January 2026

12-Point + Healthcare
Truth & Action Plan

Truth. Targets. Accountability.

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12-Point Healthcare Truth & Action Plan

Healthcare in Nova Scotia is at a turning point. People are tired of being told things are improving when their lives experience says otherwise.

Honesty is not negativity; it is the starting point for real solutions. As we start the new year in 2026, truth has never been more important than now.

Independence in public office gives me the ability to be a clear and honest voice for the people. That is real democracy. And my experience has shown me independence is grounded in community, in listening, and in putting principles ahead of partisan politics: truth, justice, and the determination that things can improve. That determination is what creates hope, and as we enter 2026, hope matters more than ever.

I am releasing this 12 Point + Healthcare Truth & Action **Plan** aimed at improving access to medical care in our province, our region, and our country. It is built from what I am hearing directly from Nova Scotians, combined with lived and professional experience: 34 years as a Registered Nurse, navigating the healthcare system firsthand as a patient and as a mother of four adult children alongside the perspective of my family through my husband's work in family medicine and obstetrics.

I am hearing from more and more people, women in particular, about lengthening wait times for care. Recently, a 45-year-old woman died on Christmas Day after a delayed cancer diagnosis, and she had shared that she was told she would have to wait two years for a gynecologist appointment. We cannot accept this as normal. When wait times reach this point, it becomes dangerous. Immediate measures are needed.

This plan calls for real accountability: clear timelines, measurable targets, and regular public reporting because people deserve truth, not spin or more PR campaigns. . It supports local decision-making and practical reforms, while also recognizing the importance of prevention, early screening, and personal responsibility in health. Above all, it is a commitment to tell the truth and to demand results.

Core principle: *Tell the truth, publish the data, set timelines, and act fast with patients and frontline staff at the center of every decision.*

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1) Put Healthcare Workers First: A Nova Scotia Staff Wellness & Respect at Work Plan

Truth: Healthcare is not a business, but it must be *run* with the same common sense that makes any organization effective. The healthcare system succeeds or fails through the people who operate it every day. If the workforce is overextended, unsupported, or unwell, the system cannot deliver safe, timely, high-quality care.

Based on my 20 years experience as a businesswoman one of the most important drivers of performance in any organization is the health and wellness of its employees. When staff are healthy, supported, and respected, they can perform at their best and patients get better outcomes.

Action:
Implement a Nova Scotia Workplace Wellness Program for all healthcare professionals that treats the workforce as our most essential resource. Ensure every healthcare professional has a primary care provider and suggest an annual periodic health review to be completed. Implement child-care in each regional and tertiary centre. Improve healthcare benefits to have comprehensive coverage for all staff and ensure there is gender equity as the needs for women are not-being met.

This program should include:

- Annual Periodic Health Review for healthcare workers,with focused testing that takes into account unique risk factors, family history, age, lifestyle, and specific work requirements.

- Preventive wellness measures (nutrition, movement, stress management, sleep support, injury prevention). Prevention measures should also be implemented to reduce workplace injuries such as better tools in the workplace.

- Make every effort to fast-track diagnostics for healthcare professionals to reduce sick-time. Missed appointments by the public could be used for staff that are waiting for diagnostics whenever possible

- Early screening tests to catch problems before they become crises

- A robust health benefits plan that reflects the reality: healthcare workers should have access to some of the best care in the world. Health plans should include women-specific coverage for pelvic floor physiotherapy and menopause.

- Psychological support should be offered proactively for all staff that work in areas that commonly deal with trauma such as emergency services (ER, EHS and ICU) and offered in other areas as needed.

- Healthcare professionals with children should have access to on-site childcare at regional and tertiary healthcare centres.

- Re-engineer workflows to ensure efficiencies and non-redundancy

- Optimize scope of practice for every role

Culture Change (required alongside wellness):
A wellness program cannot succeed in a workplace culture that silences people. Government leadership must shift from a culture of fear and control to one that is team-oriented, respectful, and collaborative, welcoming feedback and suggestions for improvement.

