STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 13:57.]

The Chair: — Good afternoon, ladies and gentlemen. Welcome to the Standing Committee on Human Services. The time being now 1:57, we will be starting. My name is Delbert Kirsch, and I am Chair of this committee. We have Ms. Danielle Chartier sitting in for Mr. David Forbes. We've got Mr. Mark Docherty, Mr. Greg Lawrence, and Ms. Laura Ross, and Ms. Nadine Wilson.

And this afternoon we will be considering the estimates for the Ministry of Health. We now begin our consideration of vote 32, Health, subvote (HE01). Minister Duncan is here with his officials. Minister, please introduce your officials and make your opening comments.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Hon. Mr. Duncan: — Thank you very much, Mr. Chair. We appreciate the opportunity to be back before the committee to discuss the 2014-15 budget as it relates to the Ministry of Health. Minister Weekes has joined me, as well as the deputy minister of Health, Max Hendricks. We have, as you can see, a lot of officials with us again this afternoon. When the opportunity arises for perhaps them to provide some of the information directly to committee members, we'll perhaps have them introduce themselves at that point.

Considering that we've already had a couple of hours on the estimates, I don't have any . . . I won't regale the committee with 25 minutes of an opening comment. So we'll be pleased to take your questions.

The Chair: — Thank you very much. And I believe Ms. Chartier is starting the questioning. Ms Chartier, you have the floor.

Ms. Chartier: — I wanted to start . . . Actually we've had some conversations last week and in the last couple of days about the children's hospital. And I wanted to let you know, and this came up in question period yesterday, that we'd received an email from a health care worker in Kelvington Hospital who didn't want to use her name, but she said:

> Our hospital beds will be cut from 12 to seven. We as staff have voiced concerns over this, but as for the beds, they say the 80 per cent rule says this is all you need.

I'm wondering what the 80 rule is.

[14:00]

Hon. Mr. Duncan: — Thank you for the question. With respect to the Kelvington integrated facility, this was one of the . . . as a part of the 13 long-term care facility replacement projects. Between the Ministry of Health and the regional health authority, looking at the current usage within the Kelvington Hospital in the last number of years, the average daily census has been trending down to the point where on average in the '12-13 year, they averaged five patients in the hospital. And so the consensus was that the beds that would be required for that facility would be seven, and that's what was approved.

Ms. Chartier: — Thank you for that. To the question about the 80 rule, do you know what the 80 rule . . . what she was referring to there?

Hon. Mr. Duncan: — No, we're not aware of a reference to an 80 per cent rule.

Ms. Chartier: — Is it something that's used in the 3P [production preparation process] process?

Hon. Mr. Duncan: — Yes. The only thing that we can think about that there would be any reference to 80 per cent would be in some construction projects. They would look at 80 to 90 per cent of what would be the average daily census for a facility, but that wouldn't necessarily be something that would be as a result of lean or 3P work around a facility. It would really just be determining what is, based on the average use of the facility, what would be an appropriate bed count.

Ms. Chartier: — So it's not used . . . In the 3P events that you've participated in, it's not part of that at all?

Mr. Hendricks: — I'm not aware in any 3P event where that has been used. Obviously when we do capital planning, we try and look at the occupancy of the facility. And you know, as the minister has said, one of the things that we do do is we usually plan a contingency where we have enough beds. We like to keep the occupancy at around 85 per cent or so, and so that might be where that number comes from. I've never heard the 80 per cent rule or anything with lean, no.

Ms. Chartier: — Okay. I might come back to that. With respect to the children's hospital, I understand that there's an announcement next Wednesday, and I'm wondering when the final decision was made about changes to the children's hospital. So we have an announcement coming up in less than a week, so when was the final decision made around the children's hospital?

Hon. Mr. Duncan: — Thank you for the question. Just with respect to when a decision would have been made, because that is a cabinet decision and the agendas of cabinet are not . . . We won't discuss that publicly. But I will say that it would have been prior to when the committee last met to discuss the estimates.

Ms. Chartier: — Can you walk me through the timeline on the children's hospital? So you just in the last year . . . So the plans were finalized in 2012 — is that correct? — the initial plans. And then the Hay Group report . . . Instead of me trying to, how about you walk me through the timeline?

