and the Premier on Healthcare sustainability in the Territory, there was discussion on the increasing reliance on agency nurses. It was noted that for 20 years, the GNWT was not using agency nurses, and in today's reality, the GNWT has had to use that resource to avoid shutting down facilities or services. Committee is extremely concerned how the increasing use of agency nurses has been affecting the morale of permanent staff.

Locum physician costs and medical travel costs are dramatically increasing, although locum physician expenditures have struggled to remain competitive with the rest of the country. The NWTMA made it clear: Not funding frontline workers adequately will make the healthcare system even more costly.

Recommendation 20: The Standing Committee on Social Development recommends the Government of the Northwest Territories demonstrate that the work of the Healthcare Systems Sustainability Unit and the Public Administrator of the Northwest Territories Health and Social Services Authority is being informed by the experiences and input of frontline health practitioners to better understand where to find efficiencies in the healthcare system, such as with medical travel, and with every decision being made and reported upon, that it notes the input that has informed the decision.

12. Core versus non-core services

There hasn't been one [initiative] where there was essentially an outside entity with the sole purpose of looking into this system, defining what core services we offer. Not only do we need to think differently about how Health and Social Services are delivered, but we also need to understand what programs and services are core to the NWT.

Honourable R.J. Simpson, Premier

As mentioned in a previous section, the Healthcare Systems Sustainability Unit (the Unit) focuses on finding efficiencies, and creating a healthcare system that's more functional, more sustainable, and a better place to work. As the GNWT noted in their briefing to Committee on April 25 2025, the Unit is undertaking an analytical approach on

determining what the NWT's core health and social service programs are, and defining what should be identified as core. Therefore, the first milestone of Unit was to conduct a preliminary analysis of programs and services, which resulted in the identification of seven program/service areas. The following seven program/service areas were identified for initial sustainability efforts:

- Adult Supported Living
- Bed-Based Addictions Treatment
- Out-of-Territory Hospitals/Physicians
- Medical Travel
- Physician Services
- Long Term Care
- Out-of-Home Care (Foster Care)

Committee is concerned that, while core programs and services were identified, no non-core services in the NWT were identified, despite this appearing to be an original objective of the Unit. Moreover, in Committee's understanding that the Unit was established to distinguish between core and non-core services, its evaluation of the sustainability of the seven program/service areas appears only loosely connected to that purpose. Committee views the work of the Unit primarily as a financial exercise and is concerned that the nuanced realities of each program/service area may not be fully understood, creating a risk of misunderstanding and subsequently a potential negative impact to the program or service. It is for these reasons that Committee provides the following recommendations:

Recommendation 21: The Standing Committee on Social Development recommends the Government of the Northwest Territories publicly release how many dollars can be saved by eliminating non-core services, including a break down per program/service area.

Recommendation 22: The Standing Committee on Social Development recommends the Government of the Northwest Territories publicly release the methodology used by the Healthcare Systems Sustainability Unit for the evaluation of the seven program/service areas identified for initial sustainability efforts, and how they will gain an understanding of each program/service area.

13. Population growth and an aging demographic

The NWTMA shared statistics regarding the NWT's population and changing demographic, including that in 20 years, the elderly population has more than doubled in the Territory (a 2.6-fold increase). They highlighted that an elderly population has more healthcare needs and these needs tend to be more complex. This means that the demand for healthcare in the NWT is skyrocketing.

During its study, Committee heard from the Yellowknife Seniors Society and the Northwest Territories Senior Society during a public briefing with Committee on healthcare accountability and sustainability¹⁵. Some of their key observations include issues with medical travel such as long wait times during travel for seniors causing extreme stress, and access to virtual appointments to decrease the need for unnecessary medical travel. They also mentioned the inconsistencies in allowing for non-medical escorts to support seniors. Difficulty understanding medical language as well as feelings that medical professionals are not understanding problems correctly were brought forward as a key issue for seniors. In addition, the Societies described the need for more support for Alzheimer's and dementia patients and families (i.e. respite care and day programming) and homecare supports to support aging-in-place. Grappling with the increase in locum doctors as well as the preference to be assigned to a family doctor for consistency in care was emphasized by the witnesses. Training for Personal Support Workers to work with seniors was described as crucial especially for seniors living in small communities. The issue of accessing medical appointments through online and phone systems, including limited computer literacy, is a clear concern for seniors.

LEADERSHIP AND GOVERNANCE

14. 2025-2028 People Strategy

In April 2026, the NTHSSA released 2025-2028 People Strategy¹⁶. This plan was developed to guide actions system-wide to strengthen the health and social services workforce. It was developed in partnership with the Department of Health and Social Services, the Hay River Health and Social Services Authority, and the Tłı̨ch̨ Community Services Agency.

Committee believes this People Strategy lacks substance, and worries that this plan was developed to address numerous concerns from the healthcare workforce in the Territory but is missing tangible actions, costing, and clear milestones. Committee is of the view that this plan needs to produce results that can be verified by an independent analysis to ensure that it meets the needs of the healthcare workforce. Committee therefore recommends:

<p>Recommendation 23: The Standing Committee on Social Development recommends the Government of the Northwest Territories demonstrate costing and milestones of the 2025-2028 People Strategy and commit to an independent analysis of its results.</p>
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15. Interest-based negotiations

When the NWTMA presented to Committee, they made it clear that NWTMA members supported moving to interest-based negotiations with Government partners. They pointed to the medical associations of Prince Edward Island, Newfoundland and Labrador and New Brunswick whereby they found that moving to interest-based negotiations was transformative for their health systems and relationships with Government. More specifically, by pivoting to an interest-based negotiation model, PEI was able to work through a lot of the challenges of their healthcare system, especially with how their primary care was structured. Being in the implementation phase now, PEI is seeing many real changes evolve from their adjusted negotiation position.

In May 2025, the GNWT advised the NWTMA of their collective interest in exploring interest-based negotiations as an alternative to traditional positional bargaining. Workshops have been taking place with both parties since June of 2025, discussing mutually beneficial outcomes including an improved relationship and potential efficiencies. During a public briefing with Committee, the Public Administrator stated his intention to meet with the NWTMA on a monthly basis. It is Committee's understanding that interest-based negotiations are underway and hopes that this new approach will have fruitful results.

16. Vacancies in key leadership roles

We currently have a top-down approach to leadership, so frontline workers are not part of any decisions being made for healthcare delivery.

Northwest Territories Medical Association

The NWTMA stated gaps and glaring vacancies in key leadership positions such as medical director roles that influence how ongoing challenges are being reported to more senior officials and how this creates constant barriers to dealing with on-the-ground issues quickly and efficiently. The SRPC also states that when frontline healthcare workers often feel demoralized when administrators do not listen to their feedback, which in turn can make the recruitment of healthcare staff even more difficult. They noted that healthcare administrators often hesitate to change because it means more work, leading to maintaining the status quo rather than establishing innovative changes.

The gap between frontline staff and leadership highlights the need for Medical Director positions that are ready to advocate for physicians and healthcare staff to more senior government officials:

The glaring vacancy in medical director roles has further increased the gap between frontline and leadership, and this is leading to significant mistrusts between both levels.

Northwest Territories Medical Association

The Department of Health and Social Services provided details to Committee that Area Medical Director and Territorial Medical Director positions have been difficult to recruit for. It is Committee's understanding that some Area Medical Director positions and the Territorial Medical Director position have now been filled, and is hoping that these long-standing problems in communication between front-line and leadership will be worked on, and improvements can be made. Due to these recent changes, Committee expects to see tangible changes to these challenges.

LICENSING AND REGULATION

17. Pan-Canadian licensure for physicians

Committee heard from multiple stakeholders on issues with pan-national licensing. The NWTMA highlighted that it can take anywhere from six weeks to six months to obtain an additional medical license in the NWT, making it very difficult to quickly fill gaps in care. It was also suggested that the recruitment of physicians leaving the United States may be a way to bring more physicians to the NWT.

The Society of Rural Physicians of Canada made it clear to Committee that one of the most impactful solutions for the Canadian healthcare system would be the implementation of a pan-Canadian licensure. Although doctors undergo similar training across Canada, currently, each province and territory independently licenses every physician¹⁷, and costs for each physician can be several thousand dollars per year. To practise medicine in a Canadian jurisdiction, physicians must pay fees to each province or territory's Medical Regulatory Authority, recognizing that costs can differ per jurisdiction¹⁸. In a survey conducted by the Canadian Medical Association, three in five doctors stated that the overall complexity of the licensing process was a major obstacle to practising in other jurisdictions. Three quarters of these doctors surveyed emphasized that national licensure would also improve access to care for residents. Other barriers to licensure discussed in this survey include the length of the process of licensing, and as discussed, the cost of getting licensed¹⁷. The SRPC noted that the implementation of a pan-Canadian licensure would lead to increased workforce mobility and therefore increased stability for healthcare systems.

Pan-Canadian licensure could immediately widen the pool of available physicians who can provide help when needed, and for this reason Committee inquired about the GNWT's work with other jurisdictions in developing a pan-Canadian licensure. It was brought forward that the Department of Health and Social Services actively participates in national conversations to ensure that the context of the NWT is considered and addressed in any pan-national framework. Other work being done in addition to being a part of national conversations includes the intention to present consequential amendments to the *Medical Profession Act*¹⁹ by Fall 2027 which will help improve labour mobility, and review internal processes for ongoing improvement. There is also preliminary discussion initiated about a tri-territorial licensing model but further discussion is needed to consider this approach.

It is Committee's understanding that preliminary discussions have been initiated about a tri-territorial licensing model. The GNWT noted to Committee that this approach may present compelling advantages for the Yukon, NWT and Nunavut given similar population sizes, geographic challenges, healthcare delivery models, and physical recruitment needs. Committee believes that implementing pan-Canadian licensure is a high priority for all jurisdictions, and would support progress with the tri-territorial licensing model as well.

Therefore, Committee presents the following recommendation:

Recommendation 24: The Standing Committee on Social Development recommends the Government of the Northwest Territories prioritize the work of advancing a pan-Canadian licensure at the national level as well as work with the Yukon Government and the Government of Nunavut to establish the tri-territorial licensing model.

18. Labour mobility of nurses

The policy context of labour mobility for healthcare professionals, particularly for nurses, has been a longstanding struggle in Canada. Academic studies have called for a better understanding of policies that affect the mobility of healthcare workers²⁰.

Notably, CANNN has entered into a commitment to enhance labour mobility for nursing professionals by facilitating common approaches to licensing with other jurisdictions. This includes conversations with 21 other nursing regulators across Canada. CANNN shared their vision for labour mobility: For nurses who want to be mobile between different jurisdictions, they are able to move between provinces and territories without there being lengthy waits. This could look like a change in licensing types, minimizing processing times for verification, and the adoption and onboarding of Nursys. Nursys is a national database of all nursing regulators to review and exchange information on license status

and once adopted, this will replace the need for verifications of registration. It was brought forward that Alberta and Quebec are the only two jurisdictions that have not signed onto the use of Nursys, which could create a challenge as most of nursing labour mobility in the NWT comes from Alberta.

19. Internationally Educated Nurses

On December 5 2025, Committee received a briefing from the Joint Territorial Nursing Council on Internationally Educated Nurses (IENs), including the action being taken, what is feasible for the NWT, and next steps²¹. They defined IENs as someone who completed their nursing education in another country outside of Canada. They noted feedback from the public: “There are IENs living in the Territory who want to work as registered nurses but face barriers”. The GNWT acted after receiving this feedback by reviewing legislation and regulatory requirements, engaging the Joint Territorial Nursing Council, and launching a working group and survey to understand the issue.

Historically, CANNN required that IENs have 1,125 practice hours in another Canadian jurisdiction before they could license them but this has been changed to 450 hours in the past two years. For those who do not have these practice hours, they are able to complete the Inspire Assessment which provides an in-depth overview of the education’s curriculum, a review of their clinical and communication skills, and a detailed report of any gaps that may impact their ability to deliver care²². Once this report is received by CANNN’s Registration committee, they can make a recommendation for coursework to fill these gaps or the Registrar can consider conditions on the IENs license to restrict the areas in which they are practicing.

CANNN identified to Committee the need for further research into other countries that do hold educational equivalencies, and are currently collating the evidence for other countries as well as implementing a “no size fits all” approach. This means that they recognize that there is a need to be agile and nimble in applications. Committee would like to see an increase of IENs based in the NWT accessing the Inspire assessment program, as Committee believes IENs are an untapped resource in the Territory. Of note, British Columbia has created financial support for IENs to help cover costs and fees related to the credentialing, registration, and remedial education required for their registration²³. This is an approach that Committee recommends the GNWT to pursue, to help see more IENs enter our healthcare system:

Recommendation 25: The Standing Committee on Social Development recommends the Government of the Northwest Territories establish a scholarship or bursary (similar to British Columbia) that Internationally Educated Nurses can access in the Northwest Territories to support

the cost of their Inspire assessment program with a condition that they work a certain number of years in the Northwest Territories healthcare system upon receiving the scholarship or bursary.

Committee is also interested in IENs and registered nurses in the Territory accessing Northern cultural training, and therefore presents the following recommendation:

Recommendation 26: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the College and Association of Nurses in the Northwest Territories and Nunavut to ensure cultural training programs are afforded to Internationally Educated Nurses as well as cultural competencies for nurses across the board.

20. Regulation of Allied Health Professionals

Regulation is often seen as red-tape; however, right touch regulation is the process of providing regulatory oversight for a profession that is interested in improving the knowledge, skills, and abilities of the profession to uphold the mandate of public safety – moving away from the punitive historical way of regulating.

Megan Wood, College and Association of Nurses in the Northwest Territories and Nunavut

During their presentation, CANNN brought forward their recommendation to Committee that the GNWT consider establishing regulation for allied health professionals, including but not limited to paramedics, health care aides, respiratory therapists, occupational therapists, and physiotherapists. They pointed to British Columbia's *Health Professions Occupation Act*, as their approach is a hybrid model of regulation to support smaller health professional bodies in their province. This approach may lend well to the NWT, as CANNN further recommends advancing allied health professions abilities to self-regulate to reduce conflicts of interest between the employer acting as the regulator. More information regarding BC's approach to regulating allied health professionals is included below.

In July 2025, the Ministry of Health of the Government of British Columbia announced that the *Health Professions Act* will be repealed on April 1st, 2026 and replaced by the *Health Professions and Occupations Act (HPOA)*²⁴. The HPOA is now the governing legislation for regulation of health professions in British Columbia, and amalgamates eleven health-professional colleges into two²⁵, representing the Government's years of work to reform and overhaul its system for regulating healthcare workers²⁶. As CANNN noted that rather than having direct government oversight and regulation, they have moved forward with implementing the HPOA and creating an arms length regulator that

encompasses all allied health professionals. Direct government oversight and regulation can be a conflict of interest, given that they can be the primary employer and regulator.

CANNN has also been hearing significant concerns from the front line regarding the lack of regulation of allied health professionals, alongside trust in these roles across the NWT. Currently, nursing is the only self-regulated profession in the Territory. More broadly, provinces across Canada – particularly in 2025 and into 2026 – have begun reassessing regulatory framework to improve public protection, enhance efficiency, and ensure greater consistency in disciplinary processes²⁷.

Committee recognizes the GNWT's efforts to bring health and social services professions under the umbrella of the *Health and Social Services Professions Act*²⁸ and emphasizes the urgency of expediting this work to include additional professions. This would support the potential adoption of a single regulatory model, similar to British Columbia's approach. Accordingly, Committee makes the following recommendation to explore this model and its possible implementation in the NWT:

Recommendation 27: The Standing Committee on Social Development recommends the Government of the Northwest Territories research a regulatory model based on British Columbia's *Health Professional Occupation Act* with the aim of creating an arms-length regulator that encompasses a group of allied health professionals in the Northwest Territories and report on their findings.

CONCLUSION

Healthcare sustainability and accountability in the Northwest Territories is a complex, and ongoing issue that requires targeted and continuous efforts for clear solutions for residents. Committee was made acutely aware of strategies to help strengthen the healthcare system by dedicated witness and experts.

Committee is grateful to all the witnesses who provided extensive information on the sustainability of the healthcare system in the Territory.

Recommendation 28: The Standing Committee on Social Development recommends the Government of the Northwest Territories provide a response to this report within 120 days.

ENDNOTES

- ¹ <https://www.practicenwt.ca/en/about-us>
- ² <https://www.gov.nt.ca/en/newsroom/caroline-wawzonek-health-recruitment-unit>
- ³ Getie A, Ayenew T, Amlak BT, Gedfew M, Edmealem A, Kebede WM. Global prevalence and contributing factors of nurse burnout: an umbrella review of systematic review and meta-analysis. *BMC Nurs.* 2025 May 26;24(1):596. doi: [10.1186/s12912-025-03266-8](https://doi.org/10.1186/s12912-025-03266-8). PMID: 40420259; PMCID: PMC12108038.
- ⁴ <https://www.gov.nt.ca/en/newsroom/gnwt-launches-ai-scribe-pilot-support-patient-care-strong-privacy-safeguards>
- ⁵ CLPNL. February 2026. [Scope of Practice Framework for Licensed Practical Nurses in Newfoundland and Labrador.](#)
- ⁶ Smith, M. & Khanlou, N. April 2013. An analysis of Canadian psychiatric mental health nursing through the junctures of history, gender, nursing education, and quality of work life in Ontario, Manitoba, Alberta, and Saskatchewan. doi: [10.1155/2013/184024](https://doi.org/10.1155/2013/184024)
- ⁷ Canadian Institute for Health Information. July 24, 2025. [Registered psychiatric nurses.](#)
- ⁸ United for Life. June 2017. [Inuusivut Anninaqtuq Action Plan 2017-2022.](#)
- ⁹ <https://www.nthssa.ca/en/about-us>
- ¹⁰ April 30, 2025. Public Briefing on Primary Healthcare Reform available at: <https://www.youtube.com/watch?v=G9Q2CDrHfDg&list=PLZiv8ITEMg4dqZsYMEW --kMWhEAsBGae&index=33>
- ¹¹ https://www.nthssa.ca/sites/nthssa/files/resources/05.30.25_-_honouring_the_voices_of_indigenous_peoples_report_-_final.pdf
- ¹² <https://cabinradio.ca/291041/news/yellowknife/i-told-them-i-was-alone-i-sobbed-on-the-procedure-table/>
- ¹³ https://www.hss.gov.nt.ca/sites/hss/files/resources/medical_travel_report_2024_2025.pdf
- ¹⁴ <https://www.hss.gov.nt.ca/en/services/minister-health-and-social-services-%E2%80%93-mandate-2023-2027/model-care-small-communities>
- ¹⁵ August 13, 2025. Public Briefing on Healthcare Accountability and Sustainability with the Yellowknife Seniors Society and Northwest Territories Seniors Society available at: <https://www.youtube.com/watch?v=ZtYYvMuEojU&list=PLZiv8ITEMg4dqZsYMEW --kMWhEAsBGae&index=35>
- ¹⁶ https://www.nthssa.ca/sites/nthssa/files/resources/nwt_health_and_social_services_system_people_strategy_2025-2028.pdf
- ¹⁷ Vogel, L. November 18, 2019. [What's the holdup on national licensing for doctors?](#) *Canadian Medical Association Journal.*
- ¹⁸ [https://mcc.ca/credentials-and-services/pathways-to-licensure/application-for-medical-registration/Medical-Profession-Act.](https://mcc.ca/credentials-and-services/pathways-to-licensure/application-for-medical-registration/Medical-Profession-Act)
- ¹⁹ [https://www.cna-aic.ca/en/policy-advocacy/2025-federal-election-platform#:~:text=A%20streamlined%2C%20pan%2DCanadian%20licensure,%2C%20northern%2C%20and%20Indigenous%20communities.](https://www.cna-aic.ca/en/policy-advocacy/2025-federal-election-platform#:~:text=A%20streamlined%2C%20pan%2DCanadian%20licensure,%2C%20northern%2C%20and%20Indigenous%20communities)
- ²¹ December 8, 2025. Public Briefing on Status Update from the Joint Territorial Nursing Council: <https://www.youtube.com/watch?v=hiH-D-IUsAQ&list=PLZiv8ITEMg4dqZsYMEW --kMWhEAsBGae&index=41>
- ²² <https://cannn.ca/internationally-educated-nurses/>
- ²³ <https://www.heabc.bc.ca/Public/Marketing/Nurses/HMBC%20NJB%20RN%20Bursary%20Info.pdf>
- ²⁴ British Columbia's [Health Professions and Occupations Act.](#)
- ²⁵ CBC News. June 28 2024. [B.C. merges health-profession colleges.](#)
- ²⁶ CBC News. August 27 2020. [B.C. moving ahead with massive reform of system for regulation health-care workers.](#)
- ²⁷ <https://www.dentons.com/en/insights/newsletters/2026/january/14/global-regulatory-trends-to-watch/dentons-canadian-regulatory-trends-to-watch-in-2026/reglementation-des-professions-de-la-sante>
- ²⁸ [Health Social Services Professions Act.](#)

APPENDIX A: SUBMISSIONS and PRESENTATIONS

Presentation to the Standing Committee on Social Development Northwest Territories Medical Association

April 25, 2025

Agenda

1. President's Message - Our asks to the Standing Committee Dr. Courtney Howard
2. Key issues facing the NWT healthcare system Drs. Cassandra Mooney and Danielle Stachiw
3. Discussion
4. Next step



Crisis in Care: Physician Engagement and Staffing in the Northwest Territories' Healthcare System

Dr. Courtney Howard MD CCFP (EM), President, Northwest Territories Medical Association
Dr. Danielle Stachiw MD FRCP, Treasurer, NWTMA
Dr. Cassandra Mooney MD CCFP, Secretary, NWTMA
William Gagnon, BEng, MSc, PMP, Executive Director, NWTMA

Speaking on behalf of the NWTMA membership and as part of our college responsibility to advocate for healthy public policy on behalf of our patient population.

Presentation to Standing Committee on Social Development
Yellowknife, April 25, 2025



Asks from the NWTMA

1. Support for Interest-Based Negotiation

Our Ask: PEI, Newfoundland/Labrador and New Brunswick medical associations have found moving to interest-based negotiations (IBN) to be transformative for their health systems and relationships with government. NWTMA members strongly support moving to IBN. We need to have a firm decision by mid-September. A public expression of support from the committee for the pursuit of IBN jointly between the NTHSSA, HSS and the NWTMA would be appreciated.

2. Fund Healthcare Frontline

Our Ask: NWT no longer pays as much as many places in Canada and we are having trouble attracting and retaining both permanent and locum physicians. Doubling of elderly population without expansion of resources is straining the system. Speedy implementation is critical to prevent service disruptions and burnout among core staff.

- A. Emergency measures - new locum contract to keep ER open over the summer ASAP
- B. Long term to focus on local contract physicians, nurses and other frontline healthcare providers.
- C. A halt to implementation of new initiatives with a focus of forced growth on the ones already in place.