That means:

- Ending the use of Non-Disclosure Agreements (NDAs) in workplace situations that protect abusers and silence survivors

- Building psychologically safe workplaces where staff can speak up about safety, staffing, and harm without fear of retaliation

- Supporting leaders who listen, act, and solve problems with frontline teams, not against them
- Invest in leadership development to ensure managers are there to support employees

Target / Measure:

- Staff wellness program launched province-wide with clear participation pathways and protected privacy
- Measure manager success by evaluating staff retention, completion of annual performance reviews, staff satisfaction surveys, sick-time as well as budgetary
- Annual public reporting on workforce wellbeing indicators (aggregated): sick time trends, retention, injury rates, staff survey results

- Policy change to stop the misuse of NDAs that silence workers and protect wrongdoing

- Measurable improvement in staff retention and patient safety indicators over 12–24 months

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2) Fix Health Human Resources: Build a real workforce plan and remove hiring/licensing barriers

Truth: An effective business or organization must have a strong human resource/staffing plan. Many of the problems known in the NS healthcare system are connected to a lack of staff. This is observed in almost all health professions. Nova Scotia cannot fix wait times, ER closures, or unsafe staffing without a serious, province-wide Human Resource plan for healthcare. Right now, workforce planning is fragmented, licensing backlogs slow down recruitment, and qualified, licensed professionals can face unnecessary barriers to getting hired.

Action:

- Create a comprehensive Health Human Resources (HHR) Plan for *all* regulated healthcare professions, updated annually and reported publicly.

- Use real workforce data: current vacancies and service gaps, current workforce by region and specialty, projected population need, projected retirements, training pipelines, recruitment targets, and retention trends.

- Make regulators full partners in planning (Colleges and licensing bodies must be at the table from the start).

- Clear licensing backlogs fast (e.g., nursing applications) by setting service standards and resourcing application processing without lowering standards.

- Remove unnecessary licensing barriers for qualified professionals coming to Nova Scotia.

- End discriminatory hiring practices: if a professional is licensed in Nova Scotia, they should be eligible to work in Nova Scotia, and the training country must not be used as a barrier. Provide proper onboarding, mentorship, and support so people succeed and stay. Sadly, our province has lost licensed nurses because NS Health refused to hire them.

Target / Measure:

- Publish an annual HHR plan + dashboard with regional targets.

- Reduce licensing processing times to clear, enforceable service standards and eliminate backlogs.

- Track vacancy rates, time-to-hire, and retention at 6/12/24 months by profession and region.

- Demonstrate year-over-year improvement in staffing stability and service availability (especially rural ER coverage and inpatient units).

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3) Patient Bill of Rights

Truth:
Nova Scotians don't just need "rights in healthcare" (ethics, respect, informed consent, privacy). They need "rights to healthcare," including the right to have medically necessary care funded and delivered in a timely way. Today, people can do everything right and still be failed by system decisions: waitlist management, staffing, OR time, diagnostics capacity, and unclear accountability. A right that can't be acted on is not a right.

Action:

- Table a Nova Scotia Patient Bill of Rights in the next legislative session.

- Public consultation first: launch province-wide engagement (online + in-person) so patients, families, frontline staff, and community organizations can shape what the Bill says.

- Make the Bill cover both:

    - Rights in care (dignity, informed consent, privacy, clear communication, access to your records, non-discrimination, support person when appropriate), and

    - Rights to care (timely assessment/diagnosis/treatment; transparent waitlist rules; navigation support; safe transitions; clear responsibility when delays happen).

- Build in accountability and enforcement, not just slogans and "buzz" words

Target / Measure:

- Consultation completed and summary report published (what Nova Scotians said)

- Patient Bill of Rights tabled in the next legislative session

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4) Restore Local: local governance, local decision-making, and establish a culture of safety and accountability

Truth: Control and power have become too centralized in Nova Scotia. This too often removes common-sense solutions that local people can provide.

Service changes have been happening without real local consultation, such as operating room scheduling, often ignoring travel time and local realities. Service design changes are also happening, ignoring physician specialists and negatively impacting patient care (a local example is a pain clinic).

Governance requirements under the Health Authority Act have not been followed as intended, leaving serious accountability gaps. This has been seen consistently in situations of families when a family member has died unexpectedly due to a lack of necessary medical care.