Hon. Mr. Duncan: — Thank you, Ms. Chartier. I'll maybe seek a little bit of clarification just in terms of how far back you'd want to go. But in July of 2012 is when — I believe that that was the date — when the design was publicly released. And at that point, we also did make a commitment of an

additional $15.5 million that would be added to the construction cost of the facility.

I think it's safe to say that late in the spring, early summer of 2013 is when I, and I think other members of government, started to hear some feedback from front-line staff and others — physicians and just general commentary in the public — that perhaps the design that had been approved and announced in 2012, that there was some concern about the size, particularly around maternity. And so there was some work done late last year to look at the projections that were used and to evaluate whether or not they would hold up based on the growth that we're seeing in the population of the province.

Ms. Chartier: — Thank you. That work that you referred to as late . . . So you've got some concerns that are being flagged late spring, early summer. When did the Saskatoon Health Region . . . I know the Hay Group report was theirs, but when did you become aware of the Hay Group report on the demographic and population projections?

Hon. Mr. Duncan: — So I believe the region worked with the Hay Group in the summer of 2013, which then helped to inform the discussion in the fall based both on their work as well as the ministry's work around projections.

Ms. Chartier: — When did it come to the ministry's attention?

Hon. Mr. Duncan: — Yes, it would have been in the fall of last year, at some point in the fall.

Ms. Chartier: — So again just around . . . I'm not asking for the agenda of the cabinet decision. I get that. But I'm wondering how recently cabinet made a decision then or when the final decision was made on the children's hospital. And the reason . . . And I'm just trying to clarify. So last week in estimates we had talked about how it was 90 per cent complete in the fall, but just referring to one of your comments in December where you said the plans were finalized. So there's a bit of a discrepancy there, so if you could clear up that discrepancy for me, that would be great.

Mr. Hendricks: — So what happened in the fall is after we had looked at our population projections and, you know, the region had raised . . . after considerable analysis and review of the Hay study, they informed me at that point, at 90 per cent drawings complete, I stopped the project, just based on the concerns to allow both the Saskatoon Health Region and my ministry to confer on the population estimates. In fact the minister, there was a bit of a delay there. Well we did some of that work before I relayed that to the minister so that we'd have an opportunity to see if there was any substance to this. So as of December, 90 per cent drawings would have still been where it was at.

Ms. Chartier: — I'm just wondering what the difference between 90 per cent and finalized though is? In your scrum and in December, you had said that the . . . I'm just trying to get a sense on timeline here and when a final decision about the children's hospital was made? So was it in December? Has it been in the last couple of weeks?

Hon. Mr. Duncan: — So I'll hopefully be able to clarify this a little bit further. So not knowing exactly the reference that you're referring to of what I said last fall, but certainly when we had announced in 2012, the indicative design would have been complete. But from that, that then goes to the architects to actually start doing the drawings, the blueprints. And so that's what would have been stopped at 90 per cent, but the overall design had been finalized in 2012.

With respect to the timing, the decision would have been made in the last couple of weeks, and it would have been prior to when this committee last met to consider estimates.

I think at that time in the committee, I did mention at that time that we were not ready to make that announcement. I know there are a couple of references to it. I probably should've stopped my comments at that point. But at that point we would have had a discussion at cabinet and an approval on it.

Ms. Chartier: — Okay. Thank you for that. Just moving on here for the moment. Again, I just want to talk a little about the 80 per cent, the 80 rule . . . I didn't hear 80 per cent rule; I heard 80 rule. But can you help me understand capital planning?

And, Mr. Hendricks, you had talked about when you do capital planning, you usually plan 85 to 90 per cent vacancy. I've never been involved in capital planning at all. If you could describe that process a little bit for me. Obviously we have a few projects on the go right now, and if you could let me know how that works.

[14:15]

Mr. Hendricks: — So maybe if I can start at a high level and we'll see if that addresses your issue. So the ministry has a considerable capital process with a considerable number of steps that lead through identification of a capital priority to the approval of that project to when it actually proceeds to a design phase.