3. Breakdown legislative barriers.

Our Ask: Various gains in efficiency could be made by getting rid of legislative or bureaucratic barriers— these issues have always been flagged by other provincial and territorial medical associations.

- A. Privacy barriers to implementing AI tools to reduce charting time and free up MD hours to see patients.
- B. Pan national licensing; need to be ready because we need it more than any other jurisdiction.

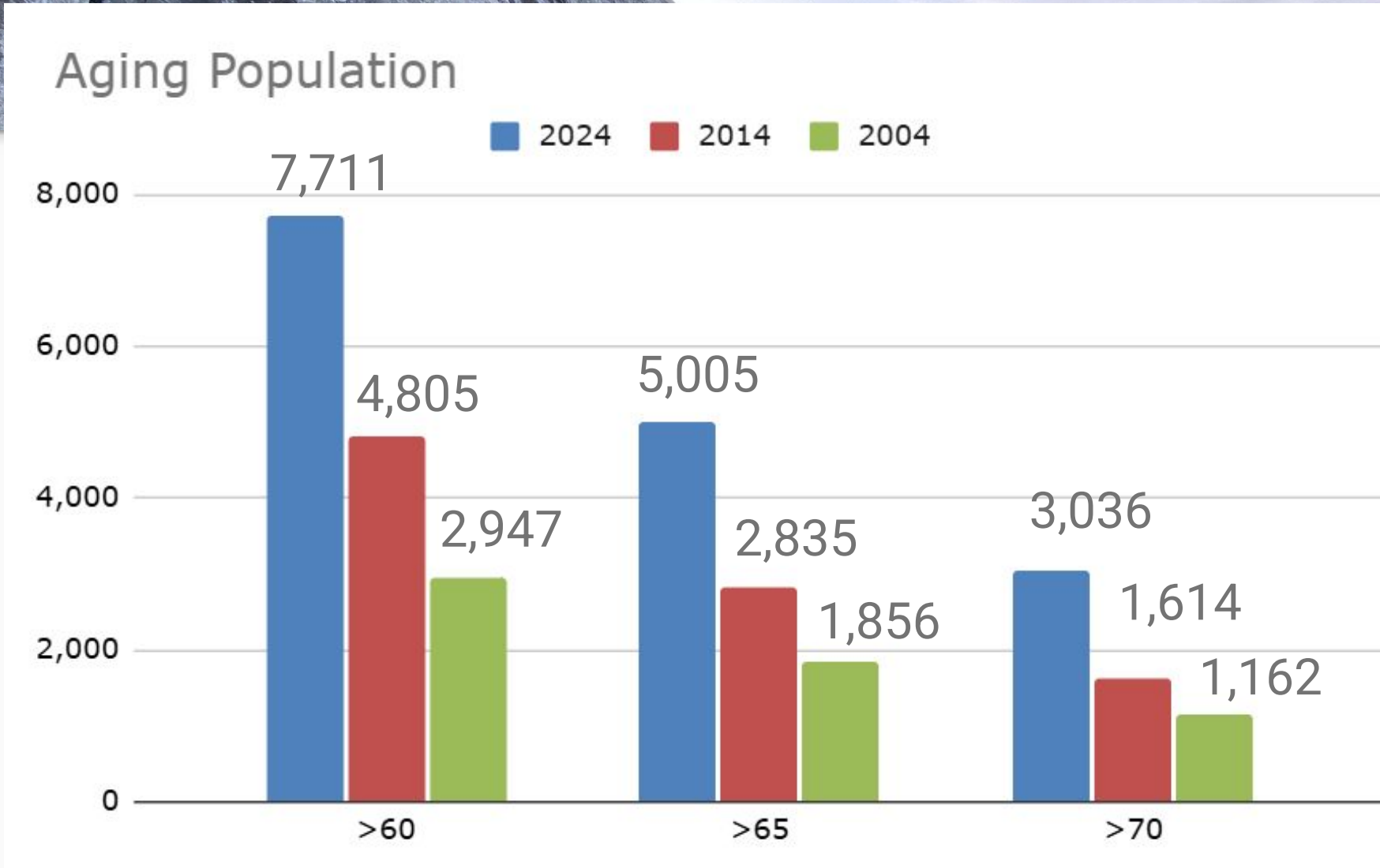




Who we are

- Leaders in their fields
- Award winners
- Committed to their patients
- Dedicated to improving patient care.
- Eager to collaborate
- Willing to embrace change with meaningful engagement and support
- Family Physician of the Year
- CCFP President-Elect
- Global leader in climate health
- Order of Canada Recipient
- Past President of the CMA
- Specialist of the Year
- Premier's Award for Excellence
- Rural Leadership Awards
- Rural Service Awards

Who we care for



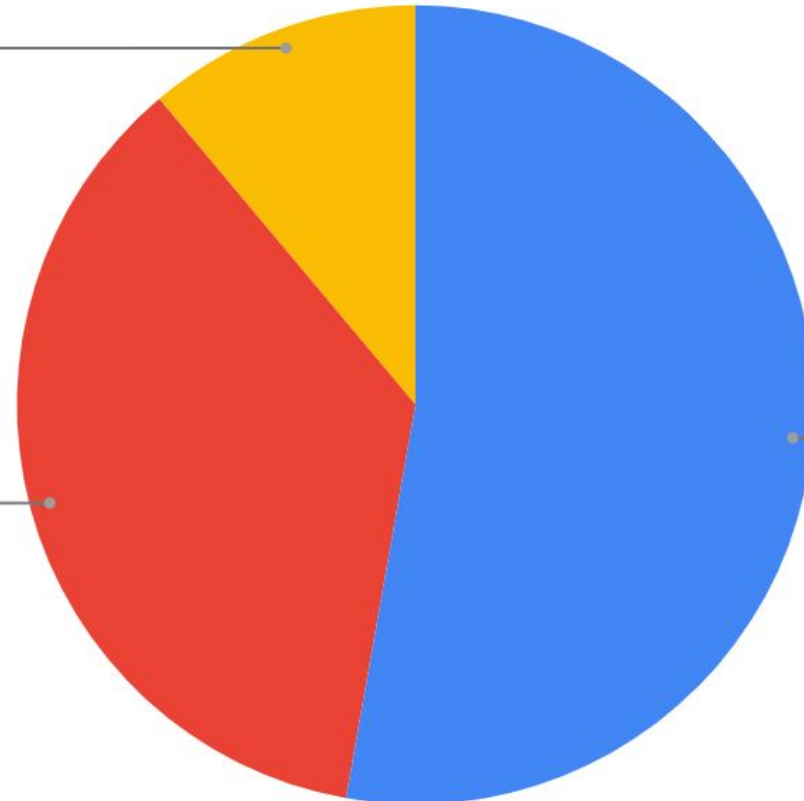
Key Survey Results

- 68% response rate from NWTMA members.
- **63.9%** **considered leaving in the past year.**

Yes, decided
11.1%

No
36.1%

yes, considered
52.8%





Key Workplace Concerns

- **Staffing Issues:** Severe understaffing, turnover, and reliance on locums.
- **Leadership Challenges:** Lack of transparency, trust, and autonomy.
- **Systemic Issues:** Bureaucratic delays and lack of contingency planning.
- **Personal Strain:** Isolation, stress, and burnout.

Declining physician numbers lead to:

- Increased workload on remaining staff.
- Burnout and further resignations.
- Deterioration in patient care and outcomes

Asks from the NWTMA

1. Support for Interest-Based Negotiation

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Questions, Reflections, and Next Steps

Presentation to Standing Committee on Social Development
Yellowknife, April 25, 2025





FOR IMMEDIATE RELEASE

November 1, 2024

Northwest Territories Medical Association Calls for Urgent Government Action to Safeguard Patient Care in Primary and Emergency Health Services

Yellowknife, NT — The Northwest Territories Medical Association (NWTMA) has issued an urgent letter to Premier R.J. Simpson, Minister of Health and Social Services Lesa Semmler, and Minister of Finance Caroline Wawzonek, underscoring the critical need for government intervention to prevent disruptions in primary care and emergency services. The NWTMA warns that ongoing staff shortages and systemic challenges are putting essential health services—and ultimately, patient safety—at risk.

Adding to these concerns, the NWTMA expresses alarm over the findings in the recent Auditor General's report on the Stanton Territorial Hospital project, which revealed significant issues with planning and management. The NWTMA emphasizes that patients are paying the price for these failures, and the Association is calling for accountability to address these missteps.

"Patients in the Northwest Territories rely on a robust healthcare system, particularly for culturally competent primary care and around-the-clock emergency services," said Dr. Kate Breen, an Emergency Physician and President of the NWTMA. "With the added findings from the Auditor General's report, it is evident that without swift action, we risk further compromising the quality and sustainability of healthcare services in the North."

Furthermore, the NWTMA is concerned about the recent commitment made in a public letter to all Yellowknife residents that every resident will be assigned to a primary care team. There has been no communication of a plan to increase staffing to be able to provide acceptable care to the whole population. Physicians have expressed concern that by increasing workload and responsibility beyond data-informed, standard panel sizes, that they will be unable to provide safe and sustainable care.

The NWTMA's letter calls for a coordinated effort to address urgent healthcare needs in the Territory. It highlights challenges that impact patients directly, including a severe shortage of healthcare providers, challenges to culturally competent care related to a lack of consistent staffing, and inadequate resources to enable emergency departments to operate safely. These issues place Northern communities at risk of longer wait times, reduced continuity of care, and reduced access to emergency medical services. The findings of the Auditor General's report



underscore the critical need for improved real-time analysis to enable better planning and management to ensure that resources are effectively allocated.

Key recommendations outlined in the letter from the NWTMA include:

- **Ensuring Competitive and Sustainable Physician Staffing:** Adjusting locum rates and enhancing physician contracts to ensure a stable, competitive workforce that can serve patients without interruption.
- **Supporting Culturally Competent Care:** Increasing efforts to retain Northern-based physicians who are familiar with the unique cultural and healthcare needs of the region and who play an essential role in providing culturally safe and community-centered care.
- **Strengthening Emergency Services:** Addressing the urgent need for staffing and resources in emergency departments, which often operate under strain. Unlike other ER departments, our territorial ER cannot close when it is understaffed, leading to situations where sick calls or inadequate staffing simply mean the covering physician can't go home, or other doctors, who should be recovering, are called in. This leads to unsafe conditions and physician burnout.
- **Reducing Administrative Barriers to Patient Care:** Physician work hours are finite, and the healthcare staffing crisis is nationwide and will not have a quick fix. To free up more MD time to spend with patients, the NWT must re-evaluate administrative demands and address regulatory barriers that prevent other providers from operating to the top of their scope in a team-based care mode. These efforts should align with national work to decrease administrative burden so healthcare providers can focus on providing direct, effective patient care.
- **Accountability and Resource Allocation:** In light of the Auditor General's findings, the NWTMA urges the government to ensure accountability for decisions made during the Stanton Territorial Hospital project. It is critical that future resources be directed toward primary care and public health—areas that evidence shows provide the greatest benefit to the population.
- **Invest in frontline healthcare workers (+/- and not in Bureaucracy)** Quality of care, safety and patient experience are directly improved with investment in front line healthcare workers including nurses, technicians, occupational and physical therapists, ect. Also, those working in the frontline, with direct understanding of the on the ground issues, need to have more opportunity to direct and guide decision making in healthcare delivery.

The NWTMA's recommendations aim to uphold the quality of care that patients across the Northwest Territories expect and deserve. The NWTMA stressed the need to prioritize solutions: "Ensuring that every patient in the North has access to culturally responsive primary care and timely emergency services is fundamental to their health and safety. Our communities need



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stable healthcare teams that understand and respect their needs, and we look forward to working alongside the government to make this a reality."

The NWTMA remains committed to advocating for a resilient, patient-focused healthcare system.

Contact:

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Northwest Territories Medical Association

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October 27, 2024

Honourable R.J. Simpson, Premier of the Northwest Territories
Honourable Lesa Semmler, Minister of Health and Social Services
Honourable Caroline Wawzonek, Minister of Finance

Re: Risk of Yellowknife Physician Staff Loss

Dear Premier and Ministers,

The Northwest Territories Medical Association (NWTMA) has recently engaged in conversations with physicians in the Yellowknife area, including those working in primary care, the emergency department, and specialist clinics. These have made clear that prompt action is essential to prevent clinical disruptions and retain staff.

Following these discussions and with an opportunity for input provided to all NWTMA members, we have drafted this letter to express our concerns regarding the significant risk of clinical service disruptions and physician staff loss in Yellowknife.

On the surface, it may appear that Yellowknife-based services are adequately staffed, as there have been relatively few visible service disruptions. However, this veneer of adequate staffing is increasingly thin and fragile. In recent years, maintaining it has required exponentially more effort from the Office of Medical Affairs and Credentialing (OMAC) and others, often at the cost of unsafe working conditions for physicians and staff. There is little to no buffer in many areas to absorb unexpected events. We are deeply concerned that current conditions will lead to further attrition of local physician staff, increasing risk to NWT patients.

While this letter does not provide exhaustive answers or suggest a comprehensive plan, it aims to highlight red flags, propose immediate actions to alleviate pressure, and offer direction for the medium and long term. We encourage the Northwest Territories Health and Social Services Authority (NTHSSA) and the Department of Health and Social Services (DHSS) to engage physicians and other clinical and non-clinical staff in ongoing dialogue about the challenges they face on the front lines. Further, we ask that our previous March 2024 submission (in response to the call for Restoring Balance: A Fiscal Sustainability Strategy) be given serious and timely consideration for broader health system changes that are urgently needed.

We are grounded in the following shared beliefs:



- Primary care is the bedrock of the healthcare system and must be prioritized.
- Low-value expenditures that do not contribute to improved care must be minimized.
- Given the nationwide shortage of healthcare professionals, which will not have a quick fix, we must care for those who provide care in the North. This includes:
 - Ensuring our systems support them to work at the top of their skill set for the greatest percentage of their working day.
 - Minimizing administrative burden (such as paperwork not requiring physician knowledge or skills).
 - Ensuring they can take the time off they need to maintain wellness, prevent burnout, and attend to illness or family emergencies.
 - Prioritizing support and value for physicians living in the North.

Challenges and Suggestions

1. Recruitment and Retention:

Both the primary care clinic and the Emergency Department (ED) have reported that staff are reaching their breaking point concerning working conditions. Recruitment efforts have been inadequate to compensate for staffing shortages.

The reorganization of the Yellowknife primary care clinic has caused major disruptions to relationships and workflow, leading some to leave or consider leaving.

The ED has faced continuous challenges in covering shifts, resulting in physicians working twelve-hour shifts, multiple consecutive night shifts, and often without the support of a second physician. Additionally, physicians are often unable to call in sick because there is simply no one to replace them: either they work while they are ill or the colleague on the preceding shift is unable to go home. Unlike other EDs in the country, our territorial department is not able to close temporarily due to staffing issues. Given the high density of decision making in the ED, it is important that physicians are rested and cognitively sharp. These conditions also impact locums, worsening their working conditions and reducing their willingness to return.

Immediate Actions:

- Increase the locum rate to what was offered in the summer, effective immediately.
- Conduct a nationwide scan of locum remuneration in comparable settings to ensure that NWT offers competitive compensation continuously.
- Offer incentives for recurring and longer-stay locums. Locums with experience in the NWT function more similarly to local physicians due to their familiarity with the complex system, allowing for increased continuity of care and cultural safety.



- Re-establish communication and build trust between physicians and physician leaders by prioritizing the filling of vacant Medical Director roles and holding regular meetings to assess progress.
- Provide local physicians with incentives for leadership positions. Finalize a contract specific to physician leadership roles, including adequate incentives to encourage participation.
- Collaborate closely with the Manager of the Office of Medical Affairs and Credentialing (OMAC) to review staffing needs and commit to right-sizing and funding that office to ensure critical functions are fulfilled.

Ongoing Actions:

- Ensure that remuneration negotiations for permanent physicians reflect these new locum rates and offer conditions that incentivize them to settle in the North.
- Engage physicians formally in recruitment efforts, as peer-to-peer work has been shown to be more effective than interactions with non-peer recruiters. Prepare for upcoming opportunities for NWT-based physicians to lead the College of Family Physicians of Canada and the Canadian Medical Association, maximizing their potential to attract new physicians to the North.
- Prioritize inclusion of physician leadership roles, with adequate support and redundancy, in health budgeting to ensure stability and sustainability of these positions.
- Commit to undertaking a system-wide multidisciplinary Health Workforce Plan, building on the foundation set by the 2020 Physician Workforce Plan document. This plan provides a clear model for team-based care and analyzes the physician resources required for all current services in the NWT, most of which remain underfunded. This document should be used to make clear recommendations for physician services funding. Share the 2020 Physician Workforce Plan with staff, decision-makers, and the public, and create a plan to adequately fund physician positions to support existing programs and services.

2. Working to the Top of Scope:

Work culture and privacy restrictions prevent current staff from working to the fullest extent of their skills and from minimizing administrative burdens, leading to frustration, inefficiencies, and burnout.

Immediate Actions:



- Undertake a critical review of the interpretation of the current Health Information Act (HIA), particularly regarding privacy-related restrictions preventing non-physician health professionals from providing team-based care. Remove those restrictions where feasible within the current legislative framework.
- Conduct a nationwide scan of practice scopes and standards for all health professions, including licensed practical nurses, community health nurses, nurse practitioners, and clinic assistants, to rapidly develop principles aligned with national standards.
- Reduce unnecessary administrative burdens on physicians, allowing them more time to provide direct patient care. This initiative has been successfully implemented elsewhere and is supported by the Canadian Medical Association as a priority.

Ongoing Actions:

- Ensure that the upcoming scheduled review and revision of the Health Information Act is undertaken with a commitment to balancing privacy protection and ensuring it does not create barriers to quality care. This process should include discussions with both clinical and non-clinical front-line workers to identify how the current act, or its interpretation, inhibits care provision.

3. Caring for the Carers:

The physician contract affords excellent benefits such as vacation, continuing medical education (CME), sick days, and special leave days, but utilizing these benefits is often challenging due to staffing shortages, contributing to distress and burnout.

While operational requirements must influence leave adjudication, current staffing shortages lead to increasing inflexibility regarding leave approval and delays in that approval. Many services, particularly the emergency department and primary care services, are so short-staffed that local staff cannot fill the schedule, even if all leave is denied. Physicians working across multiple service areas find it increasingly difficult to coordinate leave with colleagues. We are concerned that, due to recruitment challenges, local physicians are denied leave when they cannot fulfill scheduling requirements within their contracted hours, which greatly impacts their well-being. While this may be acceptable in short-term emergencies, the ongoing pattern, coming on the heels of the COVID19 pandemic and the wildfire-related evacuation of the health system is increasingly unsustainable and is likely to affect decision making when it comes to



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contract renewal.

Immediate Actions:

- Ensure that physicians can take time off for illness, family emergencies, or planned vacation/CME without fear of denial or cancellation.
- Protect scheduled time off, without expecting physicians to undertake extra or non-contracted work during those hours.
- Prioritize schedules and support for physicians residing in the North.

As the voice of physicians in the Territory, the NWTMA is committed to advocating on behalf of its members and the citizens of the North for access to high-quality healthcare. We understand that work may be underway to address some of the issues we have identified and would welcome the opportunity to engage in dialogue about how physicians can assist in moving things forward. We recently heard in the public briefing on the new Sustainability and Accountability Unit that a clinician will be an asset to the team. This would be an excellent opportunity to have a physician directly involved in this unit to give a clear understanding of the clinical and quality impacts of the decisions made, and to build upon the practical recommendations from our March 2024 submission.

Before we lose more physicians, we look forward to collaborating with you to ensure we sustain a healthy workforce, a viable system, and continue enhancing the health of Northerners.

Yours sincerely,

Dr. Katherine Breen, MD CCFP-EM
President, Northwest Territories Medical Association

cc: Ms. Jo-Anne Cecchetto, Deputy Minister of Health and Social Services
Ms. Kim Riles, CEO, Northwest Territories Health and Social Services Authority
Dr. Claudia Kraft, Territorial Medical Director



Proposed Agenda for April 11, 2025, 10 AM

Attendees

Dr Courtney Howard, President, NWTMA
Dr Sarah Cook, Member-at-Large, NWTMA
Dr Zack Bordman, Negotiations Team, NWTMA
Dr Danielle Stachiw, Treasurer NWTMA
Dr Kate Breen, Past-President NWTMA
William Gagnon, Executive Director, NWTMA

Allen Stanzell, Senior Advisor, Governance NTHSSA, GNWT
Dan Florizone, Public Administrator, NTHSSA GNWT
Kimberly Riles, CEO, NTHSSA, GNWT
Krista March, NTHSSA, GNWT

Order

1. Recording reminder
2. Introductions
3. Review & approval of agenda
4. Updates from NWTMA:
 - a. AI scribe utilization in healthcare—are there laws/privacy concerns to prohibit use, and if so, can we solve them rapidly to improve morale and retention through paperwork reduction?
 - i. NWTMA sustainability submission describes many concrete initiatives
 - b. Follow up on leadership concerns
 - i. What is TMD contract/oversight
 - c. ER summer staffing situation.
 - d. Structure of leadership:why is there no physician leadership entity.
 - e. Plan to capitalize on US physician outflow?
5. Update from NTHSSA
6. Proposal to work with GNWT to learn together about Interests-Based Negotiations
7. PEER North 2025: save the date for Mr Dan Florizone
8. Open discussion
9. Any other items
10. Next steps

Attachments

See next pages.



Position Paper: Exploring Interest-Based Negotiation (IBN) Together

Submitted by the Northwest Territories Medical Association (NWTMA)
to the Government of Northwest Territories (GNWT)
ahead of the April 11, 10AM meeting.

Executive Summary

The Northwest Territories Medical Association (NWTMA) seeks to collaboratively explore the potential of Interest-Based Negotiation (IBN) with the Government of the Northwest Territories (GNWT) as a constructive alternative to traditional positional bargaining. Rather than adopting IBN outright, we propose a joint learning process, including training and facilitated discussion, to assess its suitability in our unique territorial context.

What is IBN?

Interest-Based Negotiation (IBN) is a collaborative approach to collective bargaining that emphasizes mutual understanding, joint problem-solving, and long-term relationship-building. Unlike traditional positional bargaining, IBN focuses on the underlying interests of both parties to develop outcomes that benefit all stakeholders.

Key characteristics of IBN include:

- Joint fact-finding and shared understanding of issues
 - Focus on interests, not positions
 - Collaborative solution development
 - Emphasis on trust and transparency
-

Positive Jurisdictional Experiences with IBN

Medical Society of Prince Edward Island (MSPEI)

- MSPEI successfully implemented IBN in recent negotiations.
- The process allowed both parties to uncover and address core issues collaboratively.
- PEI experienced 34 full-day negotiation sessions over a fall-winter period, typically conducted in 3–5 day batches. While this required a significant time investment, it was equivalent to just 7–10 weeks of dedicated negotiation.
- The greatest benefit has been the trusting and collaborative relationship developed between physicians and government, which has extended well beyond the negotiation table.
- MSPEI worked with experienced IBN facilitators such as Barney Dobbins (FMCS), Peter Simpson (FMCS), and Frank DeMont, KC.