Centralized mental-health intake is failing people, with hours on hold, no appointments available, and worsening crises that spill into ERs.

At the same time, the centralized leadership culture has resulted in too many frontline workers feeling silenced or afraid to speak up about unsafe conditions, which undermines patient care and public trust.

Action:

- Bring back local authority and accountability: Establish local health leadership tables/boards with meaningful community representation and real decision-making power.

- Restore local operational decision-making: Return day-to-day operational decisions (including OR scheduling and key service design) to local leadership teams who understand patients, staffing realities, and geography. Local healthcare professionals should be respected.

- Require real local consultation: Mandate documented local consultation before any major service change, reduction, closure, or redesign.

- Fix the governance gap: Re-establish the governance structures required under legislation with clear roles, responsibilities, and independent oversight. Quality management is a key piece missing since the removal of board oversight.

- Rebuild mental-health access where people live: Create local intake and triage pathways that lead to real appointment access, backed by community-based services to reduce reliance on ERs and improve patient and family access to needed mental healthcare.

- End a culture of silence: Strengthen whistleblower protections, create safe reporting channels, and **prohibit NDAs or similar tactics** from suppressing patient-safety concerns.

- Measure what matters: Evaluate health leadership on staff wellbeing and patient outcomes. Patient outcomes should matter more than objective data. Managers should always make decisions that are in the patient's best interest, regardless of the impact on the data.

- Request the Auditor General to evaluate the effectiveness of the organizational structure of Nova Scotia Health and the Department of Health and Wellness, and make recommendations for the removal of duplication that leads to government bloat and ineffective management.

Targets / Measures (public and measurable):

- Once board(s) are re-established, publish local board/table meeting dates, decisions, and outcomes, and track turnaround time for decisions by region.

- Confirm governance compliance with the Health Authority Act through public compliance reporting and independent oversight, with clear corrective actions when standards aren’t met.

- Public reporting by region on: mental-health call wait times, time-to-first-appointment, and progress against wait-time standards.

- Create an independent reporting mechanism for safety concerns, with an annual public summary of issues raised and actions taken (what changed, where, and why).

5) Federal Leadership, Accountability, and Gender-Specific Health Strategies

Truth: Canadians are paying more in taxes and believe they are too often getting less timely access to medical care.

The Canada Health Act is not being consistently upheld, and we are seeing more barriers between provinces since the pandemic. Provinces and territories are making decisions that weaken universality and timely access, while the federal government has failed to provide consistent leadership, enforcement, and measurable national standards for years.

Action:

- Lobby the federal government to actively enforce the Canada Health Act consistently.

- Tie federal health funding to clear, measurable outcomes (primary care access, wait times, ER access, staffing levels) with public reporting.

- Establish national, measurable targets for timely access to care so every province and territory is held to the same basic standard.

- Remove interprovincial barriers that block solutions, including pan-Canadian licensing/credential recognition and workforce mobility, so health professionals can work where they're needed.

- Require transparent national dashboards so Canadians can see results by province/territory and track improvements over time.

- Create a Federal Women's Health Strategy (modelled on my Bill 166 approach):

    - Establish an Office of Women's Health to coordinate research, advocacy, training, and education. Nova Scotia Legislature

    - Appoint a Women's Health Task Force that includes clinicians, policymakers, researchers, and patients with lived experience.
    - Deliver a strategy with actionable targets to improve access and outcomes for women, with public reporting on progress.

- Create a Federal Men's Health Strategy Plan (parallel structure):
    - Establish a national framework focused on access, prevention, primary care attachment, and measurable outcomes for men and boys, designed with clinicians, researchers, community leaders, and people with lived experience.
    - Require federal/provincial collaboration and public reporting (and align it with national performance targets).
    - (This also aligns with the federal direction being discussed publicly for a men's and boys' strategy in 2026.) CityNews Halifax

Target / Measure:

- Federal–provincial/territorial agreements that include published targets, timelines, and consequences for failure to meet them.
- Quarterly public reporting on key indicators (family doctor attachment, surgical wait times, ER closures/coverage, staffing vacancies).
- Concrete steps toward national licensure / harmonized credentials in professions where exams and standards already align.
- Women's Health Strategy and Men's Health Strategy were established with a coordinating office, a task force, a defined timeline to deliver targets, and annual public progress reporting (mirroring the structure you tabled in Bill 166).