In the last couple of years, we've departed from the traditional capital approach where you would have gone out and you would have hired architects and you would have developed conceptual designs and that would have resulted in a costing and an estimate to the ministry on which we would have based our funding decisions.

Now what we do, as you're aware with lean, is we do a 3P design process. And 3P stands for production preparation process . . . or process preparation, sorry. And the idea of this is that it involves providers, families, administrators, all of those people that could be — or in-patients — that could be involved in the hospital. And what's actually, I think the best part about it is that it does involve patients and families, as I told you last time, in relation to the children's hospital. At the end of the 3P process, that group comes up with seven designs.

And it's interesting because the architect sits back during this entire process and watches as they mock up the design and look at adjacencies within the room. At that point the group will select the preferred design, and the architect will take it away and develop it further into an indicative design. And then eventually, as the minister said, that indicative design will develop into a detailed design where they put in all the mechanical and electrical and that sort of thing. So that

generally describes the process under a 3P capital process.

Ms. Chartier: — You had just made reference though when I first asked about it, about you, in construction you plan 80 to 90 per cent of what the average daily census tells you, so . . .

Mr. Hendricks: — Correct. So when we look at hospital capacity in terms of flows, you have, as you know, ups and downs. And so one of the elements that we use is we look at the average daily census of the hospital. So say the average daily census of a hospital is eight, and we would then probably plan for about 10 beds. We look at the number of days that it would actually be over the bed capacity to know what kind of risk that presents. So if there's a very low number of days where it would be 10 and above, that would sort of indicate that 10 is probably the right number. But generally we plan in about that 80 per cent range.

Ms. Chartier: — Can you tell me how, with respect to the children's hospital, there were a couple fewer maternity beds at the children's hospital, how in that kind of planning process, how you end up with fewer beds?

Mr. Hendricks: — Well one of the things that with the children's hospital is they map the flow of the patient right from the time the mother arrived on the unit till the time that she and baby were discharged to a ward. And so what they actually looked at is they look at the flow. They sped up the registration process. There's a time . . . they used a unique concept where there were delivery rooms, right, and then it actually reduced the total amount of time in certain areas of the hospital, so it was improving flow. So they felt they had the balance right, based on the current population projections.

What did change was that, between the period when the hospital design was started and last year, was that obviously we've seen tremendous growth in Saskatoon and its drawing area and also the demographics of that growth. We saw a younger population of child-bearing ages. And so, you know, I'm glad that we did actually have the opportunity to review the population information and, you know, we made amendments based on that. Because I think the worst situation we could end up with is building a hospital that couldn't manage the caseloads. So we do . . . It is very sensitive to what we expect to see in terms of the population in several factors.

Ms. Chartier: — Thank you for that. Just thinking about that, I've been at RUH [Royal University Hospital]. One of my daughters was born there. So you've got the antepartum . . . In terms of needing fewer beds and the flow, I still don't quite get it. Even if you smooth that process all out, you've got a growing population in 2009, not accounting for what's happened between then and now. Can you describe a little bit more how that came about? I'm not quite sure I get that.

Mr. Hendricks: — Okay, the biggest change with the redesign of the children's hospital following the 3P was that most labour and delivery is actually taking place in the mother's room. So no longer do we have separate labour and delivery rooms unless it's a caesarean section or something that requires a completely sterile environment. All vaginal births would be — or non-high-risk vaginal births — would be conducted in the mother's room.

So what we're doing is, previously we had 19 labour and delivery beds. That actually, labour and delivery has been reclassified to include the rooms where the mother is actually staying. So that number goes up. But you would have fewer of those delivery rooms, just straight delivery rooms where they would take the mother from her ward room, move her to a delivery room, and then back to the ward room because they're combined now.

Ms. Chartier: — Sorry, you said fewer so just help me understand here. So I understand the whole concept of labour and delivery: the antepartum, the delivery, and the postpartum. I get that. Like, I understand and would agree that continuity, staying in one room is a good thing. But do you still have labour and delivery rooms then?

Mr. Hendricks: — So in the new design, and this is before any adjustments, there were 38 labour and delivery beds, traditional postpartum beds. There were 34 in the original hospital. There are none in the new hospital because of the new design. And then there are eight antepartum beds and eight assessment beds.