Yukon Medical Association (YMA)

- YMA undertook a full IBN process with the support of the Federal Mediation and Conciliation Service (FMCS), which provided facilitators and training.
- The approach enabled robust stakeholder engagement through anonymous surveys and focus groups, revealing that many physician concerns were not financial, but structural—such as flexibility, locum coverage, and office supports.
- Though resource-intensive, YMA's experience highlights how IBN can surface deeper systemic needs that traditional bargaining often overlooks.

Ontario Medical Association

- The OMA is using a mix of IBN and traditional bargaining.

Key Components for Successful IBN Implementation (according to interview with NS and PEI experiences)

- Shared training on the IBN process for all parties involved
- Facilitator involvement, especially for first-time implementation
 - Consider reducing facilitator role as negotiations progress due to complexity of healthcare issues
- Buy-in from top leadership (e.g., CEO, board, minister, premier)
- Decision-makers present at the negotiation table
- Commitment to trust and collaboration from all parties

NWTMA's Proposed Path Forward

We do not presume IBN is the right fit for our next negotiation cycle without first engaging in a collaborative discovery process. To that end, NWTMA proposes:

Process Review-(Now) – Review materials and experiences from successful IBN implementations in other jurisdictions.

Decision With Regards to Whether to Explore Join Learning With Regards to IBN- (May 15)

If willing to explore, engage in joint learning –(May/June 2025) GNWT and NWTMA jointly participate in IBN training sessions, ideally facilitated by the FMCS or a qualified expert (e.g., Barney Dobbin, Peter Simpson).

Decision Yes or No Feasibility Assessment –(Sept 15, 2025) Determine together whether IBN is a good fit for the NWT, and under what parameters it might succeed.

> Timeframe Consideration – A complete IBN negotiation cycle may take approximately 30–35 full-day sessions, ideally spread out over the fall and winter in manageable 3–5 day blocks. This is comparable to a 7–10 week time commitment. - Between September 2024 to March 2025

> Funding Considerations—Currently the GNWT substantially finances NWTMA negotiation costs, with contractual obligations to pay for mediation and arbitration. As a small organization which does not benefit from a membership base in the thousands as do provincial medical associations, the NWTMA would also require support from the GNWT or other sources in order to move forward with Interest-Based negotiations. Please note that the Federal mediation and conciliation service of Canada has anecdotally paid for such trainings to be provided in the past to other provincial and territorial medical associations. We are in the process of exploring if such an opportunity would be available to NWT.



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> Default fallback to traditional bargaining— the NWTMA is suggesting that GNWT and NWTMA work jointly on IBN, with a fallback date at which we would revert to traditional bargaining if IBN fails.

Funding

Please note that the Federal mediation and conciliation service of Canada has anecdotally paid for such trainings to be provided in the past to other provincial and territorial medical associations. We are in the process of exploring if such an opportunity would be available to NWT.

Attachment

To further inform this proposal, we have included an informational document prepared by the Medical Society of Prince Edward Island (MSPEI). This document outlines their IBN experience in greater detail, including structure, facilitation, timelines, and key lessons learned. We encourage all parties to review this resource to better understand the practical application of IBN in a Canadian healthcare setting.

 [IBN Process and Experience NWT Nov 2024.pptx.pdf](#)

Conclusion

The NWTMA believes that IBN holds promise as a collaborative framework for addressing shared challenges in physician negotiations. Our ask is simple: let's learn together. By taking the time to jointly explore this model, we can determine whether IBN offers a path to stronger relationships, deeper mutual understanding, and better outcomes for physicians, government, and ultimately, patients across the Northwest Territories.

Contact

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Will Gagnon, Executive Director, NWTMA – nwtmda@gmail.com, +1 514 996 6284
Dr. Courtney Howard, President, NWTMA, courtghoward@gmail.com, +1 867 446 7776



Briefing Note

Presentation to the Standing Committee on Social Development

Prepared by: Northwest Territories Medical Association (NWTMA)

Meeting date: April 25, 2025

Participants:

- **Dr. Danielle Stachiw**, Treasurer
- **Dr. Cassandra Mooney**, Secretary
- **Dr. Courtney Howard**, President (joining virtually)
- **William Gagnon**, Executive Director (joining virtually)

Supporting material: [Meeting with Standing Committee on Social Development April 25 2025](#) with input from Dr. Katherine Breen, MD CCFP (EM), NWTMA Past President

Executive Summary

Our Asks to the Standing Committee:

Our asks are detailed in the following pages, but summarized here for your convenience.

1. Support for Interest-Based Negotiation

PEI, Newfoundland/Labrador and New Brunswick medical associations have found moving to interest-based negotiations (IBN) to be transformative for their health health systems and relationships with government. NWTMA members strongly support moving to IBN. A public expression of support from the committee for the pursuit of IBN jointly between the NTHSSA, HSS and the NWTMA would be appreciated.

2. Fund Healthcare Frontline

NWT no longer pays as much as many places in Canada and we are having trouble attracting and retaining both permanent and locum physicians. Doubling of elderly population without expansion of resources is straining the system. Speedy implementation is critical to prevent service disruptions and burnout among core staff.

A. Emergency measures - new locum contract to keep ER open over the



summer ASAP

- B. Long term to focus on local contract physicians, nurses and other frontline healthcare providers.
- C. A halt to implementation of new initiatives with a focus of forced growth on the ones already in place.

3. Breakdown legislative barriers.

Various gains in efficiency could be made by getting rid of legislative or bureaucratic barriers— these issues have always been flagged by other provincial and territorial medical associations.

- A. Privacy barriers to implementing AI tools to reduce charting time and free up MD hours to see patients.
 - B. Pan national licensing; need to be ready because we need it more than any other jurisdiction.
-

In more detail

Opening: Key Issues Facing the NWT Healthcare System

- Breakdown in Communication and Trust
 - The NWTMA survey reveals **63% of physicians are considering leaving** the territory—an unsustainable attrition rate.
- Dangerous Understaffing in Long-Term and Extended Care
- ER summer staffing situation
 - Stanton ED is at imminent risk of service reduction
- Implementation Stagnation: Technology, AI Scribes, and Virtual Care
- Structure of leadership: Why is there no physician leadership entity?



NWTMA Advocacy Priorities

The NWTMA is committed to the following priorities to stabilize and improve the healthcare system in the Northwest Territories:

1. Renewal of the Standard Physician Contract

- Through Interest-Based Negotiation principles, aimed at rebuilding trust and engagement.
- IBN has been undertaken by various jurisdictions in Canada, and it is often credited for the resolution of systemic issues even when an agreement is not reached and negotiations revert back to traditional bargaining.
- **An NWTMA poll reveals that 84.6% of physicians surveyed are in favor of pursuing IBN.**

Supporting document:  [NWTMA Position paper on IBN.pdf](#)

2. Strengthening Frontline Care


- Prioritize staffing current integrated care team models
- Prioritize funding to the frontline healthcare
- Prioritize the care and treatment of local physicians

3. Break Down Legislative Barriers

- A. Investments in telehealth and virtual care hardware and software will lead to long-term reduction in medical travel, which cost \$56M in 2022-2023.
- B. National Licensure for Physicians
 - i. Support for expedited licensing pathways.
 - ii. The Canadian Medical Association as well as other provincial and territorial medical associations have launched their recruitment campaigns.


4. Sustainable Healthcare Systems

- Climate resilience, adaptation to environmental health risks, and decarbonization of operations. As was seen during the 2023 wildfire evacuation, healthcare systems in Northwest Territories are not prepared for the impacts of climate change.

Urgent Government Action to Safeguard Patient Care in Primary and Emergency Health Services:  [Release November 1, 2024.pdf](#)



Risk of Physician Staff Loss, Dr Kate Breen October 2024:

 Letter Re Risk of Yellowknife Physician Staff Loss.pdf

Our Asks to the Standing Committee

The following asks to the Standing Committee would help the NWTMA accelerate the removal of barriers to the improvement of our healthcare system to both strike a few quick wins that would remove pressure on physicians, as well as build towards more longer-term sustainability.

1. Support for Interest-Based Negotiation

The NWTMA has received positive interest from the NTHSSA to pursue interest-based negotiation jointly.

The NTHSSA has notified the Department of Finance and asked for their participation but has not heard back yet.

Our Ask: PEI, Newfoundland/Labrador and New Brunswick medical associations have found moving to interest-based negotiations (IBN) to be transformative for their health health systems and relationships with government. NWTMA members strongly support moving to IBN. We need to have a firm decision by mid-September. A public expression of support from the committee for the pursuit of IBN jointly between the NTHSSA, HSS and the NWTMA would be appreciated.

2. Fund Healthcare Frontline

NWT no longer pays as much as many places in Canada and we are having trouble attracting and retaining both permanent and locum physicians. Doubling of elderly population without expansion of resources is straining the system. Speedy implementation is critical to prevent service disruptions and burnout among core staff.

- A. Emergency measures - new locum contract to keep ER open over the summer ASAP
- B. Long term to focus on local contract physicians, nurses and other frontline healthcare providers.



Our Ask:

1. That the Committee urges the Department of Health and Social Services and the Department of Finance to finalize and execute contracts that will increase locum physician capacity in the NWT for summer 2025.
2. Prioritize funding to frontline healthcare; including clerks, nurses, nurse practitioners, home care, street outreach, incarcerated patients.
3. A halt to implementation of new initiatives with a focus of forced growth on the ones already in place.

3. Breakdown Legislative Barriers.

Various gains in efficiency could be made by getting rid of legislative or bureaucratic barriers— these issues have always been flagged by other provincial and territorial medical associations.

- A. Privacy barriers to implementing AI tools to reduce charting time and free up MD hours to see patients.
- B. Pan national licensing; need to be ready because we need it more than any other jurisdiction.

Our Ask: Undertake a critical review of the interpretation of the current Health Information Act (HIA) to eliminate bureaucratic barriers.

Conclusion

The NWT healthcare system is not operating under business-as-usual conditions. The risk of collapse in critical service areas is real, immediate, and worsening. The NWTMA is committed to collaborative solutions, but this requires meaningful action, not just dialogue. We call on the Committee to exercise its mandate to review performance and advocate for justice, equity, and safety in healthcare delivery.

Contact

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SOCIETY OF
Rural Physicians
OF CANADA

Witness Presentation:

Healthcare Sustainability and Accountability Standing Committee on Social Development

Society of Rural Physicians of Canada

January 16, 2025





Society of Rural Physicians of Canada (SRPC)

Founded in 1992, the SRPC is the national voice of Canadian rural physicians.

The SRPC is a voluntary professional organization with over 3500 members representing rural physicians spanning the country.



Our Vision

Excellent health care close to home for all rural Canadians.



Objectives of the Presentation

Addressing healthcare sustainability and accountability in the NWT with a focus on rural challenges.

Our recommendations:

- Advocate for Pan-Canadian Licensure
- Allocate Funding for Training
- Develop a Comprehensive Rural Health Workforce Strategy



Pan-Canadian Licensure – A Key Solution

Enabling Workforce Mobility

- Simplifies provider movement across provinces/territories.
- Addresses workforce shortages in areas like the NWT.
- Reduces administrative barriers for locums and new recruits.
- Encourages recruitment and retention of healthcare professionals.





Funding for Training – Enhancing Local Capacity

SRPC received funding to implement a National Advanced Skills and Training Program for Rural Practice.

Build Skills Locally

- Increases access to care
- Reduces costly patient transfers
- Supports retention



**National Advanced Skills
and Training Program
for Rural Practice**

Optimizing rural care

[Skills and Training Program](#)

An aerial photograph of a small town nestled in a valley, with large mountains in the background. The town features a mix of residential houses and commercial buildings. The image is overlaid with a semi-transparent white shape that frames the text.

A Rural Health Workforce Strategy

A Strategic Commitment to Sustainability

Government needs to commit to the development and implementation of a RURAL health workforce strategy.



Benefit to the NWT

Why does this matter?

- Improved access to timely and high-quality care.
- Reduced strain on rural and urban centers.
- Strengthened community health outcomes and resilience.

Collaboration is needed between governments, healthcare organizations and communities.



Thank you!

The SRPC is committed to continue to advocate and support!

The Challenge

Access to care **close to home** is a concern for those in rural, remote, and Indigenous communities in Canada.

Few opportunities exist for rural physicians to enhance their skills once in practice.

Lack of confidence is a barrier for those interested in moving to a rural area or expanding the scope of care provided.

The Objective

Enhancing access to **advanced skills training** for rural physicians, to serve community needs.

“ I am now an independent ultrasound practitioner and can help certify other physicians. ”

“ I have a connection with a mentor I can now call. ”

Program Budget: \$7.4M a portion of the \$43M received as part of the Team Primary Care: Training for Transformation. Managed by the Foundation for Advancing Family Medicine (FAFM) & funded by Economic and Social Development Canada (ESDC).

Self-designed by rural

Training based on an identified community need:

- \$1000 / day income reimbursement
- Travel + accommodation expenses
- Preceptor payment
- Locum payment + overhead
- Course + equipment costs

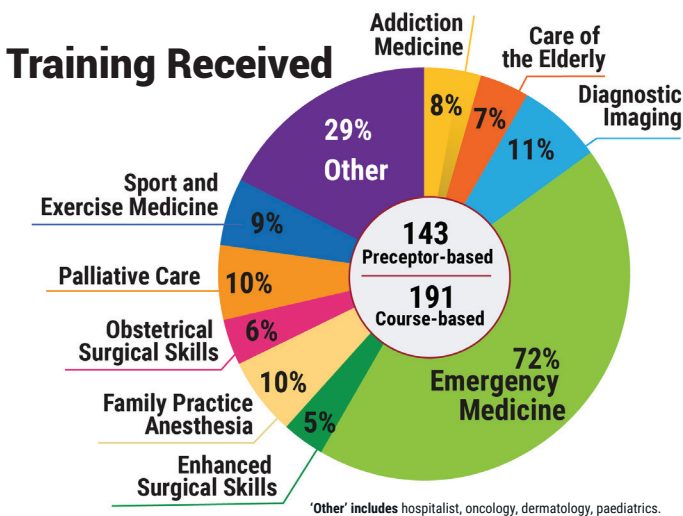


342	Rural Physicians
187	Communities
60 +	Indigenous Communities
28%	International Medical Graduates (IMGs)
8 (2.4%)	Indigenous Physicians
26 (7.8%)	Francophone Physicians

“ We can now support ongoing provision of cancer treatments locally in-territory, allowing patients to receive care close to home, in a culturally safe environment. ”

Potential benefit on health outcomes for 1,311,570 rural Canadians, 1 year after program start.

Based on an average of 3,835 patients per practice as reported by participants.



Future program directions:

- Enhanced partnership and engagement with Indigenous physician organizations
- Ongoing, sustainable funding for continued program delivery
- Targeting under-represented communities for increased participation
- Monitoring and evaluation of long-term impact on retention and service delivery in rural Canada

Overall Outcomes:

Improved Access to Care:

- Timely diagnosis of medical conditions
- Reduction of transfers and wait times
- Increased team-based interprofessional care

Enhanced Community Services & System Resilience:

- Provision of additional services, including rural emergency, surgery, obstetrical, anesthesia care

Recruitment and Retention:

- Improved working relationships with pre-hospital and nursing staff
- Self-reported increased likelihood to stay in rural communities
- Strengthened networks of mentorship and care

For more information contact:

Email: info@srpc.ca | Toll Free: 1-877-276-1949

Average projected expense per physician **\$24K**

Average amount reimbursed **\$15K**
(35% less)

100%
reported training increased access to care in their rural communities

74%
feel a better connection to a network of support

94%
still have additional training needs



RURAL PHYSICIAN PERSPECTIVES ON NATIONAL MEDICAL LICENSURE

SUMMARY REPORT



Survey Results & Analysis
April 2023



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CONTEXT

Background

There is a lot of discussion about implementing a pan-Canadian approach to medical licensure in order to overcome the barriers that prevent physicians from providing healthcare anywhere in Canada. Rural doctors face difficulties in obtaining licenses, which impedes their ability to practice in underserved and rural areas. This is a pressing issue for the Society of Rural Physicians of Canada (SRPC). Various organizations have urged the federal government to adopt a national approach to licensure to address the current shortage of healthcare professionals. However, the idea of pan-Canadian licensure has raised concerns among stakeholders and policymakers. One viewpoint suggests that implementing pan-Canadian licensure would worsen the shortage of physicians in rural Canada, as it could lead to rural doctors leaving for urban areas.



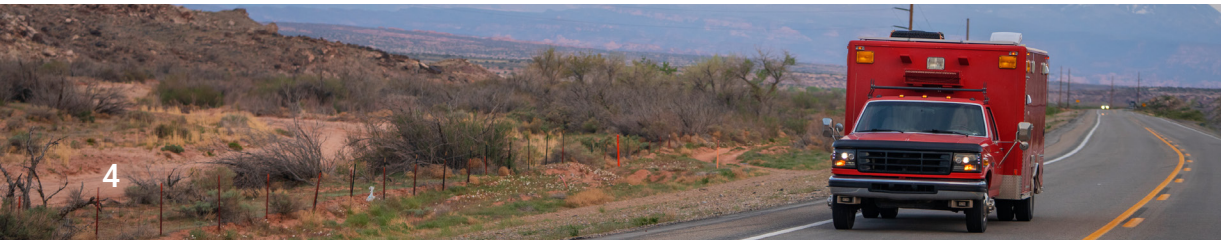
Survey Objective

In November 2022, the SRPC conducted a membership survey to determine if medical licensure is a factor that impacts a physician's decision to leave or remain in a rural community. Questions were also asked to obtain a general perspective on national licensure.



“Pan-Canadian (national) licensure is defined as the ability for physicians with full licenses to practise independently without restrictions or for medical resident trainees registered in any Canadian jurisdiction to practise or train in any other Canadian jurisdiction without having to acquire more than one license or pay additional licensing fees.”

— **Canadian Medical Association (CMA)**



METHODOLOGY

An email was sent to 5,900 SRPC contacts asking them to complete an online survey. Out of these contacts, 33% were rural physicians practicing in rural communities. A total of 1,147 participants completed the survey, which represents a response rate of 19% of the overall distribution. Among the respondents, 1,000 indicated having a rural practice.

Out of the 1,147 participants who responded to the survey, 362 provided written responses. The data results and analysis were reviewed by the SRPC (qualitative) and the CMA (quantitative) in aggregate and de-identified form.

LAUNCH: NOVEMBER 3, 2022

CLOSE: DECEMBER 5, 2022

1,147 TOTAL RESPONSES

*Respondents identified as full-time practice, locum, clinical practice with academic appointment, retired and part-time.

KEY FINDINGS

When asked whether they had ever left rural practice to move to an urban practice due to licensure

71% of survey respondents indicated they had never left rural practice.

Among those who had left rural practice, the top reasons provided for moving were:

- 50%** To be closer to family and friends
- 29%** To be closer to their spouse or partners
- 26%** A more attractive community or lifestyle
- 21%** Education and professional development
- 21%** To provide locum services



In written responses to this question, reasons for leaving included feeling burnt out, lacking support to make the practice sustainable, receiving job opportunities, needing a better lifestyle for family, and being unable to provide specialized services (e.g., anesthesia) for the rural community.

KEY FINDINGS

Top 3 reasons for applying for a license in another province

Provide locum services

76%

Seek/explore adventure

53%

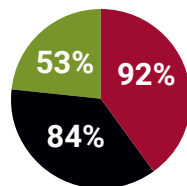
Be close to family

21%

Better compensation

21%

Top 3 obstacles encountered in applying for an additional license



- Length of time or process to obtain a license
- Cost of getting licensed
- Credential verification

How implementation of national licensure would affect practice

- 78% Seek locum opportunities in other provinces/territories
- 77% Practice temporarily in rural/remote areas in other provinces/territories
- 76% Relieve/assist my colleagues/other practitioners
- 75% Remain in Canada rather than seek opportunities abroad
- 69% Continue to practice part-time during retirement
- 69% Seek professional development educational opportunities

KEY FINDINGS

Several themes emerged from qualitative responses to the survey :



Restrictive licenses and administrative burdens enforced by provincial/territorial regulators (such as fees and paperwork) create challenges in attracting physicians to work in rural communities outside of their home provinces.



Semi-retired or retired rural doctors who are interested in doing locums have been deterred from pursuing licensure outside their home provinces because of burdensome regulatory requirements.



National licensure would help address rural physician workforce shortages by making it easier for doctors (including urban physicians) to practise in rural and underserved communities and provide locum coverage.

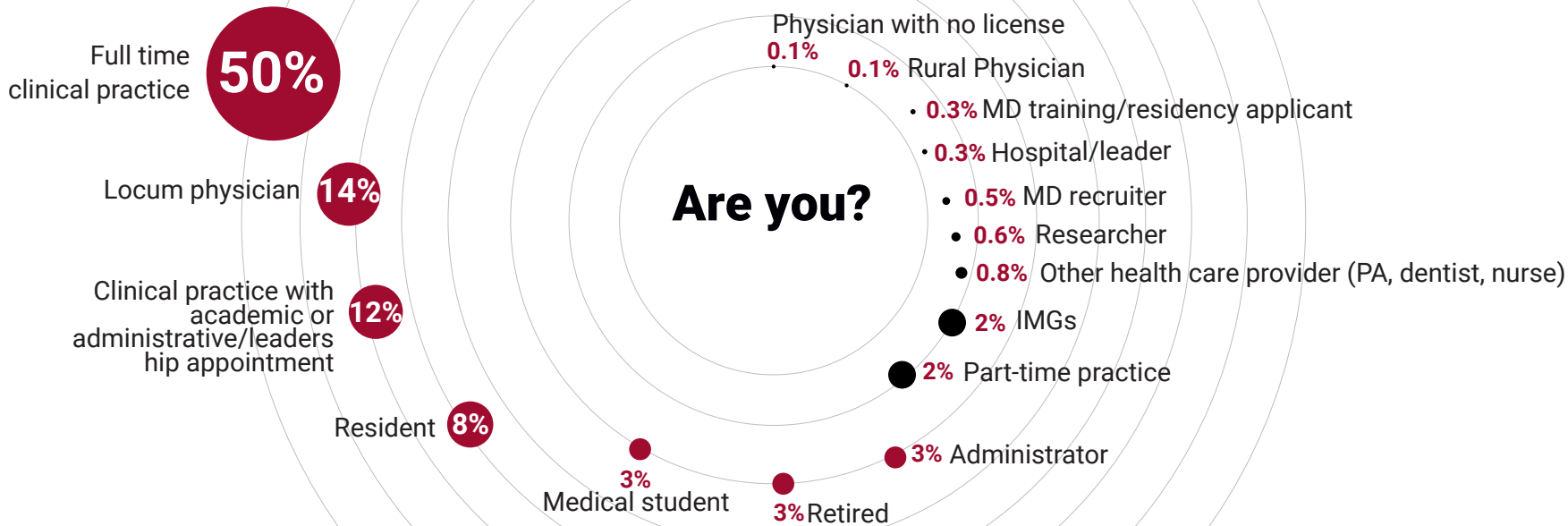


National licensure would alleviate rural physician workforce shortages by simplifying the process for doctors, including urban physicians, to practice in rural and underserved communities and offer locum coverage.