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6) Primary care for every person: end the “two-tier” reality

Truth: Everyone wants to see improved access to health care in Canada.

Some people think access to private healthcare is the answer, and some people don’t and campaign against a “two-tiered system”. The fact is, we already have two tiers — those with a family doctor/primary care team, and those without. I support universal access, which does not mean the rich get in faster. I believe timely access to care can be achieved within a universal healthcare system, but changes are needed.

Action:

- Create an active recruitment team that meets with every family medicine resident in Canada with a real offer to set up a practice in Nova Scotia. Provide recruitment packages: moving costs + optional stipend/loan support tied to a return-of-service agreement.

- Create an active “collaboration team” to support family practices in hiring **family practice nurses** and expanding team-based care, with the expectation that each practice receiving funding to hire a full-time family practice nurse will take on an additional 400 patients. Family practice nurses can participate in the delivery of patient care in many areas, such as chronic disease management (COPD, Diabetes, Cardiac Disease, HTN) as well as preventative and early screening, well baby visits, prenatal care, education and more. Every family physician and nurse practitioner could have a family practice nurse to improve efficiencies and patient and family care
- Address efficiencies in family practice. Optimize roles with primary care, including the admin role. Delegation of paperwork.
- Offer a one-time bonus of $10 000 to each family physician and nurse practitioner who will take on an additional 50 patients in 2026.

Target/Measure:

- Public quarterly reporting by region: attachments, vacancies, and time to attachment.
- Government report to the public the status of their recruitment plan for more family physicians in Nova Scotia, who is doing the recruiting, what is the budget and share results monthly

- Expand capacity fast: one family practice nurse can add 400 patients to a practice; scaling that province-wide is one of the fastest ways to shrink the waitlist
- There are approximately 1300 family physicians and 170 nurse practitioners practicing primary care in Nova Scotia. If every family physician and nurse practitioner took on an additional 44 patients, it would remove everyone on the wait list, which is currently at 69420. The healthcare teams have a responsibility to the public to assist the government in finding people basic primary care providers. There must be a real effort to get every Nova Scotian their own primary care provider

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7) Restore reliable rural emergency access

Truth: Rural ER closures have happened, and downgrades to appointment-based urgent care models mean people are being turned away, and that's not how emergency care should work. These closures should not have happened without increasing capacity at larger centres and ensuring additional emergency ambulance services were in place.

Action:

- Stabilize rural ER coverage with scheduling certainty and transparent service hours.
- Ensure rural pay and policy **do not discourage locums** from taking rural shifts, and restore locum physician wages that were reduced on April 1st, 2025. Physicians providing virtual care should not be paid MORE than physicians providing in-person care.
- Require an evaluation of "virtual-first, then refer to ER" models when they create an extra burden for patients and the receiving ER

Target/Measure:

- Publish dashboard: closures, reasons, hours lost, and plan to restore reliable access, community-by-community.

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8) End hallway medicine and unsafe overflow care

Truth: Patients are being placed in hallways/closets without proper call bells, oxygen/suction access, and safe monitoring - this is dangerous and unacceptable.

Action:

- Set a “no hallway medicine” safety standard with escalation triggers.
- Immediate equipment standards for any overflow area (call bells, oxygen, suction, monitoring capability).
- Create surge beds and staffing plans that activate before the crisis level.

Target/Measure:

- Monthly public reporting: overflow hours, location type, patient impact, and corrective steps.

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9) Free up acute beds by fixing ALC and long-term care flow

Truth: Roughly **1 in 5 acute beds** are being used by people waiting for long-term care, which blocks ER flow and delays surgeries/admissions.

Action:

- Rapidly transition available/underused spaces (including facilities being emptied through “Remedy”) into:
    - **Long-term care beds**
    - **Transitional/complex care beds**
    - **Restorative care pathways**
- Stop paying for empty beds in LTC and Residential care while patients wait in the hospital.