Ms. Chartier: — Okay.

Mr. Hendricks: — And I should point out there were only 19 labour and delivery in the current hospital design, and that's going to 38.

Ms. Chartier: — Okay. Sorry, 19 in the . . . When you say current hospital design, what are we referring to?

Mr. Hendricks: — I'm sorry. Through the pre-3P design, sorry. On the traditional design, we would have said there would have been 19 beds.

Ms. Chartier: — Okay, so just forgive me here. Was there a design prior to the 3P? Are we working on . . .

Mr. Hendricks: — Yes, that was what being planned initially. Because there was an initial plan, and then we took it through a 3P process to look at how we could deliver the services more efficiently and improve flow.

Ms. Chartier: — So there's an initial plan that was done, and then there were 3P events, and it was finalized in 2012. And then we get numbers last year, and then there will be changes to that that will be announced next week when we're not in session. Is that correct?

Hon. Mr. Duncan: — Yes, that's correct.

Ms. Chartier: — Okay. How much was the initial plan, how far . . . Prior to the 3P event, how far developed was the initial plan? It sounds fairly well developed.

Hon. Mr. Duncan: — So that the pre-3P work, that was just a schematic design. That wasn't a detailed design at all.

Ms. Chartier: — Okay, I need to ponder these numbers here for a bit. But just going back to the start of the conversation, Mr. Minister, you'd asked . . . I had mentioned that in December, you had said that, you used the words final approval. So I just want to tell you where that's from, in *The StarPhoenix*

on December 4th, 2013, from a story titled "Children's hospital will have fewer maternity beds."

> The design that has been given final approval, that the region is working off of, in terms of the total number of maternity beds compared to the existing RUH maternity ward, it's really a slight change.

So the design that had been given final approval, had that already been given cabinet approval then, like when you had said that in December?

Hon. Mr. Duncan: — Yes. So that would have been given approval when the, I guess it would have been the 2012, July 2012 announcement of the design of the hospital. That would have been included in that.

Ms. Chartier: — Okay. And in the meantime though you knew that there were possible changes coming when you had made the comment in December.

Hon. Mr. Duncan: — No. I wouldn't say that in December I would have been . . . At that point it would have been too early to say if additional beds would have been added.

Ms. Chartier: — Okay. Okay. Thank you for that. I may come back to that. One thing that I've asked some written questions about, I'd like to talk a little bit more about mental health again, carrying that conversation on from last week. And I had asked some written questions, and perhaps they weren't incredibly well worded at the time, but I asked about how many clients of the community living service division who are waiting for a group home placement are residing in mental health in-patient facilities.

So I have some numbers. Obviously the highest number was in Saskatoon and then, I believe, in North Battleford as well. But I'm wondering a couple things here. What those up-to-date numbers are, if you have them. And the question that I'm asking is if maybe my question didn't capture all those people. After our conversation last night when we talked about mental health centre, and you think about the beds, the three or four beds that might be set aside, did that question capture those individuals?

Hon. Mr. Duncan: — So with respect to the first part of the question, so those numbers that you did receive through the written questions, those would be the most up-to-date numbers that we would have because we don't keep those as a ministry. So when we provided those answers, we went to the regional health authorities to provide those. So if you were to ask for updated numbers, we'd again have to go back to the regional health authorities for them to update those numbers. And your second part of your question, sorry . . .

Ms. Chartier: — Well just, I'm wondering if my question captured all those smaller, what would now be referred to as mental health centres, smaller numbers of beds. Like not just a place like the Dubé Centre, but the three or four beds that might be in another facility somewhere else set aside for mental health.

[14:30]

Hon. Mr. Duncan: — So the numbers that you've been provided with through the written questions, and again we'll . . . If you wanted updated numbers we'd have to go back to the regional health authorities. But those would capture, if I'm getting your question correctly, the answers in the written questions would capture all of those that you're looking for.

Ms. Chartier: — Okay. Yes. And sometimes you're not sure if you're asking exactly the right question, so I just wanted to clarify that that would indeed . . . And especially after our discussion last night about the mental health centre and what it means, I wanted to make sure that . . . I actually would like an update on those numbers. Should I be asking written questions or are you able to go back to the ministry?