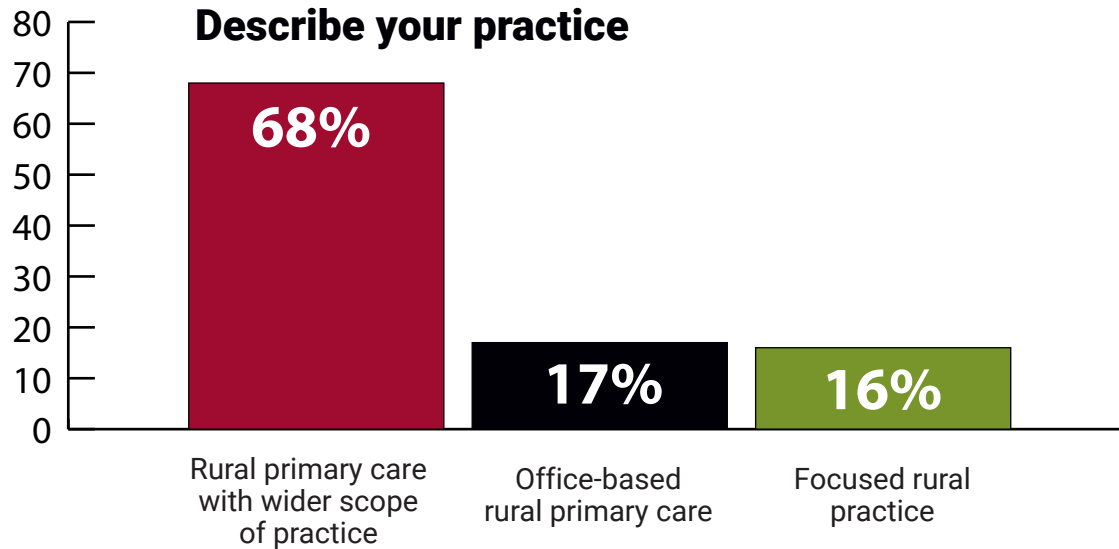


Minimal support from regulators and policy-makers is a key factor affecting the implementation of pan-Canadian licensure.

RURAL PHYSICIAN LANDSCAPE

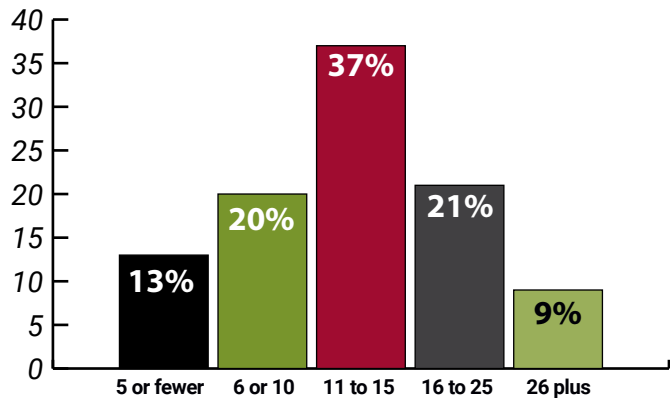


RURAL PHYSICIAN LANDSCAPE

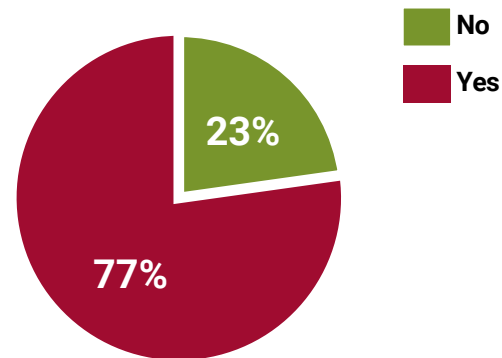


RURAL PHYSICIAN LANDSCAPE

How many full-time years have you been practising rural medicine?

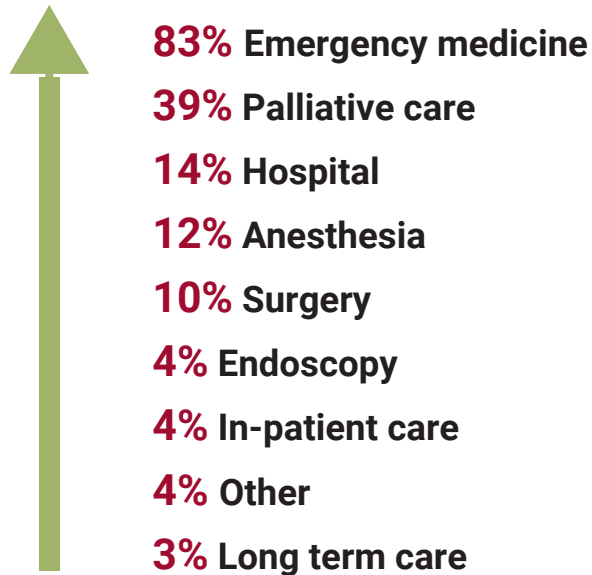


Is your medical practice within 50 km of a provincial/territorial border?



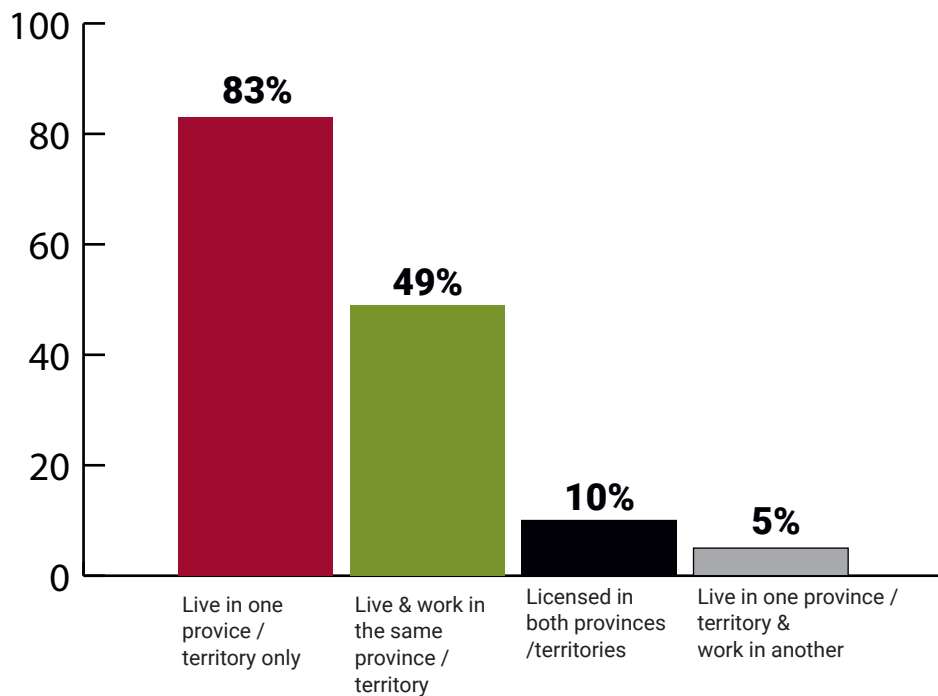
RURAL PHYSICIAN PRACTICE PATTERNS

Rural primary care with a wider scope of practice.



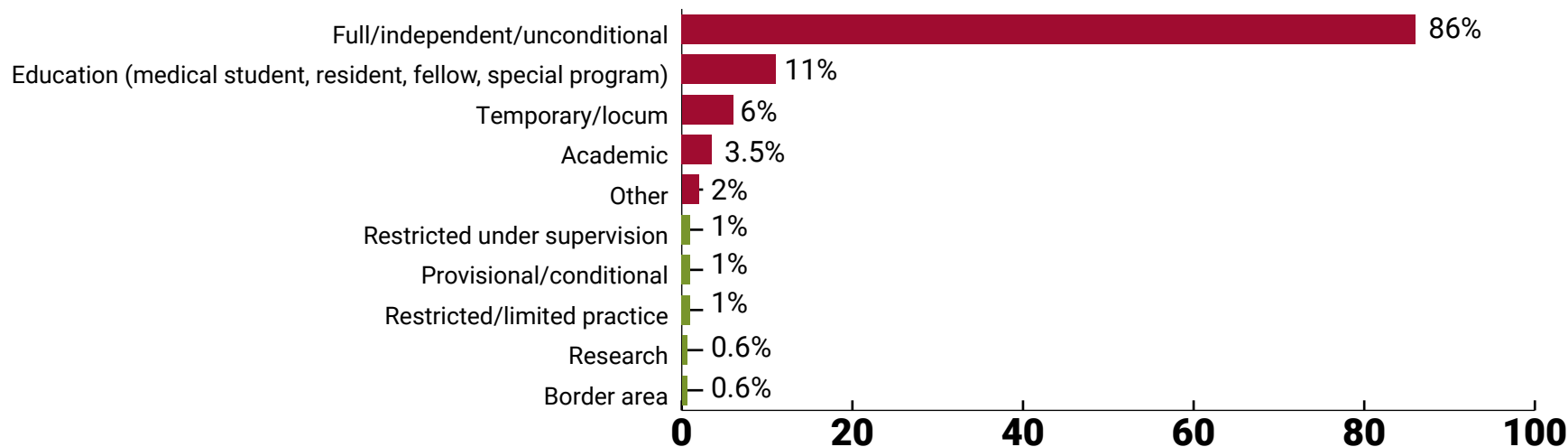
LICENSURE EXPERIENCE

Medical practice within 50 km of a provincial/territorial



TYPE OF LICENCE

Kind of medical licence(s)/registration – check that apply



HOLD ACTIVE LICENSE

Canadian jurisdiction(s) currently hold an active license

Alberta	13%
British Columbia	29%
Manitoba	7%
New Brunswick	3%
Newfoundland and Labrador	6%
Northwest Territories	12%
Nova Scotia	7%
Nunavut	7%
Ontario	33%
Prince Edward Island	2%
Quebec	3%
Saskatchewan	6%
Yukon	7%

In what province or territory do you primarily work?

Alberta	11.37%
British Columbia	25.45%
Manitoba	5.73%
New Brunswick	2.21%
Newfoundland and Labrador	5.84%
Northwest Territories	3.92%
Nova Scotia	5.73%
Nunavut	2.21%
Ontario	28.67%
Prince Edward Island	1.51%
Quebec	3.12%
Saskatchewan	5.33%
Yukon	4.43%

Survey respondents were asked in which Canadian jurisdiction(s), do they currently hold an active licence. Respondents selected more than 1 jurisdictions that applied to them directly. The results also show the home province of the respondents who completed Question 1 – “Who are they?”

HOLD ACTIVE LICENSE

Primary Region of those who have multiple active licenses

		Frequency	%
Valid	British Columbia	68	31%
	Alberta	22	10%
	Saskatchewan	7	3%
	Manitoba	8	4%
	Ontario	51	23%
	Quebec	10	5%
	Atlantic	17	8%
	Territories	34	16%
	Total	217	100%

Total includes those who indicated having a license in multiple provinces and indicated their primary province/territory.

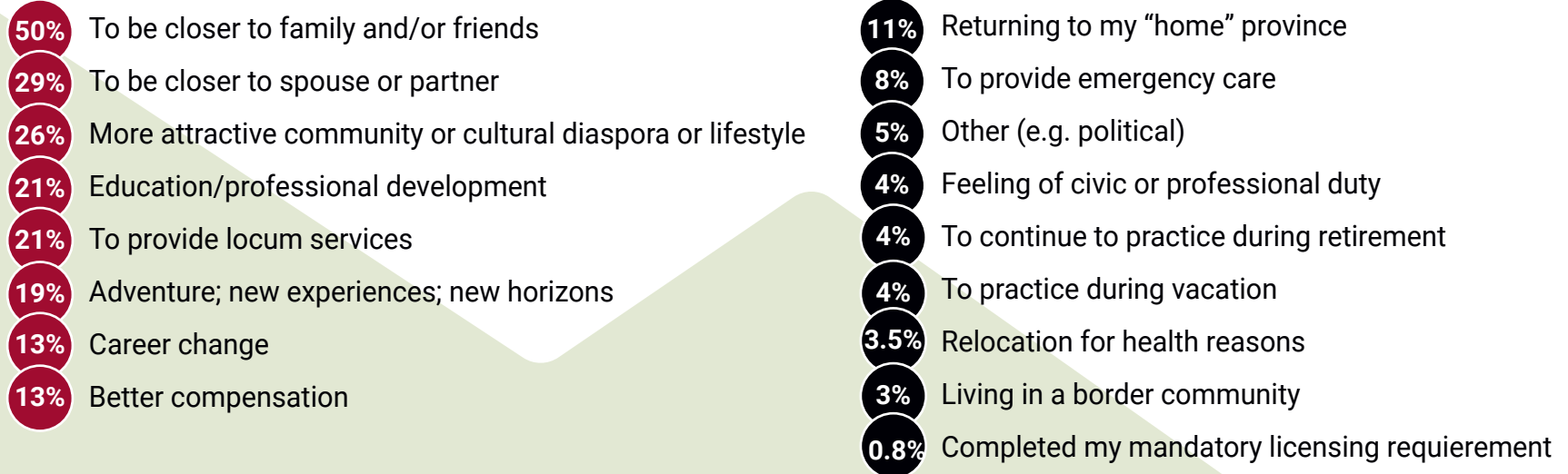
REASONS FOR MULTIPLE LICENCES

In holding a licensure in more than one jurisdiction, what were the top three reasons for applying for a license in another province/territory

- | | | | |
|------------|---|-----------|--|
| 76% | To provide locum services | 9% | To be closer to spouse or partner |
| 53% | Adventure; new experiences; new horizons | 8% | Career change |
| 22% | Better compensation | 7% | Living in a border community |
| 22% | To be closer to family and/or friends | 4% | Other(e.g. keep options open, maintain skills, benefits) |
| 20% | Feeling of civic or professional duty | 2% | Completed my mandatory licensing requirement |
| 20% | To provide emergency care | 2% | Relocation for health issues |
| 20% | More attractive community or cultural diaspora or lifestyle | | |
| 20% | Education/professional development | | |
| 17% | To practice during vacation | | |
| 16% | Returning to my “home” province | | |
| 13% | To continue to practice during retirement | | |

LEAVING RURAL PRACTICE

Reasons for leaving your rural practice – select any that apply.



LEAVING RURAL PRACTICE

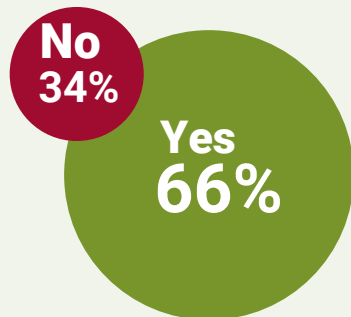
“Started a family, urban spouse, no real childcare or viable education options on small reserve.”

“To provide a better education and better possibilities to our kids.”

“Burnout practicing in UNDER resourced rural settings”

PRACTICING OUTSIDE JURISDICTION

Considered practicing outside home province but could not due to licensure requirements

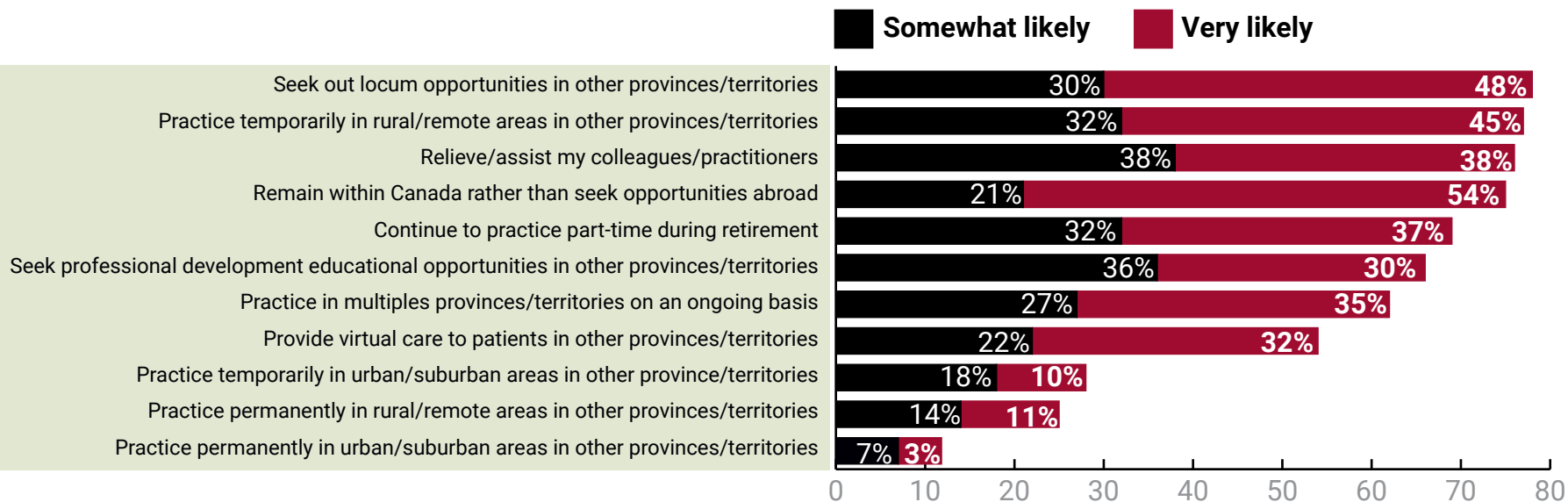


Factors identified as significant obstacles or would make physicians hesitate in applying for licensure in another province or territory

92%	Length of the process to obtain a licence in the other province or territory
84%	Cost of getting licensed in the other province or territory
53%	Obtaining credential verification/Certificate of Practice (CPC) for or from the provincial/territorial regulatory authority
32%	Obtaining reference or character letters
31%	Obtaining letter(s) of good standing from the provincial/territorial regulatory authority
25%	Obtaining police record check
3%	Other (e.g., language exam, unclear payment models, international credential verification)

SUPPORT FOR THE IMPLEMENTATION OF NATIONAL LICENSURE

% who selected somewhat likely or very likely



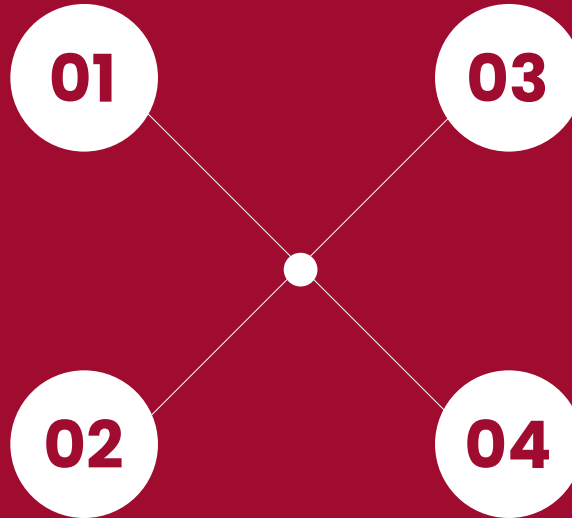
SURVEY LIMITATIONS

Not mandatory questions

It was not mandatory that all survey questions be answered as SRPC indicated to participants to exercise their discretion on whether to answer all or some questions.

Response rate dropped off

While there was a high response rate with some questions, it was noted that respondents skipped other questions, and mid-through the survey, the response rate dropped off. It is assumed that the survey design and its application through SurveyMonkey may not have been fully utilized.



Exclusion criteria:

Students were excluded from the analysis on questions that were practice related.

Exclusion criteria:

While 1,150 completed the survey – 2 respondents were removed as they did not complete Question 1 in identifying who they are.

RURAL PHYSICIANS HAVE THEIR SAY

Written responses to the survey provided additional insights into the potential benefits of pan-Canadian licensure. The following quotations reflect common themes expressed in favour of national licensure.



RURAL PHYSICIANS HAVE THEIR SAY

“

Administrative headache of licensure

“I’ve been licensed in 5 provinces/territories so [I am] VERY familiar with the different licensing processes, which are all duplicative! I have actively NOT worked when I could/would like to have done so in rural regions due to cost, timelines, and [the] administrative headache of licensure.”

”

“

I would love to return

“I would love to return to rural locums in other provinces/territories when semi-retired if it is easier and less expensive to apply for and maintain licensing.”

”

RURAL PHYSICIANS HAVE THEIR SAY

”

“During my earlier years I moved between provinces, and the administrative paperwork was a real bother. I would have been much more likely to do locums had there been easier cross-Canada licensing.”

I would have been much more likely to do locums

“

“

Why on earth should we need provincial licenses?

“For us to address part of the shortage in family physicians in different regions, we need easier access to these regions, and this all starts with a national licence. Our education is nationally relatively the same, so why on earth should we need provincial licenses? ... At the very least, provide an option for locums.”

”

RURAL PHYSICIANS HAVE THEIR SAY

“

**National
licensure
would
greatly
improve
healthcare
access**

“National licensure would greatly improve healthcare access to people who live in areas without enough doctors. When I worked as a locum in the Northwest Territories, many of the physicians I worked with also were locums who lived in other parts of Canada. Still, there were not enough physicians to meet the needs of the territory.”

”

“

**I feel national licensing
would enlarge our pool
of potential locums.**

“Our rural hospital has been on the brink of closure for many months. I feel national licensing would enlarge our pool of potential locums. We are close to a breaking point and need this to move forward.”

”

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:



Many rural physicians who are retired, semi-retired, or approaching retirement **wish to continue practising in rural communities where needed**, but they do so only when and where licensure requirements are not barriers. Rural physicians tend to go to jurisdictions with minimal or no licensure requirements.

Staffing shortages leave many physicians unable to take breaks from practice without disrupting patient care. **Improving the availability of locums would enhance rural physicians' work-life balance** and help them avoid burnout, and it could attract more physicians to rural areas.

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:



A lack of administrative support and poor access to other health care services have made rural practice unsustainable for some physicians.

“Red tape” related to credentialing and privileges creates barriers for all physicians wanting to practise in rural settings, whether they are Canadian medical graduates, international medical graduates, or residents.

SRPC OBSERVATIONS

While the survey revealed that medical licensure was not a factor in rural physicians' decisions to leave rural practice or rural communities, it did provide other insights about the rural physician workforce.