Target/Measure:

- Reduce ALC (Alternate level of care) occupancy in acute care monthly with a published target until capacity stabilizes.

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10) Minimum nurse-to-patient ratios

Truth: Nurses are routinely forced to work short-staffed. It can be impossible for them to meet minimum standards of care, morale injury rises, and burnout grows. Some people believe that minimum nurse-to-patient ratios cannot be met due to a lack of nurses; however, I believe that this will actually improve retention of nurses and increase the number of nurses that stay in active practice.

Action:

- Implement **minimum ratios** (starting with the highest-risk units: ER, medicine, ICU, long-term care).
- Build staffing plans that include float pools, sick coverage, and surge protocols.
- Align incentives to retention: workload, scheduling, mentorship, and safe orientation.
- Managers held accountable for the minimum nurse-to-patient staffing ratio

Target/Measure:

- Unit-level ratio compliance reporting
- Track overtime, sick time, turnover, and adverse events.
- Advocate for the government to pass Bill 147 in honour of Shavonne Lees, who died unexpectedly from sepsis at a young age. She was triaged as a Level 1 upon arriving at the ER, but sadly, the nurse had a large number of patients that day. Based on the document below, Shavonne ideally would have had 1:1 nursing https://nslegislature.ca/legislative-business/bills-statutes/bills/assembly-65-session-1/bill-147
- https://nursesunions.ca/wp-content/uploads/2025/06/PostSummitReport-ENG-Final-1.pdf

11) Prevention, Early Screening, and Community Wellness

Truth: Missed or delayed screening means cancers are found later, when treatment is harder, and outcomes are worse. Outdated imaging technology can miss disease (especially in women with dense breasts). Prevention also isn't a slogan; it requires accessible services and a culture shift that makes healthier choices easier.

Action:

- Modernize screening and diagnostic equipment (especially breast imaging)

- Replace/upgrade mammography and diagnostic imaging where needed. Specifically replace mammography equipment that is less effective for women with dense breasts with Contrast Enhanced Mammography (CEM) machines, where clinically appropriate.

- Where replacement costs are not included in capital plans, engage local Hospital Health Foundations and community partners to help secure funding to replace old equipment (in addition to pushing the government to fund core capital needs).

- Expand and promote evidence-based screening programs, building on the success of the home colon cancer screening program.

- Ensure abnormal screens trigger timely/immediate diagnostics and referral, so "screening" actually leads to early diagnosis and treatment.

- Ensure each regional hospital has capacity for skin screening and prevention education, especially where incidence is rising (e.g., melanoma)

- Build clear, fast referral pathways for suspicious findings.

- Establish Community Prevention Clinics at regional hospitals (by the end of 2026)
  Create prevention clinics that offer:
  - Well-women cervical screening clinics
  - Prostate screening clinics

- Skin screening for melanoma using the latest AI technology in conjunction with Melanoma specialists
- Mammography pathways (navigation, follow-ups, diagnostic coordination)
- Prevention education based on age, family history, and medical history
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Timeline: Clinics established by the end of 2026, with defined staffing and service targets.

Province-wide “Get Fit / Eat Local” prevention push

- Launch a province-wide Get Fit campaign (like particip**ACTION**) paired with a local food / healthy eating campaign.
- Involve schools, communities, and workplaces, and include healthcare worker wellness supports to model prevention from within the system.

Targets / Measures (reported publicly, by region):

- Screening participation rates (breast, cervical, colon, skin, where applicable)
- Time from abnormal screen → diagnosis → treatment
- Prevention clinic utilization (visits, referrals, follow-ups completed)
- Measurable population prevention indicators over time (activity levels, healthy eating/local food uptake where trackable)

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12) Digital Health Modernization: broadband access, no limits on virtual care, and a pan-Canadian EMR

Truth: Technology can improve care — electronic medical records (EMRs) are a great example. But virtual care only works if people can reliably get online, and it only helps access if it isn't artificially restricted. Right now, too many Nova Scotians can't consistently use virtual appointments because of weak internet/cell service, and even people *with* a family doctor or nurse practitioner often struggle to get timely appointments. Virtual care can safely support follow-ups and routine issues, but a strict cap (like limiting people to two virtual visits) blocks a practical solution. At the same time, health information must be protected: stronger digital systems must come with strong privacy, confidentiality, and security.