Based on SRPC members' perspectives, it is noted that:



Practising rural medicine (generalism) requires having a broad skill set, including enhanced skills in areas such as emergency medicine, anesthesia, surgery, and maternity care. The survey revealed that **most rural physicians have wide scopes of practice and there was high interest in training opportunities** that would help them better serve the health care needs of their communities.

While licensure is one way to address rural physician workforce issues, **all of the above elements must be addressed** to ensure the sustainability of the rural physician workforce.



CONTACT

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SRPC Lead, Ad Hoc Group on Licensure

Email: info@srpc.ca

The SRPC wishes to acknowledge CMA's support and their contributions to the quantitative analysis of the survey.

SRPC.CA

Final Evaluation Report

May 23, 2024

Submitted to: Dr. Sarah Lespérance

Submitted by: Daria Parsons, Daria Parsons Consulting Inc.



National Advanced Skills and Training Program for Rural Practice

Optimizing rural care



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National Advanced Skills and Training Program for Rural Practice

Optimizing rural care



Executive Summary

The SRPC received \$7.4M as part of the \$43M *Team Primary Care Training for Transformation* project managed by the Foundation for Advancing Family Medicine (FAFM) and funded by Economic and Social Development Canada (ESDC). Team Primary Care collaborated with multiple organizations, including the SRPC, to broaden the capacity of interprofessional comprehensive primary care in Canada, in an attempt to reduce critical labour shortages and enhance labour mobility and utilization. The SRPC project's objective was to implement the *National Advanced Skills and Training Program for Rural Practice* to support training and continuing professional development programs for practicing rural family physicians to enhance their skills to meet identified rural community needs and improve access to care in rural, remote and Indigenous communities.

The response to the National Advanced Skills and Training Program for Rural Practice significantly exceeded the target number of 166 rural physicians. SRPC received 375 applications between March 2023 and March 2024 and funded training for 342 rural physicians – more than double the anticipated number. Participating physicians represented 187 communities across all provinces and territories, with at least 60 Indigenous communities benefiting from the program. Thirty percent of trainees were international medical graduates. The majority of trainees selected emergency medicine (72%) as the area of training followed by diagnostic imaging (11%), family practice anesthesia (10%) and palliative care (10%).

All key performance indicators were achieved for the project except for one - the number of participating Indigenous physicians. The success of the program was aided by the implementation of the Communication Plan. The program was promoted through emails and newsletters to SRPC membership, full page advertisements in six physician journals, and engagement with 60 provincial and national organizations and 50 provincial and regional physician recruitment organizations. A social media strategy was developed including videos and testimonials to promote the training program.

The feedback from trainees was resoundingly positive. Ninety-eight percent of participants reported that they successfully implemented their training plan and met their learning objectives. All trainees reported the training program enhanced their knowledge (100%), and 99% reported that the training program enhanced their skills, confidence and competence in providing care in their rural communities. Ninety percent of trainees indicated that the training program helped to develop their team's confidence. Eighty percent of trainees reported the training program made them feel greater connectedness to referral centres or a network of support. Eighty-two percent of participants who had a preceptor reported that



National Advanced Skills and Training Program for Rural Practice

Optimizing rural care



they established an ongoing relationship with them and 79% of preceptors reported the training program positively impacted their clinical practice. Ninety-seven percent of trainees reported they will be able to make evidence-informed changes to their practice as a result of the training program.

Trainees reported the self-directed nature allowed the program to suit individual physician and community needs. They described the program as well-funded, low barrier, high yield, flexible, practical, accessible, providing interactive high-quality learning opportunities.

SRPC was able to address an unmet training need for rural physicians across Canada. Participating rural physicians reported they were better equipped to offer more timely diagnosis of medical conditions in local communities, thereby reducing unnecessary transfers and wait times, increasing team-based interprofessional care, and improving communication during transfers when needed. In addition to meeting this need, 98% of trainees reported the training program helped to maintain services in the rural communities they serve.

Introduction

The Canadian healthcare system is currently facing significant challenges, as it struggles with critical shortages of skilled healthcare workers in all sectors. Efforts are underway to understand the health human resources landscape, to identify who is providing what care, to train the next generation of healthcare professionals to meet the evolving needs of a team-based healthcare system, and to capture data that will help inform the ongoing health human resource needs of this country. Meanwhile, there is an urgent need to implement practical, effective strategies to stabilize health services.

Healthcare needs are even more magnified in rural, remote and Indigenous communities. While nearly one-fifth of Canadians (18%) live in rural communities, they are served by only 8% of the physicians practicing in Canada.¹ Rural communities face ongoing challenges in recruiting and retaining family physicians resulting in critical shortages of skilled physicians. As a result, individuals in rural areas experience greater challenges accessing health care compared to their urban counterparts. Moreover, when they do access health care services, they tend to have less favorable outcomes. Access to health care close to home is of particular concern for rural Canada. Factors such as geographic isolation from urban centres, poor weather conditions impairing access to remote locations, and lack of

¹ Wilson CR, Rourke J, Oandasan IF, Bosco C; On behalf of the Rural Road Map Implementation Committee; Au nom du Comité sur la mise en œuvre du Plan d'action sur la médecine rurale. Progress made on access to rural health care in Canada. *Can Fam Physician*. 2020 Jan;66(1):31–6. PMID: PMC7012120.



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communication technology infrastructure have made it challenging for the Canadian health system to sustain equitable provision of quality health care services to rural and remote communities.²

An additional challenge is that physicians practicing in rural communities must have skills that extend beyond comprehensive primary health care e.g., emergency care, anesthesia, obstetrics, surgery, palliative care, and mental health. These core services, provided by rural generalists, are essential to ensure patients are able to access high quality care in rural communities. Unfortunately, the current rural physician workforce is not well equipped to offer the full scope of services required. While some physicians may choose to complete additional skills training prior to completion of their medical training, few opportunities exist for rural physicians to enhance their skills based on identified community needs once they are in practice. In addition, physicians interested in broadening the scope of their practice, or those who wish to relocate to rural communities, often cite a lack of confidence in various skill areas as a barrier to making such a transition.

In select regions of Canada and internationally, such as Australia, well-established programs exist that offer ongoing enhanced training opportunities for health care providers to improve their skills and knowledge continuously. Review of these programs indicated they are highly effective as part of a rural health human resources strategy to sustain services, respond to the healthcare needs of communities, and enhance retention of providers.^{3,4,5}

The Society of Rural Physicians of Canada (SRPC) has been an advocate for rural healthcare providers and communities for over 30 years. To address the gaps in rural healthcare, the SRPC proposed developing the *National Advanced Skills and Training Program for Rural Practice* to increase opportunities for access to training and continuing professional development programs by providing financial support to practicing rural physicians, including international medical graduates and those in their first year of practice, to increase their skill sets based on the needs of their rural, remote, and Indigenous communities.

² Soles TL, Ruth Wilson C, Oandasan IF. Family medicine education in rural communities as a health service intervention supporting recruitment and retention of physicians: Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. *Can Fam Physician*. 2017 Jan;63(1):32-38. PMID: 28115438; PMCID: PMC5257217.

³ <https://www.health.gov.au/sites/default/files/documents/2022/03/review-of-the-rpgp-and-gppts-evaluation-report-review-of-the-rpgp-and-gppts-evaluation-report.pdf>

⁴ https://www.acrrm.org.au/docs/default-source/all-files/rural-procedural-grants-program-management-guidelines.pdf?sfvrsn=5d7a87eb_19

⁵ <https://rccbc.ca/our-work/reap/reap-research-and-evaluation/>



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The SRPC received \$7.4M for the *National Advanced Skills and Training Program for Rural Practice* as part of the \$43M *Team Primary Care Training for Transformation* project managed by the Foundation for Advancing Family Medicine (FAFM) and funded by Economic and Social Development Canada (ESDC). Team Primary Care collaborated with multiple organizations, including the SRPC, to broaden the capacity of interprofessional comprehensive primary care in Canada, in an attempt to reduce critical labour shortages and enhance labour mobility and utilization. Team Primary Care's overall objectives were to:

1. Enhance interprofessional comprehensive primary care skills of health care practitioners;
2. Improve labour market integration of Indigenous and internationally-educated health practitioners (IEHP), maximizing their utilization;
3. Support the creation of healthy work environments for diverse and resilient team members to practice at their optimal scope and capacity; and
4. Demonstrate, spread and scale leading integrated primary care workforce planning, practices, tools and resources

The objective of the SRPC's *National Advanced Skills and Training Program for Rural Practice* was to support training and continuing professional development programs for practicing rural family physicians to enhance their skills to meet identified rural community needs and improve access to care close to home in rural, remote and Indigenous communities across Canada.

Methods

Infrastructure

The SRPC assembled an Expert Advisory Committee (Appendix A) to oversee the *National Advanced Skills and Training Program for Rural Practice*. The committee included rural physicians from across Canada including an Indigenous physician and an expert from the Rural Coordination Centre of British Columbia (RCCbc), the program upon which the training program was based. A Project Manager and Coordinator were hired to develop and implement the training program.

Application Process

Interested rural physicians submitted an application through the SRPC's website portal. The portal and the reimbursement processes were established to be as simple and straightforward as possible while ensuring a paper trail for accountability purposes. In order to be considered, each application had to be accompanied by the participant's CV and a letter of support from the hospital chief of staff or regional medical director confirming that the training being proposed was needed in a rural community. Each



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application was reviewed by two SRPC staff and two alternating members of the Expert Advisory Committee. Physicians who met the eligibility criteria were notified of their approval as quickly as possible. Rural physicians identified their training requirements based on community needs and had to identify or develop learning opportunities to address these needs.

Eligibility Criteria

To be eligible for the program, physicians had to:

- Have an active license to practice in Canada
- Be an SRPC member
- Have practiced in a rural community for a minimum of six months in the past year. Physicians could be practicing in more than one rural community
- Indicate their intention to return to a rural community for at least six months after training
- Identify training that could be completed by March 26, 2024 to align with funding from ESDC

Exclusions:

- Residents were not eligible to apply
- Training that began prior to approval

Rural physicians received funding for up to 30 days of training, travel, accommodation, locum expenses, preceptor stipend and overhead costs up to a maximum of \$35,000. Table 1 provides a detailed summary of the available funding categories.

Table 1: Funding Reimbursement for Rural Physicians

Expense	Maximum reimbursement
Income stipend	\$1,000 per day stipend to cover rural physician’s income loss for up to 30 days
Travel	Up to \$2,000. Additional funding was available for physicians practicing in northern and remote communities
Land travel	Mileage reimbursed at \$0.55 per km
Accommodation	Up to \$200 per day - receipts required (\$75 per day if staying with family/friends - no receipts are required)
Locum payment or backfill physician	Up to \$1,000 per day



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Expense	Maximum reimbursement
Overhead	Costs paid depending on the type of practice (e.g. rent, EMR, admin staff)
Course cost	No limit set
Equipment Cost	Funded if required for course
Preceptor payment:	\$250 per day

Participants were required to adhere to the following guidelines. Training:

- Could include courses that directly related to trainee’s learning objectives
- Could be completed as a course or in a small-group or one-on-one training with a preceptor(s)
- Had to occur in Canada, and applicants were encouraged to seek opportunities within their referral region
- Could not be fully funded by another source
- Could only commence after approval of an application
- Could be virtual or hybrid, if appropriate

Once training was complete, physicians completed a Claim Form and submitted receipts for reimbursement. Trainees completed the evaluation survey at the time of reimbursement.

Project Timeline

Phase 1 of the project involved establishing the infrastructure in terms of hiring staff and identifying Expert Advisory Committee members. A project plan including a communications plan and evaluation plan, and promotional material were developed. Phase 2 involved the official launch of the project in March 2023 and promoting the *National Advanced Skills and Training Program for Rural Practice* to rural physicians. As most rural physicians in Canada were not members of SRPC, it was imperative to develop a multi-prong approach to increase awareness locally, provincially, and nationally. Components of the communication strategy are outlined in Table 2. Phase 3 included the reimbursement phase for participating physicians and the data analysis for the evaluation.

Table 2: Project Timeline Overview

Timeline	Activities
Months 1 to 4 Nov 2022-Feb 2023	Phase 1: Development Phase <ul style="list-style-type: none"> • Hire staff



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Timeline	Activities
	<ul style="list-style-type: none"> • Establish SRPC’s Expert Advisory Committee • Establish eligibility criteria for application approval • Develop a Project Plan outlining timelines, communication plan, stakeholder engagement plan, evaluation plan • Develop website portal content (e.g., registration data elements for trainees and preceptors) in English and French • Develop branding guidelines • Develop promotional material in English and French (e.g. invitations to participate for SRPC members and non-members, posters, 2-pagers for trainees and preceptors, FAQs, key messages, post cards, retractable banners, videos) • Develop evaluation forms for trainees and preceptors • Develop manual for successful trainees (e.g., evaluation form, claim form, letter of completion, locum and cross-covering physician payment forms, and preceptor payment receipt form) • Develop an Evaluation Framework and Evaluation Plan including the identification of data elements and data sources (e.g., a survey to trainees and preceptors, key informant interview guide, registration and reimbursement data)
<p>Months 5 to 10 Mar 2023-Dec 2023</p>	<p>Phase 2: Implementation Phase</p> <ul style="list-style-type: none"> • Media release for official launch of the <i>National Advanced Skills and Training Program for Rural Practice</i> in March 2023 and opened the portal to receive applications • Promoted the Training Program using the following platforms: <ul style="list-style-type: none"> ○ Email invitation to SRPC membership list, partners and committees ○ Invitation to participate mailed to all rural physicians who were not SRPC members across Canada ○ SRPC newsletters ○ Other stakeholder newsletters ○ Conference promotion <ul style="list-style-type: none"> ✓ SRPC – booth/session ✓ CAEP – booth



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Timeline	Activities
	<ul style="list-style-type: none"> ✓ FMF – poster ✓ NL College of FP - booth ✓ CASPR –post cards ✓ RCCbc – post cards ✓ NS College of FP Conference ○ Physician journals <ul style="list-style-type: none"> ✓ Canadian Family Physician (CFP) ✓ Canadian Journal of Rural Medicine (CJRM) ✓ Canadian Medical Association Journal (CMAJ) ✓ Medical Post ✓ Journal of Obstetrics and Gynecology (SOGC) ✓ Canadian Association of Emergency Physicians (CAEP) ○ Social Media including LinkedIn, X, Facebook and Instagram ○ Presentations to organizations e.g., CASPR ○ Meetings with interested stakeholders e.g. NOSM ● Established process for review of applications and notification to applicants ● Approval of applications (until Feb 2024)
Months 11 to 13 Jan 2024-Mar 2024	Phase 3: Reimbursements and Evaluation <ul style="list-style-type: none"> ● Physician reimbursement ● Start evaluation process including summarizing trainee and preceptor survey results and conducting key informant interviews
Months 14 to 17 Apr 2024-May 2024	<ul style="list-style-type: none"> ● Develop evaluation report for approval by Expert Advisory Committee

Three sources of data were used as part of the evaluation including: 1. registration forms, 2. feedback surveys completed by trainees and preceptors, and 3. key Informant Interviews. Trainees were invited to complete a survey about their experience with the *National Advanced Skills and Training Program for Rural Practice* when they completed their claim form and an evaluation link was sent to preceptors at

the end of the project. In addition, key informant interviews were conducted with trainees and preceptors to collect more detailed information about the training program.

Results

Registration Results

Between March 2023 and March 2024, 375 physicians submitted an application for the *National Advanced Skills and Training Program for Rural Practice*. Of these, 98% were approved (n=367). Two percent of applications were not approved either because they did not meet the eligibility criteria or the proposed training occurred before or after the training program dates. Seven percent (n=25) of rural physicians whose applications were approved for training dropped out in the last month of the program. By March 2024, 342 rural physicians, representing 187 communities (60 of which were Indigenous), completed their training plan and submitted a reimbursement form to SRPC. Almost all trainees (98%) completed the evaluation survey. Forty-three percent of trainees conducted their training with a preceptor and 57% of trainees took a course, of which the highest percentage was related to enhancing ultrasound skills.

The average estimated budget on trainees' applications was \$24,000 while the average actual trainee reimbursement was \$15,553 which was 35% below the average estimate. Table 3 summarizes the registration results such as number of applications received and the breakdown of the type of training.

Table 3 Registration by the Numbers

Number (%)	High Level Results by the Numbers
375 (100%)	Rural physicians submitted an application
367 (98%)	Applications were approved
8 (2%)	Applications were not approved
342 (93%)	Trainees completed their training program (submitted a claim form)
25 (7%)	Trainees dropped out
334 (98%)	Trainees completed the evaluation survey of approved applications
143 (43%)	Trainees had a preceptor for their training
191 (57%)	Trainees took a course for their training
133	Physicians registered on the SRPC portal to be a preceptor
187	Rural communities involved across Canada



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Number (%)	High Level Results by the Numbers
238 (70%)	Applicants joined SRPC so they could apply for funding
\$24,000	Average trainee budget estimate
\$15, 553	Average trainee reimbursement

The outputs and corresponding targets set for the *National Advanced Skills and Training Program for Rural Practice* are outlined in Table 4. Targets that were met or exceeded are highlighted in green and the one target that was not met is highlighted in yellow. All key performance indicators were achieved for the project except for the number of participating Indigenous physicians. Eleven Indigenous physicians participated in the training program rather than the minimum target of 25.

Table 4 Project Outputs and Targets

Output	Result	Status
Utilize existing program from RCCbc's REAP and expanded/offered at a national level	Yes	Target achieved
Number of health workers participating in new/redesigned advanced rural FM skills training	342	Target exceeded (Target was 166)
Support networks and mentorship developed between rural communities, as well as with tertiary centres of care	79% of trainees reported the training program made them feel greater connectedness to referral centres or a network of support	No target set
Number of external organizations engaged in work pertaining to rural health care delivery	60	Target exceeded x3 (Target was 20)
Number of physician recruitment agencies engaged in collaboration	50	Target exceeded x10 (Target was 5)
Number of provincial/territorial jurisdictions involved	13	Target met
Percentage of rural population captured in access to care in rural/Indigenous communities 342	22%	Target exceeded (14-18%)



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Output	Result	Status
trainees x3835 avg number of patients =1,311,570/ 5,957,695=22%		
Improved access to care for rural/Indigenous communities	187 communities engaged	No target set
Increased access to training programs for Indigenous rural physicians	11	Target was missed (target was 25)
Increased access to training programs for Francophone rural physicians	8%	No target set
Number of physicians feeling more competent providing care in their rural community as they enhanced their skills	99% reported by trainees and 66% reported by preceptors	No target set
Access to training for essential health services in rural communities: anesthesia, surgery, maternity care, mental health	80% of trainees reported the training program increased access to training for essential health services in their rural community i.e., anesthesia, surgery	No target set

Table 5 shows that the SRPC met the six outcomes established for the *National Advanced Skills and Training Program for Rural Practice*.

Table 5 Outcomes for the National Advanced Training Program

Outcomes	Results	Status
Expanded skills and capacity of physicians working in rural areas	98% of trainees reported they achieved their training plan and met their learning objectives	Outcome met
Improved and new national programs/approaches to enhancing rural primary care physician skills	342 rural physicians participated	Target Exceeded
Improved relationships and communication between primary care physician and specialist physician mentors	83% of trainees reported they established an ongoing mentorship relationship with a preceptor as part of their training program	Outcome met



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Outcomes	Results	Status
Increased availability of expanded clinical services to rural populations across Canada	<p>Trainees reported the training program enhanced their knowledge (100%), skills (99%), confidence (99%) and competence (99%).</p> <p>Almost all trainees (98%) reported the training program helped to maintain services in rural communities they serve.</p>	Outcome met
Developed best practice approach to developing skills	97% of trainees reported they will be able to make evidence-informed changes to their practice as a result of the training program.	Outcome met
Increased employment of IEHP and Indigenous practitioner utilization	<p>For trainees who responded to the evaluation survey:</p> <ul style="list-style-type: none"> • 29% were IMGs • 3% (n=11) were Indigenous • 8% (n=26) were Francophone • 4% (n=14) were Black Canadian • 28% (n=94) were another racialized group or visible minority • 7% (n=24) were newcomers to Canada <p>For preceptors who responded to the evaluation survey:</p> <ul style="list-style-type: none"> • 2% (n=1) were Indigenous • 11% (n=5) were Francophone • 2% (n=1) were Black Canadian • 35% (n=15) were another racialized group or visible minority • 5% (n=2) were newcomers to Canada 	Outcome met

Other Trainee Results from the Evaluation Survey



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Appendix B includes additional tables based on results from the evaluation surveys that are not included in the inputs and outcomes tables.

Notified About the Program

Table 6 outlines the various avenues through which trainees learned about the program. Forty-one percent of trainees heard about the program through word of mouth.

Description of Participants

Table 7 describes the trainees who participated in the project. Ninety-four percent of the trainees who participated in the program were family physicians and 6% were specialists. Almost 29% of trainees were international medical graduates. The average age of trainees was 41 years. The average years in practice was 9.5 years and the average years of training since medical school was 3.1. The reported average number of patients per practice was 3,835.

Equity Deserving Groups

Table 8 outlines the percentage breakdown of equity deserving groups.

Province

Table 9 provides the percentage breakdown of trainees by province/territory.

Area of Interest

Twenty seven percent of trainees reported they had a Certificate of Added Competency (CAC). Table 10 shows the areas of interest that trainees applied for. Emergency medicine was the most popular for training by participants (72%) followed by diagnostic imaging (11%), family practice anesthesia (10%) and palliative care (10%). Specific examples of training included vascular access, chronic pain and mobility impairment, EMS, gastroenterology, dermatology, adult pulmonary medicine, critical care medicine, orthopedics, neonatal intensive care, and gynecological oncology.

Likert Scale Results

Table 11 presents the questions trainees were asked to rate, using a 5-point Likert scale, regarding their level of agreement as part of the training program evaluation.

Offload Tasks

Table 12 shows that the majority of trainees (84%) will not offload clinical or administrative tasks to their team after completing the training program, and (50%) anticipate training may actually increase their workload.

Qualitative results from the evaluation surveys can be found in Appendix C. Suggestions on ways the application process could be improved are outlined in Appendix D. Appendix E provides examples of testimonials from trainees.

Preceptor Results – Evaluation Survey

At the end of the project, preceptors who worked with trainees were invited to complete the evaluation survey. Fifty-one (36%) preceptors completed the survey out of 143.

Table 13 shows the province/territory of preceptors. Table 14 presents a comprehensive summary of the questions preceptors were asked to rate their level of agreement with using a 5-point scale. Ninety-six percent reported that participating in the training program was a positive experience. In addition, 82% of preceptors reported that the training helped to maintain services in rural communities they serve and 75% reported the training program will increase access to training for essential health services in their rural communities. Table 15 shows that 80% of preceptors reported they established an ongoing relationship with their trainee and 70% reported the training program positively impacted their own clinical practice. Table 16 outlines self-reported equity-deserving groups. Two percent self-reported as Indigenous and 11% were Francophone.

Key Informant Interview Results

Between March 1 and March 20, 2024, 45-minute virtual interviews were conducted via zoom with nine physicians who participated in the *National Advanced Skills and Training Program for Rural Practice*. Six interviews were conducted with trainees and three were preceptors. Appendix F outlines background information on the physicians who participated in key informant interviews. Physicians provided consent to participate in the interview. There was significant alignment in the information provided during the key informant interviews and the evaluation survey results.

Preceptors

Two out of three preceptors were family physicians and one was a specialist. Preceptors' participation in the program was motivated by trainees' interests and willingness to learn, as well as their own desire to help fellow physicians gain experience. Additionally, preceptors were driven by their desire to support rural physicians attempting to address challenges encountered in their rural communities.



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The program was well received by preceptors who noted that the *National Advanced Skills and Training Program for Rural Practice* provided structured learning opportunities that allowed trainees to gain valuable insights into healthcare system operations and upskill themselves. They highlighted the program's flexibility, which allowed participants to continue their practice while gaining experience. Preceptors reported that this program will improve access to care in rural areas. They advocated for the program's continuation, citing its significant impact on both preceptors and trainees, and stressed the benefits the program brought to rural communities.

Trainees

Five out of six of trainee key informants were family physicians and one was a specialist. Trainees were motivated to participate in the program for several reasons. The program provided both time and financial support to take courses as they acknowledged that cost and busy schedules are often barriers to further education. Trainees also recognized the benefits of upskilling, understanding that it could lead to savings in time, money, and unnecessary transfers for patients requiring further testing or examination (e.g., ultrasound). Trainees were cognizant of the limited availability of specialists in their region and saw the importance of expanding their own skills to meet the demand for healthcare services. They expressed a genuine interest in learning new skills and enhancing their practice, particularly in areas where they lacked recent experience. Some trainees were also influenced to sign up for the program due to the positive experiences shared by other rural physicians who had participated.

Trainees expressed deep appreciation for the *National Advanced Skills and Training Program for Rural Practice*, with one describing it as one of the best initiatives ever offered by SRPC. Physicians reported that the program encouraged them to pursue new training opportunities that they might not have considered otherwise; provided an opportunity to learn from experienced physicians; boosted their confidence in practice; and facilitated the ability to make connections, so that they now feel they have a network of support they can rely on. They highlighted that the program was easy to apply for and that the program's flexibility allowed them to tailor their learning to better meet their community needs. Key informants discussed the importance of such programs for rural physicians, emphasizing its potential to be a game changer in healthcare. Preceptors and trainees expressed an interest in participating in future skills and training programs with SRPC.

Additional results from the key informant interviews can be found in Appendix G.



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Summary

In response to rural communities facing critical shortages of skilled physicians, the SRPC's *National Advanced Skills and Training Program for Rural Practice* offered support for rural physicians to access a variety of training opportunities to increase their generalist skill set to help address service gaps in rural, remote and Indigenous communities. The project was a resounding success and surpassed the targets for training opportunities to upskill practicing rural physicians, including specialists, nationwide, which enabled them to meet specific community needs and reduced the need for patient transport out of communities to receive these services, thus increasing care close to home. The program allowed for self-directed learning opportunities to improve primary care and additional community services including rural emergency, surgery, obstetrical, and anesthesia care where needed to address the health care needs of rural communities across Canada. The evaluation was intended to assess the effectiveness, impact, and overall success of the *National Advanced Skills and Training Program for Rural Practice Project*. By implementing a well-structured evaluation process, SRPC aimed to measure not only the tangible outcomes but also the intangible effects that contributed to the success of the endeavor.

Lessons Learned

- The implementation of *National Advanced Skills and Training Program for Rural Practice* was successful in demonstrating proof of concept. All trainees reported the training program enhanced their knowledge (100%), and 99% reported that the training program enhanced their skills, confidence and competence in providing care in their rural communities. Ninety percent of trainees indicated that the training program helped to develop their team's confidence. Almost all trainees (98%) and 82% of preceptors reported the training program helped to maintain services in rural communities they serve which was the primary objective of the program.
- Some trainees reported that requiring a letter of support from their regional medical director or chief of staff was a burden and significantly slowed down their application submission. In fact, a large number of trainees did not know who their regional medical director or chief of staff were. One of the intangible benefits of the program may have been establishing the relationship between rural physicians and regional medical directors and/or chiefs of staff. SRPC could have increased awareness about the *National Advanced Skills and Training Program for Rural Practice* with regional medical directors and chiefs of staff to expedite the process for trainees.



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- The project was originally established for rural physicians to implement their training plan with a preceptor to encourage that relationships be established based on referral patterns. In order to meet an expressed need from rural physicians, however, the SRPC expanded the criteria to include courses in response to a demand for ultrasound skills. In addition, physicians reported that securing hospital privileges proved challenging so courses were more appealing. If future funding is secured, SRPC could promote the courses that are available across Canada and identify and promote preceptor opportunities by province to expedite the registration process. Enhanced collaboration, and raising awareness of the Program with regional health authorities could help alleviate the burden related to privileging encountered by physicians participating in the future. Because the most popular areas of interest were emergency medicine (72%) and diagnostic imaging (11%), it might be feasible to establish and promote training programs for these areas of interest. Anticipating the need for preceptors, SRPC developed a portal for physicians to register as preceptors at the start of the project and took every opportunity to match trainees with the 133 preceptors who registered. Future training could increase the number of preceptors on this list and provide more detail on the type of skills the preceptors can offer.
- Applications were approved for rural physicians in all provinces and territories for more than double the anticipated number of physicians. The success of the program was facilitated by the development and implementation of the multi-prong Communication Plan. The program was promoted through emails and newsletters to SRPC membership, other stakeholder newsletters, advertisements in physician journals, engagement with provincial and national organizations and provincial and regional physician recruitment organizations. Beyond these traditional methods of promotion, SRPC added a key component to target non-SRPC members. An invitation to participate was mailed to rural physicians who were not SRPC members. Seventy percent of trainees became SRPC members because this was a criterion for submitting an application, and given 41% of trainees learned about the training program by word of mouth, identifying new channels of communication to reach beyond SRPC membership into the informal networks of rural physicians was important to exceed the target number of trainees.
- Ninety-four percent of trainees were family physicians and six percent were specialists. The average age of trainees was 41 years (minimum age was 30 and maximum age was 59 years). The average years of practice was 9.5 years (minimum was 8 and maximum was 40 years). The average years of training since medical school was 3 years (minimum was two and maximum was 25 years). These data demonstrate that the *National Advanced Skills and Training Program for*



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Rural Practice had wide appeal to international medical graduates (29%), and rural physicians across a wide range of ages, years of practice, and years of training after medical school. It was anticipated that the training program may appeal to rural physicians early in their career but it became clear that there was no typical profile for rural physicians and the training program successfully engaged a wide demographic.

- The average number of patients per practice reported in the trainee survey was 3,835 which means the *National Advanced Skills and Training Program for Rural Practice* could improve health outcomes for 1,311,570 patients across all provinces and territories.
- All key performance indicators were achieved for the project except for the number of participating Indigenous physicians. Despite repeated engagement attempts through meetings and emails with Indigenous organizations and stakeholders who were associated with SRPC and Team Primary Care, it proved difficult to engage Indigenous physicians in the *National Advanced Skills and Training Program for Rural Practice*. A future objective would be to strengthen partnership with the Indigenous Physicians Association of Canada to facilitate engagement and awareness of this program amongst Indigenous physicians.
- Although the project duration was insufficient for full evaluation of impact on attracting new rural physicians, the eligibility criteria required that rural physicians that applied for the *National Advanced Skills and Training Program for Rural Practice* had worked in rural communities for six months and promised to continue to work in rural communities for at least six more months. On a small scale, the training program increased retention of physicians in rural communities. It is likely that, similar to what has been observed in other jurisdictions⁵, sustained funding could facilitate recruitment and retention of rural physicians if the program is scaled and spread.
- Notably, the actual budget (\$15,533) submitted by trainees was 35% less than the average trainee approved budget (\$24,000). This highlights the pragmatic approach that rural physicians took to use of the Training Program, using only the funds required to meet their needs. However, this provided budgeting challenges as many funds were allocated that then went un-used. In addition, 25 trainees were approved for training but unexpectedly dropped out in the last two weeks of the project. If SRPC secures sustainable funding, a longer timeline for project implementation could facilitate trainees completing their full training programs. Regular contact with approved participants e.g., a quarterly check-in may have provided sufficient time to



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reallocate funds. In addition, explicit participation of nurse practitioners and nurses may have provided additional support to rural physicians enhancing positive outcomes.

- Demand for training outpaced funding and 95% of rural physicians who participated said they had additional training needs if funding were to extend beyond March 2024. The SRPC portal currently allows physicians to register for the wait list. With future funding, SRPC will immediately be able to promote the program to physicians who have already expressed interest in additional training.
- In addition to implementing the training program, it was important that SRPC participate in the larger Team Primary Care project by attending the Summits and sitting at a number of the tables including Alignment, Communication, Engagement and Strategy (ACES) meetings, Team Optimization and Cross-Cutting Team meetings so that successes and challenges of the National Advanced Skills and Training Program for Rural Practice could be broadly shared.

The SRPC was able to address an unmet training need for rural physicians across Canada. The SRPC successfully facilitated the delivery of training opportunities that served the needs of its rural physician members, enhancing equity in access to care for the populations they serve. Participating rural physicians reported they were better equipped to offer more timely diagnosis of medical conditions in local communities, thereby reducing unnecessary transfers and wait times, increasing team-based interprofessional care, and improving communication during transfers when needed. On the evaluation survey, trainees reported that the program:

- Gave rural physicians more status, and rendered their practices more interesting, actually enviable
- Promoted rural excellence and support for generalist practice
- Provided an opportunity to meet experienced physicians who challenged them to improve their practice
- Changed patient care e.g., ultrasound reduced the need for transport out of the community
- [Skills acquired have already been put into practice
- Allowed acquisition of important usable skills that would not otherwise be affordable or possible
- Strengthened team rapport because they completed training with non-MD clinicians
- Provided an increase in vital services to patients in rural communities
- Provided an opportunity to network with colleagues across Canada which created a greater sense of personal fulfillment with being a rural physician



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The *National Advanced Skills and Training Program for Rural Practice* offers one solution that leverages the strengths, adaptability, and skills of rural healthcare providers, and provides a sustainable, practical, and proven solution to the urgent health human resource crisis in rural Canada.

As further funding was not available from Employment and Service Development Canada (ESDC) after March 2024, the SRPC seeks to secure funding to continue to support the expressed interest from rural physicians for advanced skills training in rural, remote and Indigenous communities across Canada.



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Appendix A: Expert Advisory Committee Membership

Dr. Sarah Lespérance, SRPC President, Chair, Petitcodiac, New Brunswick

Dr. Elaine Blau, Tobermory, Ontario

Dr. Isabelle Cochrane, Baie-St-Paul, Quebec

Dr. Brian Geller, Regina, Saskatchewan

Lisa Hetu, Administrative Manager, Rural Education Action Plan, Vancouver, British Columbia

Dr. Stuart Iglesias, McDougall, Ontario

Dr. Sivaruban (Ruban) Kanagaratnam, Swift Current, Saskatchewan

Dr. Kàh enti:ne Maracle, SRPC Resident Member & Indigenous Representative, Tobermory, Ontario

Dr. Gavin Parker, Pincher Creek, Alberta

Dr. Sonja Poole, SRPC Resident Member, Yellowknife, Northwest Territories

Dr. James Wiedrick, Nelson, British Columbia

Staff

Jennifer Barr, Chief Operating Officer

Kristen Kluge, Project Coordinator

Daria Parsons, Project Manager

Appendix B: Trainee and Preceptor Survey Results

Additional tables from the trainee and preceptor surveys are outlined below.

Table 4 Notification about the Training Program (n=334)

Method	% (n)
Word of mouth	41% (136)
SRPC newsletter/email	30% (101)
SRPC conference	6% (20)
SRPC website	5% (16)
Other association newsletter	2% (7)
Social media	2% (7)
SRPC media release	2% (6)
Other conference	0% (1)
Other	12% (40)

Table 5 Trainee Description (n=334)

Trainee Description	% (n)
Type of physician <ul style="list-style-type: none"> • family physician • specialist 	94% (291) 6% (21)
International medical graduate	29% (89)
Mean age (minimum, maximum)	41 years (30, 59)
Average years of practice (minimum, maximum)	9.5 years (8, 40)
Average years of training after medical school	3.1 years (2, 25)
Average number of patients per practice	3,835

Table 6 Participants Who Self-Identify as “Equity-Deserving Groups”

ESDC’s Equity-Deserving Group	% (n)
Women	47% (157)
Indigenous	2% (8)

ESDC's Equity-Deserving Group	% (n)
Francophone	8% (26)
Black Canadian	4% (14)
Another racialized group or visible minority	28% (94)
Person with a disability	2% (8)
LGBTQ2+	6% (20)
Newcomer to Canada	7% (24)

Table 7: Trainee Province/Territory of Practice (n=334)

Province/Territory	% (n)
Alberta	14% (48)
British Columbia	13% (43)
Manitoba	5% (16)
New Brunswick	0.3% (1)
Newfoundland and Labrador	5% (18)
Northwest Territories	5% (18)
Nova Scotia	3% (10)
Nunavut	2% (6)
Ontario	51% (171)
Prince Edward Island	1% (3)
Quebec	2% (5)
Saskatchewan	8% (25)
Yukon	4% (13)

Table 8 Trainee Training Area of interest (n=334)

Trainee Training Area of Interest	% (n)
Addiction Medicine	8% (25)
Care of the Elderly	7% (22)
Diagnostic Imaging	11% (37)



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Trainee Training Area of Interest	% (n)
Emergency Medicine	72% (240)
Enhanced Surgical Skills	5% (18)
Family Practice Anesthesia	10% (34)
Obstetrical Surgical Skills	6% (20)
Palliative Care	10% (32)
Sport and Exercise Medicine	9% (30)
Other e.g. hospitalist, oncology, dermatology, pediatrics	29% (96)

Table 9 Trainee Evaluation Survey Likert Scale Questions

Trainee Evaluation Likert Scale Questions	Agree/Strongly Agree % (n)
Participating in the National Advanced Skills and Training Program for Rural Practice was a positive experience	98% (327)
My training plan was successfully implemented and I was able to achieve my learning objectives.	98% (327)
The training program enhanced my knowledge.	100% (333)
The training program enhanced my skills.	99% (332)
The training program enhanced my confidence.	99% (332)
This training program helped to develop my team's confidence.	88% (294)
In my opinion, the training program will make me feel more competent providing care in my rural community as I enhance skills.	99% (332)
This training program made me feel greater connectedness to referral centres or a network of support.	79% (265)
I will be able to make evidence-informed changes to my practice as a result of the training program.	97% (324)



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Trainee Evaluation Likert Scale Questions	Agree/Strongly Agree % (n)
This training program helped to maintain services in rural communities I serve.	98% (326)
This training program increased access to training for essential health services in my rural community. i.e. anesthesia, surgery etc.	80% (266)
The SRPC website clearly articulated the eligibility criteria for the training program.	96% (319)
The application process was straightforward.	90% (299)

Table 10 Trainee Evaluation Categorical Questions

Trainee Evaluation Categorical Questions	% Yes (n)	% No (n)
Given your advanced skills training, will you offload clinical or administrative tasks to your team?	16% (50)	84% (259)
Do you anticipate that your additional advanced skills may increase your workload?	50% (153)	50% (156)
Did you have a preceptor as part of your training program?	43% (143)	57% (191)
I have established an ongoing mentorship relationship with a preceptor as part of my training program.	83% (118)	17% (25)
Do you have any other training needs for advanced skills if funding were to extend beyond 2024?	95% (316)	5% (18)

Table 11: Preceptor Province/Territory of Practice

Province/Territory	% (n)
Alberta	24% (12)
British Columbia	16% (8)
Manitoba	10% (5)
New Brunswick	0% (0)
Newfoundland and Labrador	2% (1)



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Province/Territory	% (n)
Northwest Territories	0% (0)
Nova Scotia	6% (3)
Nunavut	0% (0)
Ontario	33% (17)
Prince Edward Island	2% (1)
Quebec	2% (1)
Saskatchewan	8% (4)
Yukon	2% (1)

Table 12 Preceptor Data with a Likert Scale

Preceptor Evaluation Data Likert Scale Questions	Combined: Strongly Agree and Agree % (n)
Participating in the National Advanced Skills and Training Program for Rural Practice as a preceptor was a positive experience.	96 % (44)
This training program helped to maintain services in rural communities I serve.	82% (36)
In my opinion, the training program will make me feel more competent providing care in my rural community as I enhance skills.	66% (29)
This training program increased access to training for essential health services in my rural community. i.e.; anesthesia, surgery etc..	75% (33)

Table 13 Preceptor Data with Categorical Data

Preceptor Results with Categorical Data	Yes % (n)	No % (n)
I have established an ongoing mentorship relationship with a trainee as part of the National Advanced Skills and Training Program.	80% (37)	20% (9)
Did the training program positively impact your own clinical practice?	70% (31)	30% (13)



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Table 14: Preceptors who identify as Equity Deserving Groups

ESDC's Equity-Deserving Group	Percentage
Women	32% (14)
Indigenous	2% (1)
Francophone	11% (5)
Black Canadian	2% (1)
Another racialized group or visible minority	35% (15)
Person with a disability	0% (0)
LGBTQ2+	2% (0)
Newcomer to Canada	5% (2)

Appendix C: Qualitative Results from Survey

1. Describe aspects of the training program that could be improved if the program funding continued beyond March 2024:

- Increase deadline to finish training
- Increase promotion to rural physicians
- Preapprove and promote existing training opportunities including courses
- Link trainees to preceptors through hospitals and facilitate privileges
- Administrative requests: increase meal allowance, reimburse for travel days and reimburse physicians as they complete training rather than at the end

2. Please describe two strong features of the training program

Trainees reported that there was good communication about the *National Advanced Skills and Training Program* and rural physicians felt supported during the application and reimbursement processes. They reported that the application process was straightforward. Physicians reported a strong feature of the training program was the unlimited range of training options, the comprehensive and intensive training programs and the relevance to their practices.

Trainees reported the self-directed nature allowed the program to suit individual physician and community needs. They described the program as well-funded, low barrier, high yield, flexible, practical, accessible, providing interactive high-quality learning opportunities. Participants reported the program made it possible to attain skills that allowed them to provide better care to their patients in their rural communities across Canada.

Physicians reported the National Advanced Skills and Training Program:

- Made training feasible
- Established new working relationships and increased connectedness/networking with colleagues in different specialties and across disciplines
- Encouraged sharing of experiences and knowledge with preceptors
- Was significant and comprehensive enough in reimbursement (stipend/travel/office expenses/locum/preceptor) for preceptors and trainees to encourage training
- Provided a structure to approach institutions/preceptors for training
- Provided excellent interprofessional collaboration
- Encouraged rural and Northern physicians to seek ways to improve patient care
- Provided an opportunity to refresh knowledge and training not used in a long time
- Offered multiple avenues to achieve advanced training (courses, preceptorships, rotations etc.)



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Trainees reported the program provided an opportunity to:

- Self-identify learning objectives
- Train in a larger centre with a higher patient volume and a formal PICC insertion training program
- Learn a standard of care with a preceptor
- Engage in team-based learning e.g., with nursing, paramedics and MD group
- Train in larger centre with a higher patient volume and a formal PICC insertion training
- Learn and share experience with excellent preceptors who were very knowledgeable in rural medicine as well as specialist medicine
- To build teamwork and improve communication as part of a team which increased trust to work well together

3. What is the greatest impact your participation in this program has had on your: Community

- Increasing capacity in underserved areas
- I can reduce the strain on some rural communities
- Improved care for children
- We will be able to handle trauma cases in our rural ER
- Improved patient centred care
- Reduce wait times and travel
- Safe transfer when needed
- Better assessment in emergent cases
- Increases community capacity to retain a patient instead of transferring them out of community
- Extend services to a broader population with enhanced skills
- Extra skill for better care
- Increased access to advanced care for cardiac arrest will hopefully improve survival of cardiac arrest
- Enhances/improves care for community members, improves transfer experience
- Serving the community in a more efficient, safer, and more skilled manner
- Make our community a safer place
- Increased efficiency and speed with procedures, exams, interpretations of imaging which will allow for shorter wait times. I will be able to do more palliative care offloading some of the burden on community palliative care team.