Action:

- **Make virtual care possible everywhere: Treat reliable broadband and cellular coverage as a healthcare access necessity, with clear regional targets and public reporting.**

- Remove the cap on virtual appointments: End limits (e.g., "two virtual visits") for patients who have a primary care provider. Let clinical need and appropriateness guide use, not arbitrary quotas.

- Use virtual care to expand access (not replace in-person care):

    - allow virtual visits for follow-ups, medication renewals, reviewing test results, chronic disease check-ins, and post-op/post-ER follow-up

    - Keep clear pathways to in-person assessment when needed

- Build a pan-Canadian EMR standard: **Push for a nationwide approach so records can move with the patient across provinces/territories and care settings, reducing duplication, delays, and missing information.**

- Protect privacy and confidentiality:

    - strong consent and role-based access (only the right providers see what they need)
    - robust audit trails so patients and the system can know who accessed a record and why
    - clear penalties and accountability for inappropriate access
    - plain-language patient information about how data is used and protected

Target / Measure:

- % of Nova Scotians with reliable broadband/cell coverage that meets a virtual-care standard (reported by region).
- Time to next available primary care appointment (in-person and virtual), by practice/zone.
- Virtual appointment completion rate (dropped calls/failed video visits due to connectivity).
- Reduction in duplicate tests/referrals due to missing records.
- Privacy performance: number of breaches, time to notify, and compliance reporting (publicly reported without compromising patient identities).

Add on:

Efficiency & Effectiveness Action Team (6-month sprint, real rewards)

Truth:
Inefficiencies are everywhere in the system — empty beds in one place while patients wait elsewhere; paid-for beds going unused (LTC/RCF); bottlenecks in diagnostics and discharge. Too often, people work in silos and miss opportunities to improve flow. Frontline staff see the waste every day and can identify practical fixes that improve patient care. Better scheduling and coordination can unlock capacity without compromising safety.

Action:
Launch a 6-month Efficiency & Effectiveness Sprint to deliver measurable improvements quickly, including:

- Frontline-led problem solving (staff closest to the work identify the fixes)
- Rapid removal of barriers (fast decisions and escalation pathways to unblock change)
- Real rewards for innovations that improve flow, access, and patient outcomes
- Scale what works across zones once proven

Target/Measure:

Monthly public reporting on throughput gains, including:

- Bed days saved
- Surgical volumes increased, and reduced cancellations
- Improvements in diagnostic throughput and discharge timelines (where available)

Summary: A Plan Built on Truth, Timelines, and Results

This is a Recommended 12-Point + Healthcare Truth & Action Plan to stop pretending the system is “fine” when people’s lived experience says otherwise.

It is rooted in a simple principle: tell the truth, publish the data, set timelines, and act fast with patients and frontline staff at the centre of every decision.

The plan focuses on practical fixes that can deliver real improvements: putting healthcare workers first through wellness and culture change; building a serious Health Human Resources plan to recruit, license, and hire faster; restoring local decision-making and accountability; and establishing a Patient Bill of Rights that makes timely access a real, enforceable expectation.

This plan also targets the system pressures that drive unsafe care: restoring reliable rural emergency access, ending hallway medicine, and freeing up acute beds by fixing long-term care flow. It strengthens the foundations of care by expanding primary care attachment, implementing minimum nurse-to-patient ratios, and launching a rapid efficiency sprint that rewards frontline solutions and scales what works.

Finally, this plan looks upstream to prevent illness and catch disease earlier through modern screening, community prevention clinics, and a province-wide “Get Fit / Eat Local” push while modernizing digital health so virtual care is accessible and unrestricted, and health records can move securely with patients through a pan-Canadian EMR approach.

This is an accountability plan, and most importantly, it improves access to timely medical care.

We don’t need one more person to die needlessly because they didn’t get access to care.

This plan calls for measurable targets, public dashboards, and regular reporting so Nova Scotians can track whether the government is delivering. Because in healthcare, “soon” isn’t good enough. People deserve access to timely, safe care and positive results. **It’s time for Truth and Action.**