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- improving patient health and trust in me as their provider (++) important with indigenous pts) i.e. to better know when to encourage a patient to go to referral centre when they don't think it's necessary
- I can offer patients more complete care
- Pts have faster recovery and early return to work.
- A whole new skill set to reduce patient transfers
- Support ongoing provision of cancer treatments locally in-territory, allowing patients to receive care close(r) to home, in a culturally safe environment
- Improve patient care and clinical outcomes
- Reduced ER closure days
- Improved time to diagnosis
- Community members will have improved emergency and family medicine care
- Nurse and physician recruitment and retention for keeping our hospital and clinics open in an underserved rural area
- Better equipped to deal with acute care/ trauma in the rural ED
- Reduce travel to larger centers when not needed based on more confident and informed diagnoses, faster and more efficient care for patients.
- Enhanced learner experience translates into recruitment opportunities
- There has been threat of closure and diversion: I can help obviate this.
- Provide weekly cast and minor injury clinics locally
- Better working relationships with pre-hospital and nursing staff
- Ensuring that a safe obstetrical program with full surgical back up is available in the community
- I will be able to apply to the CPSO to be designated as having a focused practice

4. What is the greatest impact your participation in this program has had on your: Local healthcare team

- Improved patient access to care
- Better communication
- More available skills
- Facilitates communication to assess patients
- Increases confidence in local decision making
- Alleviate the burden on referral centers by effectively managing more challenging cases
- Providing higher quality care
- Allows me to support my colleagues in their care for patients



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- Added a new level of skill for the emergency department team
- Better coordination between me and the team
- More confident running codes and trauma as team leader
- Less frequent calls to specialist teams offloading burden to colleagues
- Avoid utilizing provincial healthcare resources
- Less pressure on the already resource-strapped local health clinic
- Ability to better utilize resources in both how and when
- More access after-hours to at least some imaging
- More excitement about CME
- Unity among team
- Trust in my competence
- I learned to be a team-player
- Working as a team with the same protocols, improving relationships with referring centres

5. What is the greatest impact your participation in this program has had on your: Individual practice

- Reassured me that I have the skills to practice remotely
- Increased my ability and confidence to work in remote isolated settings
- Booster confidence in using skills
- Airway management
- Enhance diagnostic skills for acute care
- Enhanced surgical skills for minor procedures
- Critical care in resuscitating unstable patients to diagnose the cause of shock
- Improved time to diagnosis and decreased ED LOS
- I will now spend 25% of my time exclusively in oncology (previously none)
- Increased confidence in my abilities and knowledge for managing various patient presentations
- Confident screening and managing clients with addiction, particularly around ETOH use disorder

6. What will your ongoing relationship with your preceptor look like?

- I keep scanning the patients and will revise them with my preceptor in the future
- Preceptor is added to my network of colleagues
- I work with a preceptor on occasion in the OR; he is open to having me practice intubations and procedures in the future



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- He will be available via email/phone calls if I have any further questions
 - He provides consults on every patient we are considering for treatment
 - Shared care of complex patients
 - I have a wonderful mentorship relationship with my preceptor who is a local anesthesiologist. He has been so quick to answer questions at any time, and has welcomed me to come back to his OR to practice. He often comes to my resuscitations in the ED and lends a hand, even when he is not on call. We have learned to work very well as a team.
 - Improved interactions, collaboration and knowledge sharing as we work in the same ER
 - Ability to call/text/email, hopefully some ongoing clinic shadowing and training - they were both kind enough to invite me back
 - Consult discussions, referrals for services not attainable at our center, follow-up assessments for services done through the preceptor's center, and periodic in-person continued training and practice discussions.
 - Consult discussions, referrals for services not attainable at our center, follow-up assessments for services done through the preceptor's center, and periodic in-person continued training and practice discussions.
 - We use a discord server where all fellows and faculty are able to share and collaborate daily.
 - Ability to send videos of scans for review or follow up
 - Regular follow-up and hopefully working as colleagues in the future.
 - They will mentor me in the delivery of rural skills
 - I meet with him every 2 weeks on zoom to go over cases. We communicate by email as well in between.
 - Peer support, mentorship, sharing of resources
7. How will your training improve team-based primary care e.g., interprofessional care?
- Now on a first-name basis with prehospital staff, feel much better about working as team
 - With ability to do PoCUS as an independent practitioner, I am better able to communicate with specialists and arrange for appropriate referrals.
 - I am able to present when consulting other colleagues, and also when working with my local team to come to a diagnosis.
 - Training will foster a cohesive and synergistic team, ultimately benefiting patients through comprehensive, patient-centered care.
 - Using my skills, I will be able to help my colleagues to diagnose and treat their patient more efficiently



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- Improves diagnostic clarity and ability for team to provide care in acute care settings
- Work better with other physicians but more importantly nurses, RT and allied health care in my facility by providing improved patient care.
- My training has increased my skills and knowledge which I have already passed along to my colleagues and residents/students. Better interpretation of exam findings, physical exams, splinting etc. which allows for better follow-up care or consultation when required
- I will be able to support my colleagues with bedside ultrasound skills
- Improve quality of multidisciplinary care by providing better information to nursing team and specialists
- Better understanding when to involve colleagues in care of patients
- Ultrasound is important for ER which is a team-based department (nurses, RT, etc.)
- The decisions to treat is now team-based
- OT, PT have relevant patient info sooner rather than waiting days for advanced imaging (CT, ECHOs) in admitted patients
- I have been able to work with my RT colleagues much more since my training, and we have become very collaborative. Now that I have a functional understanding of ventilation and more nuanced airway skills, we work together to optimize our challenging airway/resp patients and are both on the same page.
- Training was team based. Will help us work together as a unit
- My training in a high-volume setting has highlighted some of the rare but life potentially life-threatening situations that can arise in surgical obstetrics. By being in this setting, I was able to see how the full healthcare team worked together. I hope to have meaningful conversations and education with the obstetrical care team to plan for unexpected emergencies that can arise;
- in rural communities, primary care is multifaceted and this emergency care course brought together MDs, nurses, learners, paramedics to problem solve, self-evaluate and provide feedback to each other - improved communication

Appendix D: Application Improvements

Aspect of Program	Comments from Trainees
Application Process	<ul style="list-style-type: none"> • The evaluation form had questions that were not applicable to courses • More clearly identify what types of training are being approved • Ensure the application can be saved to reference later on • Some aspects of predicting costs up front are unpredictable • Clarity up-front on maximum travel and accommodation budgets e.g., inclusion of HST • I was impressed at how flexible the application process was and how they were able to increase my funding to cover more training. A very reasonable amount of paperwork considering the payoff • Improve descriptions of budget categories e.g., clarify if meals are covered • Streamline application process so there are checkboxes as you progress • Application required too much paperwork e.g., a letter of support should not be required • The application should include a built-in spread sheet to help remind physicians of things (mileage, police checks), etc. • Recognize that IT infrastructure at a rural site is not always up to urban expectations. E-forms, e-signatures and having everything digital is not realistic. Faxes are a 100% legitimate way of communicating • The application should clearly indicate that physicians had to be SRPC member to participate
Timelines	<ul style="list-style-type: none"> • Extend the deadline beyond March 31, 2024 e.g., a full 12 months to use the funding • Speed up approval process
Reimbursement	<ul style="list-style-type: none"> • Allow participants to apply for reimbursement as training is complete instead of at the end • Allow automatic access to full \$35,000 • Facilitate the trainee’s ability to increase the budget • Reimburse equipment costs



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Aspect of Program	Comments from Trainees
	<ul style="list-style-type: none"> • Ensure fair allocation of funds – consider reducing the total budget of \$35,000 so more physicians can participate • Simplify the reimbursement process • After completing the training, the funding could be released with the certificate of completion only. Getting all the paperwork is a lengthy process. It would be better to receive the funding up front to pay all the expenses rather than paying from our own pocket first • The receipt that the preceptor signs saying they have been paid (to complete the application) before we have paid them • Clear communication is required that changes to the estimated budget must be communicated to SRPC • Allow for a group application particularly when it is a course.
Preceptors	<ul style="list-style-type: none"> • Provide access to preceptors far and wide within and after the training period • The preceptors for this program should be advised on how to objectively assess their trainees • SRPC should take a lead to communicate with the preceptors before training
Eligibility Criteria	<ul style="list-style-type: none"> • Extend to all physicians beyond rural communities

Appendix E: Testimonials

- Best thing to happen to the SRPC in years! Exactly what rural skills training needed.
- I never in a million years would have done this course if I had to pay out of pocket but I LOVED the course and am really excited about the new skills I have. If the program is extended, I will definitely take the rest of the resuscitation ultrasound course.
- I would like to thank you so much for providing this opportunity for rural doctors to improve their skills to provide higher quality of cares to the patient. I greatly appreciate it.
- I am highly appreciative of the SRPC funding, as I would not likely have been able to do this course without the support and funding. Just to be able to concentrate on the course and the skills training was challenging enough, and not to have to worry about the funding, made the training more enjoyable and fruitful.
- My training was excellent and I really could not be happier. As a rural family physician, there are many different areas I could train in. This program was concise, direct, and practice changing.
- Thank you so much for supporting this opportunity and the improvement of access to clinical care for rural underserved populations across our vast nation!
- This was an incredible opportunity and I am grateful to have been accepted. I am optimistic the patients of our region will find the increased level of service/availability for treatment beneficial to their lives.
- This was quite literally a dream come true. I always wanted to learn POCUS but it was not integrated into our school/residency curriculum and the cost of this course was quite prohibitive. As a recent grad, it was amazing to get this skill under my belt and start using it quite literally next day in emergency. It was also such a blessing to my mental health to be able to interact with other docs in the same situation, learn about the successes and struggles of their respective practices and hospitals, and overall, the collegiality was great. I cannot



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recommend this course enough to other docs. I will certainly be applying again if future funding available.

- Excellent. I am so glad I got this opportunity. I know a lot of colleagues waiting on the next opportunity. We are all on the lookout. Thank you to all involved in organizing this.
- I could not speak more highly of this program nor the access it gave me to training I could not otherwise obtain. I have already seen first-hand how it has changed the quality of care I provide to patients with tangible examples. Please work hard to obtain further funding like this in the future.
- This program was a great opportunity to improve my skills and improve care for patients, collaboration with team members and my confidence in managing patient care in rural and remote settings.
- This program was invaluable to combat burnout in my practice and gave me the confidence to continue my practice as a rural generalist. The first time I've felt like I've had real support from the government or an organization that recognized there was value in investing in me.
- I practice in a recognized rural community where I do comprehensive family medicine, including inpatient, ER, and oncology care. This program has significantly improved my skillset for my community, and improved my confidence with high acuity low occurrence scenarios. I also have incorporated ultrasound-guided musculoskeletal injections for local patients who normally have to drive 2 hours to receive the same level of care. Thank you from the bottom of my heart.
- Thank you for the funding. Definitely felt like the government went above and beyond in trying to tackle the rural physician shortage in another way.
- Thank you for the funding - it will really improve my ER care and confidence in managing some of the sickest patients in our rural ER.
- Thanks for having this program. CME is extra expensive when rural and so very needed when trying to keep up with the expectations and skills needed to be working in remote practice.



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- This was an amazing experience. I was able to complete my 30 days training with a 3-month period hence had the best of both worlds. I feel better equipped to serve my community the ED despite the prior experience I got during family medicine residency.
- One great side benefit for me from the process was taking up membership in SRPC. I am at a stage in my career where I want to contribute to the recognition and continuation of this unique brand of medical practice.
- Thank you for this incredible opportunity. It is difficult to obtain extra training while living and working in a remote northern community, this program made that attainable.
- I am better equipped to offer procedures and care in my local community. Hence reducing unnecessary transfers, working with local interprofessionals to deliver local care, and improving communication during transfer when needed.
- The training improved my diagnostic skills.
- I have a renewed interest in shared care, team-based care.
- I have more confidence in rural decision making – we take on a lot of risk when we try to keep patients in the community. Ultrasound training has helped with the confidence in my team.
- The training increased my knowledge of systems, referral patterns, group norms and Canadian guidelines.
- By efficiently managing my patients, this will impact the entire health system, time spent with each patient, decrease wait lists.
- Please consider continuing this program and having it embedded in relationships between rural and urban centres to foster mentorship and longitudinal skills development. The cognitive and time efforts required to set up rotations and self-designed programs without any administrative support or existing infrastructure is a barrier to physicians seeking out new opportunities. Consider if referral centres and academic community hospitals may just be able to offer opportunities and house this in a database

Appendix F: Key Informants

Trainees	Position	Province
1	Family Physician	Manitoba
2	Family Physician	British Columbia
3	Family Physician	Newfoundland and Labrador
4	Family Physician	Alberta
5	Family Physician	Manitoba
6	Specialist	British Columbia
Preceptors	Position	Province
7	Specialist (Neonatologist)	British Columbia
8	Family Physician	Nova Scotia
9	Family physician	Alberta

:

Appendix G: Key Informant Interview Summary

Question 1: Can you reflect back on some memorable learning experiences you had while participating in this program? Describe the program you participated in.

Preceptors

Memorable lessons learned during the program included the value of one-on-one hands-on learning sessions, the principle of treating each patient equitably regardless of their condition, and the critical role of clear communication between family physicians and hospital staff. Participants recognized the importance of open discussions regarding patient management and decision-making processes. A noticeable shift towards a team-based approach in patient care emerged. A preceptor reported that their trainee's handling of acutely ill patients and honing procedural skills, which are often underutilized in family practice, was found to be fulfilling. One preceptor stated that the experience of teaching a trainee with a high level of experience was unique and enriching.

Trainees

Participants thought that the exposure to diverse medical cases and various approaches to patient care provided invaluable experience and perspectives, which enhanced their understanding and approach to patient care and bolstered their confidence. Some trainees admitted initially experiencing panic during certain procedures but noted a steady increase in confidence with continued exposure. They also discussed that while they previously had to rely on specialists for confirmation, they were now more confident in their decisions (e.g., medication management). Trainees emphasized that the program underscored the importance of understanding protocols and safety measures, and highlighted the significance of collaboration among colleagues in following the same protocol, ensuring consistency in patient care and understanding among team members. Trainees felt fortunate to have had the opportunity to learn from experienced clinicians and believed that exposure to different physicians enabled them to pick the best practices from each and develop their own approach. One trainee expressed excitement about returning to hands-on work, stating that they felt almost a decade younger.

Trainees indicated the wide range of areas in which they furthered their skills some of which include gaining more experience with acute care, emergency medicine, minor surgical skills (e.g. vasectomies, colposcopy, urological procedures such as cystoscopy), pediatrics and neonatal care (e.g. resuscitation and intubation), obstetrics care (e.g., new methods of induction), and ICU-based procedures. In addition, trainees were interested in ultrasound training including ultrasound-guided injections for pain management.



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Question 2: How will this enhanced training enable you to provide better care closer to home for your patients? (trainee question only)

Participants reported numerous benefits gained from the program, notably leading to better care for patients. Trainees reported that their involvement in the program enhanced their ability to address common medical issues encountered in their practice. They report that they now follow clearer guidelines which are in alignment with established protocols. This has facilitated smoother communication and explanations to patients and have improved patient understanding. Additionally, participants noted an increase in confidence and skill sets has enabled them to better manage complex or emergency cases and fostered collaboration between family physicians and specialists. The training equipped participants with skills that enabled them to offer services that patients would otherwise have to wait for or travel long distances to receive (e.g. vasectomies). One participant cited that, upon returning to practice, their newly acquired skills were immediately put to use in confirming a diagnosis in the emergency department, emphasizing the efficiency and accuracy it brought to patient care, suggesting that proficiency in skill can lead to more efficient and effective patient care.

Question 3: How will your training improve team-based primary care e.g., interprofessional care? (trainee question only)

Participants emphasized the importance of teamwork, and expressions of appreciation for the opportunity to collaborate with various healthcare professionals and observe how different roles contribute to patient care. They highlighted the importance of standardized protocols in their clinic, stating that protocols ensure consistency in patient care among colleagues. Participants stressed the value of building relationships with colleagues, involving them in patient care decisions and being on the same page stating that these elements foster a sense of teamwork and mutual support. This team-based approach represents a shift from previous practices, where communication may have been less consistent. Participants reported that they are committed to replicating these collaborative practices in their current work environment to enhance patient care and teamwork.

Question 4: Given your advanced skills training, will you offload clinical or administrative tasks to your team? If not, why? (trainee question only)

Trainees' responses were mixed regarding whether the additional training would cause them to off load work. One participant reported that they would offload follow-ups to nurses (e.g. stitches removal), whereas others reported that they had no intention to offload tasks.

Question 5: Do you anticipate that your additional advanced skills may increase your workload? Why? (trainee question only)



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Trainees were mixed in their feeling that acquiring new skills led to an increase in workload. Some felt that the training would help them perform their job more effectively and allow them to make more informed decisions in their practice. One participant said that the increase knowledge did result in a shift in responsibilities rather than a straightforward increase in workload.

Question 6: Are you planning to maintain a mentoring relationship with your trainee? If so, what does it look like? (preceptor question only)

While there is currently no formal requirement or funding to support this interaction, preceptors reported a desire to continue to maintain a relationship even though the official program was over.

Question 7: Describe any challenges and opportunities for improvement

Throughout the interview both preceptors and trainees shared challenges they encounter with the training program and identified opportunities for improvement

Challenges - Preceptors

Some of the challenges encountered during the training program, included financial constraints, logistical difficulties in organizing boot camps and exams, heightened activity level of the emergency department and limited timelines for completion of the training. Additionally, preceptors noted that many colleagues were unable to participate due to time constraints and insufficient notice about the program's deadlines.

Challenges - Trainees

Trainees noted challenges with the timelines, reflecting that it was difficult to come up with a program or find a preceptor in the time allotted for the *National Advanced Skills and Training Program*.

Opportunities for Improvement - Preceptors

Preceptors emphasized the need for clear communication regarding program details, their role as preceptor (e.g. how many hours to spend with the trainee), defined goals/objectives and the value add to their practice to enhance the effectiveness and coordination of the program. Fixed dates or a schedule was also suggested to support trainees learning as some preceptors noted they had many students coming in and out and it was difficult to coordinate their learners.

Opportunities for Improvement - Trainees

Trainees recommended the development of a list of preceptors who are willing to share their skills and emphasizes the importance of facilitating connections between learners and experienced practitioners. One participant recommended the need for clarity regarding budget and another about the importance of raising awareness about training opportunities.



COLLEGE AND ASSOCIATION OF NURSES
Northwest Territories and Nunavut

Healthcare Sustainability in the Northwest Territories

Feedback Presentation

December 10, 2025

CANNN – the College and Association of Nurses of the Northwest Territories and Nunavut has been in existence since 1975 when we were established as both the regulatory body and association for Registered Nurses practicing in the Northwest Territories.

Since that time the organization has grown to represent both the Northwest Territories and Nunavut, and in 2023 expanded to regulate all designations of nursing: Registered Nurses, Nurse Practitioners, Registered Psychiatric Nurses and Licensed Practical Nurses

Dual Mandate Organization



Protect the Public



Advocate for Nurses



COLLEGE AND ASSOCIATION OF NURSES
Northwest Territories and Nunavut

**Future State:
Establishing an
independent
association to
amplify the voice
of nurses**



What are we doing?



Interjurisdictional Nursing Licensure & Labour Mobility

CANNN has entered into a commitment to enhance labour mobility for nursing professionals by facilitating common approaches to licensing with other jurisdictions. This includes the shared principles of remaining:

- Client Centric
- Focused on protection of the public
- Constitutionally Valid
- Stable
- Focused on continuous improvement

Interjurisdictional Nursing Licensure & Labour Mobility

What does this look like?

- Change in licensing types
 - Home vs. host licenses to reduce requirements for nurses that are providing short term contract and/or locum care
- Minimum processing times for verifications
 - Verifications to other jurisdictions are processed in less than 10 business days
- Adoption of Nursys
 - Onboarding of Nursys – a national database of all nursing regulators to review and exchange information on license status. This will be an additional safeguard for the public through the assignment of a unique identifier. Once adopted, this will replace the need for verifications of registration.

Expanded Scope of Practice for Licensed Practical Nurses

The regulator is responsible for determining the scope of practice – the knowledge, skills, and professional judgment that LPNs are required to possess to do their work safely. In November of 2024, we released a new – adopted - scope of practice for the profession which allows them to work to their highest possible scope of practice, while also remaining within the confines of legislation. This means, that the regulatory scope of practice supports LPNs advancing their skills and abilities, so long as they are properly supported, educated and trained to deliver care.

RN & RPN Prescribing

We have established the Nursing Practice Committee to advance our legislative ability to regulate advanced practicing Registered Nurses and Registered Psychiatric Nurses. This committee will work towards determining what is required to consider an RN or PRN to have an expanded scope of practice and allows them to prescribe medications and communicate diagnoses for the purpose of prescribing those medications. This committee will determine the educational requirements, as well as any restrictions for medications that these designations are able to prescribe and any settings in which they are able to do so.

Internationally Educated Nurses

Nursing education is not the same in every country and so there are differences in the knowledge, skills, and abilities of nurses who are integrating into the Canadian Healthcare system. Historically we required that these nurses have 1,125 practice hours in another Canadian jurisdiction before we would license them. We have recently updated this to 450 hours in the past two years. For those who do not have these practice hours, they are able to complete the Inspire Assessment. This assessment provides an in-depth overview of their education's curriculum, a review of their clinical and communication skills, and a detailed report of any gaps that may impact their ability to deliver care.

Upon receiving a report, the Registration committee can make a recommendation for coursework to fill these gaps, or the Registrar can consider placing conditions on the IENs license to restrict the areas in which they are practicing.

This is another way in which we are improving how accessible it is to work in our healthcare system, while still upholding our mandate of public safety.

Research

In collaboration with the Nunavut Tunggavik Incorporated. CANNN has secured funding for a research project that is being executed in collaboration with the Institute of Circumpolar Health Research (ICHR) to explore Indigenous Nursing students' experiences writing their licensing exams.

We also hope to further explore the unique recruitment and retention issues impacting northern nursing practices.

What are the perceived needs?



Utilization of RPNs

At this time, there are less than 40 Registered Psychiatric Nurses employed in the Northwest Territories and Nunavut. Less than five of these professionals are being utilized in the Northwest Territories.

Registered Psychiatric Nurses (RPNs) are health care professionals who provide holistic, client-centered care for clients with complex psychosocial, mental health and addictions, and physical needs. RPNs coordinate care for individuals, families, groups, and communities in a variety of health care settings with a variety of health care professionals. RPNs unique scope of practice focuses on mental health, addictions and neurodevelopmental disorders.

Recommendations:

- Review current job descriptions within the health and social services system to see where RPNs may be utilized
- Consider the establishment of RPN educational programs that would meet the unique needs of our mental health system.

Increased Scope for LPNs

With the increase scope of practice for LPNs, comes the inevitable need for education and training for LPNs who are already employed in the system and for those considering applying for jobs in the Northwest Territories. Nurses wish to work to their highest scope of practice, but they need the supports in place to be able to do so. In our survey conducted we heard this specific feedback from many respondents, some quotes shared included: “Bringing in qualified nursing staff is more difficult because people become frustrated that they are not able to work to the full scope of practice.”

“I feel right now that the RNs get all the glory and the LPNs are left behind and treated unfairly. In all other parts of Canada, LPNs are given opportunities to work in various departments such as ICU, ER, Public Health, Dialysis etc. But that opportunity is not given here to LPNs. Nurses comes in many classifications. Not just RN.”

Recommendation:

- NTHSSA is providing skills and education to LPNs; however, additional investment may enhance the sustainability of the healthcare system.

Utilization of Nurse Practitioners

Nurse Practitioners (NPs) have an independent scope of practice and are authorized to provide autonomous care across various clinical settings. Their role is particularly valuable in regions with limited access to physicians.

A 2022 report by the Canadian Nurses Association found that jurisdictions utilizing NPs in expanded roles experienced improved patient outcomes, shorter wait times, and cost efficiencies due to decreased dependency on physician services.

Recommendation:

It is recommended that the territory continue to expand and support the integration of Nurse Practitioners, especially in rural and remote communities, to improve access to timely primary care services and reduce system reliance on locum physicians.

Regulation of Allied Health Professionals

Regulation is often seen as red-tape; however, right touch regulation is the process of providing regulatory oversight for a profession that is interested in improving the knowledge, skills, and abilities of the profession to uphold the mandate of public safety – moving away from the punitive historical way of regulating. Being a regulated, particularly self-regulated profession provides reassurance to the profession, and those who work with them that they are held to certain standards. At this time, nursing is the only self-regulated health care profession in the Northwest Territories. As of late, we have heard of significant concerns from the front line regarding the lack of regulation of allied health professionals.

Recommendation:

- Consider regulation for allied health care professionals, including but not limited to: paramedics, midwives, health care aides, respiratory therapists, occupational therapists, physiotherapists etc.
- Advance professions abilities to self-regulate to reduce conflicts of interest between the employer acting as the regulator.

Funding for Nursing Education Programs

CANNN completes educational program approvals for any nursing education opportunities provided in the NWT. This ensures that programs meet national standards for their students. We hear about the gaps when nurses can't get the training they need in territory – to no fault of the educators, but due to a lack of resources. Some program gaps include:

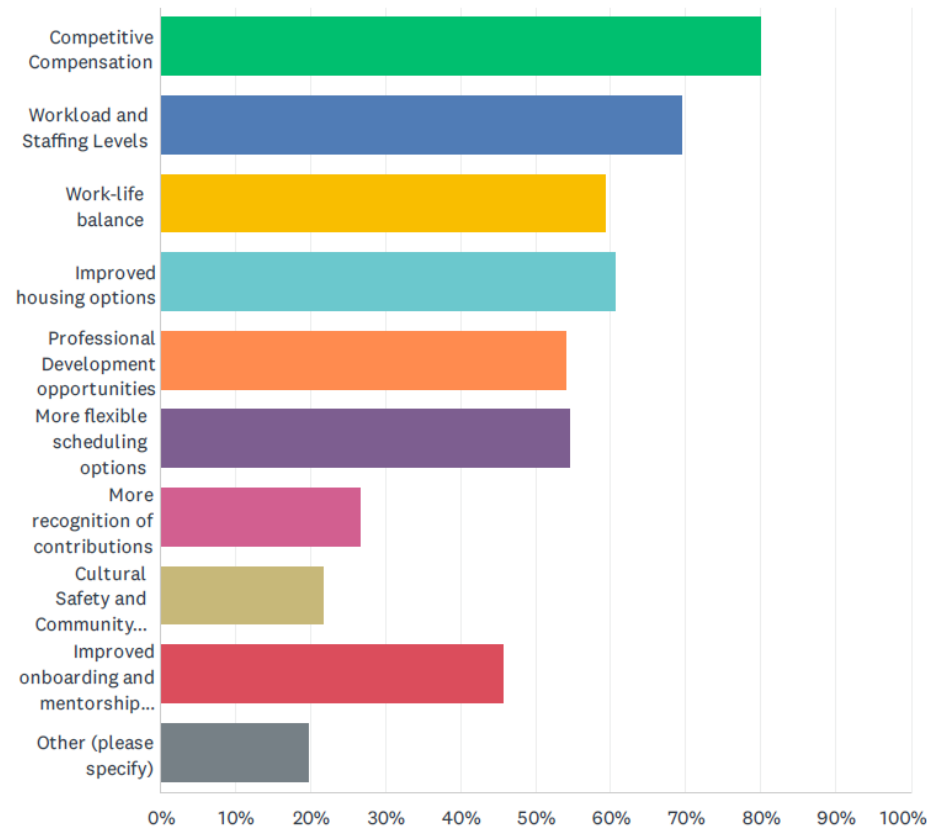
- Nursing refresher programs
- Nurse Practitioner programs
- Nursing Bridging programs
- Registered Psychiatric Nursing programs
- Midwifery programs
- Prescribing and Diagnoses programs

Survey Results

Recently we asked nurses what they want. What would entice them to be recruited or retained in our health care system.

In your opinion, what specific changes or initiatives do you think would entice nurses to work in the Northwest Territories and Nunavut?

Answered: 207 Skipped: 3



Qualitative Results - Survey

- “Improved, consistent safe nurse-patient ratios; More collaborative leadership; Value experience of staff; Listen to staff, allow them to be part of the discussion and solutions”
- “I believe that more flexibility in job status would benefit the north. There are nurses who live in the communities who are there because of a partners job, who do not have the capacity to take a position with the GWNT but who would love to be able to work as a casual, picking up shifts as needed. This model is consistent with many other health regions. There is no real disadvantage and obvious advantages of using the local resources available. Job shares while not as beneficial as regular full time permanent employees help create a stability in the work-place that supports best patient outcomes.”
- “Access to childcare”
- “Paid nursing school practicums with a term casual employment opportunity signed prior to graduating nursing school”
- “Improve management practices”

THANK YOU.

CANNN.CA



Speaking Points

By

Lisa Little, RN, BNSc, MHS, FCAN

CEO, Lisa Little Consulting

1st Vice President, Board of Directors, International Council of Nurses

To

Standing Committee on Social Development

Northwest Territories Legislative Assembly

Study On Sustainable and Accountable Healthcare

November 14, 2024

Thank you Madame Chair and members of the Standing Committee on Social Development, for the invitation to present to you on the topic of Healthcare Sustainability and Accountability. My name is Lisa Little and I have spent 35 years as a registered nurse in clinical, management, education, policy and leadership positions both here in Canada and globally. I spent 10 years at the Canadian Nurses Association leading their research and policy work on nursing and health human resources, as well as many health system challenges such as accessibility, affordability and sustainability. I have been working as a consultant for a northern healthcare system in Canada for the last 5 years. I currently serve as the 1st Vice President of the International Council of Nurses, which represents more than 130 national nurse associations and 28 million nurses globally.

I want to begin by saying the challenges that the NWT is experiencing is not unique as it relates to nursing and healthcare systems. Half of the world's population do not have access to universal health care, the world's population is aging, and non-communicable diseases or chronic diseases account for 71% of deaths worldwide. And unfortunately, the world is experiencing a global nursing shortage estimated to be anywhere from 10 to 30 million nurses. Without a health workforce there is no health system or healthcare. Nurses comprise 70% of the health workforce in Canada. Investing in nursing is key to ensuring health system sustainability and improving the quality of care, life, and wellbeing of residents and healthcare staff in the territory.

I would direct you to ICN's latest International Nurses Day report this year **Our Nurses. Our Future. The economic power of care**, available on our website.

In the report economists reveal the true, full value of nursing to societies – how elevating the nursing profession can catalyse transformative improvements in health care delivery, economic development, and societal well-being. What they have told us is what we already knew: that investing in nursing jobs, education and leadership results in an excellent return on investment that means every dollar spent pays for itself many times over. Nursing is not a cost to the health system, but rather it is an investment in the health of populations and health systems.

And ICN believes investment in nursing jobs should be prioritized in primary care and embracing a primary health care approach. The key to health system sustainability is to invest in the principles of primary health care as first articulated in Alma Ata in 1978 including- illness prevention and health promotion, team based care, appropriate use of technology,

intersectoral collaboration. This means investing in more care outside of hospitals, that is integrated across settings and providers, is patient focused and with special consideration for reaching underserved communities and populations.

More nurse practitioners and nurse led models of care can transform the health system and improve access to care and improve the health of the population. We have decades of research to show this. And we know that this is definitely a reality in the territories, where nurses provide the bulk of healthcare. Prioritizing investments to enable healthcare workers to work to their full scope of practice, including Advanced Practice Nurses and nurse led models of care, improves health system efficiency and effectiveness. According to the OECD, seventy-six percent of doctors and 79% of nurses reported being over-skilled for the roles they were performing in their day-to-day work. This means supporting nurses with more administrative support, and unregulated providers to assist with non-nursing tasks. Research

shows that 30 % of what nurses do does not require nursing education- like paperwork, faxing, stocking shelves, finding equipment. Given the cost and length of education programmes for doctors and nurses, this represents a huge waste in human capital.

This also means connecting nurses in territory with nurse specialists outside of the territory through telehealth. Clinical nurse specialists in the area of wound care, gerontology, mental health and addictions, women's health. These are just a few examples. They can be supporting direct care through nurse to nurse consultations, but also supporting the ongoing continuing education of nurses in the NWT.

The ICN **Charter for Change** presents **10 vital policy actions** that governments and employers must take to create and sustain health care systems that are safe, affordable,

accessible and responsive, and to shift the paradigm and align nurses to be visible, valued and vital for the health of our countries and to nurse the world and profession back to health.

I encourage you to read it. I would like to highlight just a few. We know that nurse burnout is a common phenomena post COVID, with rates of greater than 80% in Canada and it requires immediate attention. ICN urges governments to urgently address and improve support for nurses' health and well-being by ensuring safe and healthy working conditions and respecting their rights including zero tolerance for violence in the workplace and creating psychologically safe work environments. And have work environments that support the health of nurses through stress relieving activities and fitness equipment. And most importantly, put in place systems to ensure safe staffing levels to meet population health needs, never allowing nurses to work alone.

Investing in nursing also means supporting them to excel at their job. ICN urges employers to uphold positive practice environments that listen to nurses and provide them with the resources they need to do their job safely, effectively and efficiently. Invite nurses to the decision making tables – they have solutions to many of the system’s health challenges. For too long, their voices have been absent. I urge you to consider funding recognition programs and professional development activities across career trajectories. Nurses need enhanced digital literacy to help transform healthcare into the digital age. The appropriate use of technology is key to healthcare sustainability and supporting accountability with an abundance of digital health and health system data. I urge you to also support flexible models of employment and scheduling. Our colleagues in Australia have shown us how job shares and fly in/out models of employment can serve rural and remote settings. Ultimately, nurses want to feel valued and respected. Ask them what they want – what is meaningful to them?

I cannot understate the importance of nurse retention and I urge you to review the Nurse Retention Toolkit released by Health Canada under the leadership of the Chief Nursing Officer, with practical, evidence based examples. The best nurse recruitment strategy is an effective retention strategy.

One aspect of recruitment and retention that I think you may find helpful to your rural and remote setting is the work of an Australian researcher Cathy Cosgrove who speaks to the importance of professional, social and personal integration. This requires creating a seamless orientation and professional onboarding experience that helps new healthcare professionals settle in quickly and comfortably within your organisation in terms of their role and responsibilities. This means ensuring that new staff feel supported, valued, and motivated from day one, laying the groundwork for long-term retention. It also means settling and

connecting new employees and their families into the local community events, schools, churches, etc. And for the individual it means understanding what motivates them, what do they personally seek out of their life in NWT and to provide them with information to make that a reality.

The other principle underlying a recruitment and retention strategy is for it to resonate with the five generations we now have working in our health systems. What attracts 20-year-olds is not the same as what attracts 40 year olds. And the same applies for retention. One thing we notice with the younger generation is that they are not necessarily looking for a 20 or 30 year career with one employer, like my generation did. They will most likely work for you for a few years, gain the skills they want, explore your wonderful landscape and then move on. And we have to accept that and build into our workforce planning.

And key to it all is developing nursing and health workforce plans that take into consideration community health needs, primary health care including a shift to greater illness prevention and health promotion, emerging models of care, team based care and enhanced technology, all integrated across the continuum of care. ICN urges you to create workforce self sufficiency with your government partners across Canada and follow the WHO Global Code of Practice on the international Recruitment of Healthcare Professionals, not relying on recruitment of nurses from other countries who are also experiencing a nursing shortage, often in worse positions than us.

Health system accountability will continue to strengthen as you embrace evidence based health care and decision making, and use the abundance of digital data to annually or

quarterly report on key indicators for the health system goals you have set for your territory. And that includes nursing specific data to show the impact of nursing care. Investment in electronic data systems is key. As Peter Drucker has stated, “you can’t manage what you can’t measure”.

Thank you for the opportunity to share a few thoughts with you today and I would be happy to answer any questions.



Health and Social Services System Sustainability

Social Development Standing Committee Presentation

October 23, 2024

Government of
Northwest Territories



Objectives of the presentation

1. Provide background on previous health and social services system sustainability initiatives and status update on previous Committee Recommendations
2. Summarize current system deficit and cost pressures that the health and social services system is facing
3. Present on the purpose of the Health and Social Services System Sustainability Unit under the Department of Executive and Indigenous Affairs (EIA)
4. Identify next steps



Background - HSS Deficit

- Annual deficits in the HSSAs have been a longstanding challenge, dating back well over 20 years.
- DHSS has regularly taken the largest share of supplementary and forced growth funding available.
- The cost of service delivery has continued to exceed funding and efforts to align the two have not been successful



Latest work to address HSS Sustainability

- 19th Legislative Assembly initiative focused on finding operational efficiencies towards quality improvement in health and social services
 - 2020 Sustainability Plan and Action Plan for the HSS System
 - 3 tiers of transformation that the system would undertake:
 - Internal controls and cost containment
 - Operational review and quality improvement
 - Funding and service levels
 - 2022 establishment of a System Sustainability Office in the NTHSSA
 - System Sustainability Steering Committee
 - NTHSSA Deficit Recovery Plan 2023
 - GNWT Restoring Balance



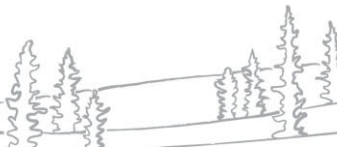
HSS System - Financial Status

- HSSAs Accumulated Deficit - \$265 million (March 31, 2024)
- HSSAs 2024-25 Budget Shortfall – (\$61 million)
- HSSAs 2024-25 Forecast Q1 – (\$72 million)
- DHSS has forecasted \$21 million deficit for 2024-25
- Total HSS System shortfall for 2024-25 is \$93 million; cost drivers expected to continue into next year without service reduction
- HSS heading into 2025-26 \$93 million short, not considering unforeseen and forced growth expected (e.g. inflation)



Establishing the Healthcare System Sustainability Unit (HCSS Unit)

- Develop and implement an evaluative approach of the health and social services system to determine sustainable service levels and explore opportunities for greater efficiency
 - In coordination with DHSS and the HSSAs
- Supports the 2023-27 Mandate of the GNWT and the priorities of the 20th Assembly.
- Created within the Department of Executive and Indigenous Affairs
 - Objectivity
 - Accountability to the Premier



Resourcing the HCSS Unit

- Funded through the Territorial Health Investment Fund

2024-25	2025-26	2026-27	2027-28	Total
\$1,647,000	\$1,906,000	\$1,995,000	\$2,033,000	\$7,581,000

- The composition of this unit will consist of nine staff, who collectively, will have competencies in economic and financial analysis; program monitoring and evaluation; and policy development and implementation.



Clarifying roles of EIA, DHSS and Authorities related to sustainability

- Clarifying sustainability roles and responsibilities between the HCSS Unit, the Department and the Authorities a key first step
- HCSS Unit functions:
 1. Establishment of a core services inventory that has financial impacts quantified and operational needs qualified
 2. Understand current oversight and accountability of budgeting and operational process; suggest improvements if required
 3. Establishment of a monitoring and evaluation framework and continuous improvement approach



HCSS Unit Accountability

- Project management approach with regular status updates
 - Will be required for specific projects developed by the HCSS Unit
- Developing Job Descriptions and staffing
- Briefings to Social Development DMC, COC, and Standing Committees as well as the Leadership Council, as appropriate
- Submissions to FMB and Cabinet as appropriate
 - Current direction to develop a monitoring and evaluation framework that demonstrates how progress in sustainability will be measured by March 31, 2025
 - Report back every six months thereafter



Questions?





Health and Social Services System Sustainability

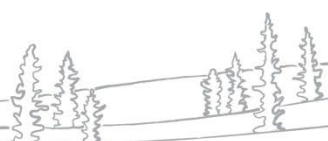
Social Development Standing Committee Presentation

April 25, 2025



Outline

- Background
 - Monitoring & Evaluation Framework
- Progress Update
 - Staffing
 - Inventory of HSS Programs/Services
 - Engagement
- Current Focus
 - Validation of Program/Service Inventory
 - Preliminary Analysis
- Next Steps
 - Evaluative work towards validation of Core Services
 - Transparency and Accountability
- HRHSSA Migration to GNWT

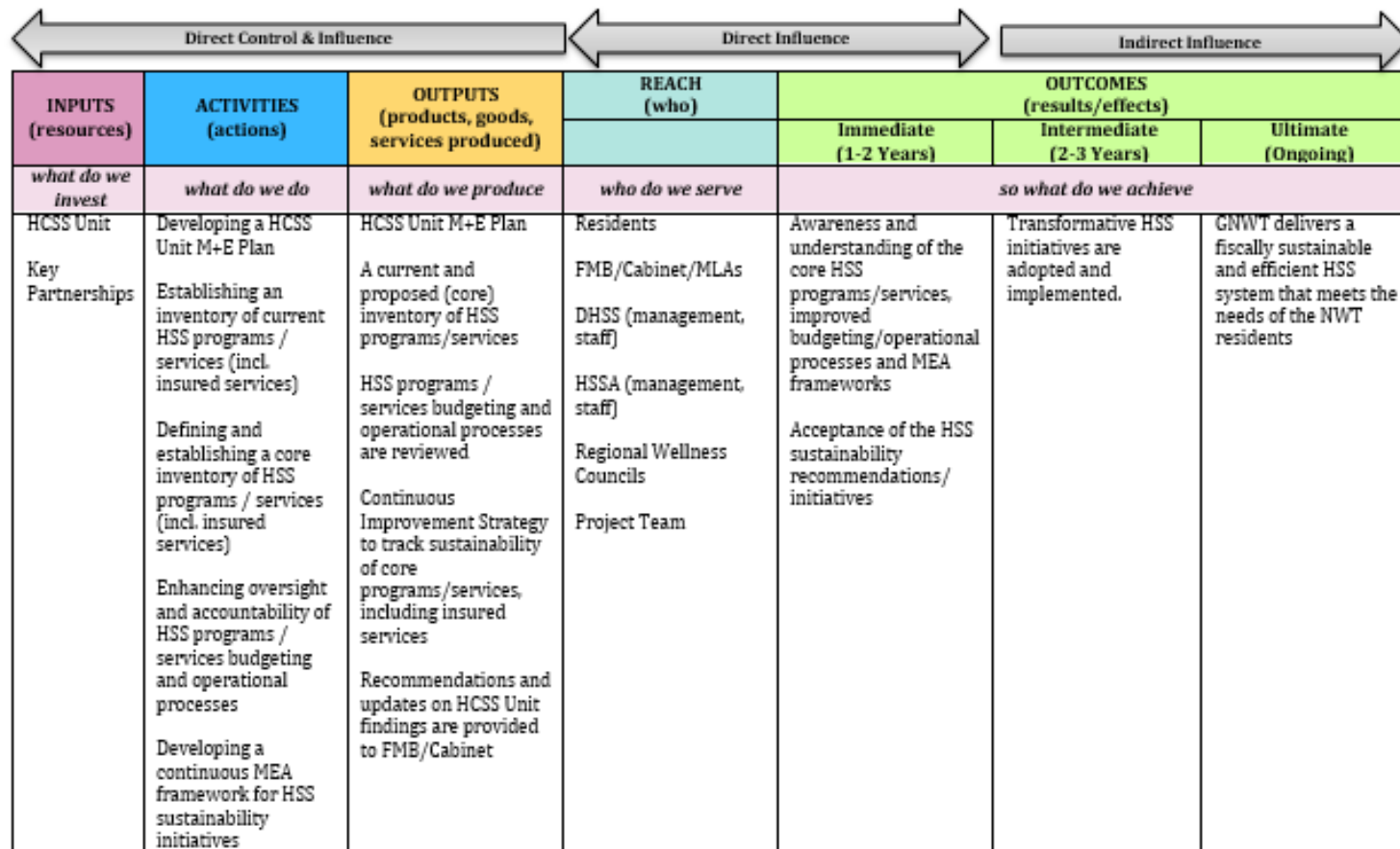


Background

- Monitoring and Evaluation (M&E) Framework
 - Phased evaluation plan
 - Preliminary Analysis: Inventory and prioritization of HSS services/programs.
 - Going Forward: Further evaluation of select services/programs.
 - Logic model and performance management plan



Background Cont'd – Logic Model



Progress Update

Staffing

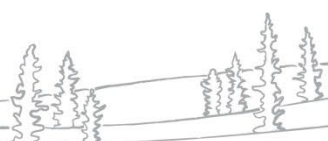
- 7 of 9 positions filled

Inventory of HSS Programs/Services

- Inventory currently being finalized, validated, and prioritized

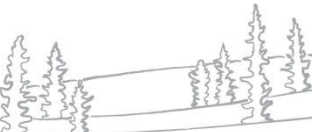
Engagement

- Over 40 engagement sessions conducted with HSS sector stakeholders and ongoing



Current Focus

- Phase 1: Preliminary Analysis
 - First level summary of current health and social services inventories.
 - Identification of priority programs/services for further evaluation



Next Steps



Detailed Dive into Programs



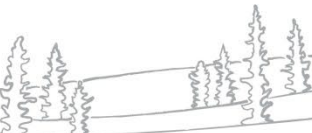
Identification and Validation of Core Services Suite



Ongoing Transparency and Accountability

HRHSSA – Future Considerations

- New initiative to investigate the merit of amalgamating HRHSSA into the GNWT.
- Work recently started to review the cost implications to the GNWT and the logistics involved.
- Gather information for a future decision



Questions?



Joint Presentation NWT Healthcare System

Real Life Issues for Seniors in the Northwest Territories



The Yellowknife Seniors' Society and the NWT Seniors' Society would like to thank the Standing Committee on Social Development for inviting us to present today.

Introduction

Lived Experience of Seniors

- This presentation is intended to provide a point of view regarding real life issues that NWT seniors' face when accessing the healthcare system.
- The Yellowknife Seniors' Society and the NWT Seniors' Society are representing seniors by providing information about seniors' service experiences.
- We believe that these issues relate to accountability of the NWT Health System.

Seniors' Lived Issues

Medical Travel

Travel can be difficult for seniors for numerous reasons.

- Seniors very often have physical limitations which make travel difficult,
- Many patients must travel from a community to YK for an appointment that could be done by phone or virtually – Why?

Seeing a Health Professional

- Seniors sometimes have difficulty getting or understanding the health info they need due to language issues and the terminology used by the professionals and
- Seniors feel unheard – that the professional is not hearing us as we describe our problem(s)
- There is a need for more support for Alzheimer's and dementia patients and their families.
- Homecare supports need to be increased to support aging in place.

System Morale

- We are losing long time doctors and other health professionals.
- There seems to be a disconnect between medical staff and administration/Minister regarding staffing issues, problem fixing and the overall health system.
- We recommend that the Committee interview doctors and nurses' organizations, and system managers to find out why medical personnel are leaving.

Staffing

- We believe that the below questions need to be considered in a sustainable and accountable health care system.
 - How does GNWT qualify/certify doctors, NPS, nurses, other service providers?
 - Does GNWT policy re certification of foreign trained health professionals encourage them to come here?
 - Why does it take so long? Can it be shortened, streamlined?
 - Will NWT align with other provinces and Territories on credentials to make it easier for professionals to get accredited sooner and then be able to work in NWT where we so desperately need them?

Education of Professionals

- We believe the number of nurse practitioners should be increased throughout the Territory.
- We believe GNWT should push programs (i.e., Aurora College) to produce more Personal Support Workers (PSW), Nurses and Nurse Practitioners – especially for communities.

Extended Health Benefits

- Both Seniors' organizations are concerned about comments from the Administrator of NTHSSA that the system is looking at income testing for health services for all patients.
- GNWT Health has long said there would be no changes to seniors' benefits.
- Need clarity around the future of Extended Health Benefits for Seniors.



Thank you.