Hon. Mr. Duncan: — We'll go back to the regional health authorities and get those updated numbers for you.

Ms. Chartier: — And adding to that, I asked the particular question about the longest client stay. But adding to that, I'm interested in the length, not just the longest client stay but how long for the five individuals, for example, who were at the centre in Saskatoon, how long each of them had been. So not just the longest stay, but how long each individual had been there would be very helpful. Thank you.

Hon. Mr. Duncan: — Okay.

Ms. Chartier: — Still on the discussion of both the mental health and the new emergency room, and the fact that there is a commission or some consultations going on right now, one of the things I understand that was part of a presentation in the Saskatoon Health Region on flow, emergency room flow, part of it that was presented in the fall was on the third door option. Well right now all families have basically especially . . . Your options are cops and courts or an emergency room, trying to get your loved one to an emergency room.

So I'm wondering, I'm thinking about the development of this children's hospital and this co-located emergency room and some of the stuff that came out of this presentation that looked at that third door option, both in Toronto and out of Sydney and out of Texas, where you do have a special or a separate place not just for people with mental health challenges to come to but also as an emergency room, but a few beds — short-term, one- or two-day beds — to help stabilize people and assesses them, stabilize them, and get them home with supports. So I have some concerns that that hasn't been factored in, into this current design.

Mr. Hendricks: — So I believe, I think I understand what you're talking about when you refer to third door. So our view and approach to design of the new emergency room in Saskatoon, we haven't viewed these issues as actually a design issue, so much as the way that we treat mentally ill people when they do come to the hospital. So it's part of our ER [emergency room] flow and our long-term goal to reduce ER wait times to zero.

And one of the things that we looked at in Saskatoon was direct rooming, so the notion that patients wouldn't be in a waiting room. They would go directly to a room where they would start receiving care. With patients that have chronic issues with

mental health, they have explored options to take them to separate assessment areas, not even necessarily the ER, where they could receive care that is more specific to their needs, or directly in some cases to the mental health unit of the hospital.

So in our view it's not so much again about building a third door or having a separate area for them. It is about how we actually bring those patients in and provide immediate care in an environment that isn't disruptive to those patients. And so these are part of the reasons that we have these discussions with patient groups when we do design these hospitals, is to get that input.

So our view, longer term and for all ERs in Saskatchewan, is to try and reduce or eliminate that time that they would spend in a common waiting area.

Ms. Chartier: — Obviously with the children's hospital, I think you said last week that it was 2017, so that's a ways down the road. But in terms of making those changes, when can people expect to see in facilities across Saskatchewan that approach around mental health?

Mr. Hendricks: — So we have our . . . Saskatoon is our ER no wait times lead out. They're doing what we call the model line in it. So what we do is we look at Saskatoon. We make improvements there, and then we replicate it.

One common misunderstanding about 3P work is that even in designing a new facility, that sort of thing, there is an assumption that we wait till the new facility is up before we start working that way. In fact if I use the case of Moose Jaw, they're already working diligently to try and map the flows and work the flows that will be required in the new hospital. So well ahead of the hospital actually being finished, you're seeing the care improvements happening. And that's one of the nice things about 3P, and actually I would say improving them over that period between the time the 3P is completed till the hospital is ready for occupation.

Hon. Mr. Duncan: — If I could just add on that, that would be the same case for the children's hospital. So the intention is whether it be maternity or other types of services that are going to be provided in the new children's hospital, that the staff would start to work to adjust for the new facility while they're still in the existing facility so that we're not moving into a new facility and then immediately expecting staff and patients to function in a different way than they normally had been used to. And so part of that is the lead out into a new facility.

Mr. Hendricks: — Just adding one other point, sorry. The other element of providing good mental health care to those patients is that we're trying to avoid having as many of them come to an emergency or to an acute care facility in an acute stage. And so we recognize as a province that there's a lot more that we can be doing. There are primary health care sites to provide that mental health support and, quite frankly, it is a lot of the work that our family physicians do now. But we can get a lot better at supporting people with mental health issues in the community to help them better manage their illness so that we can try and avoid as many acute interventions as possible.

Ms. Chartier: — I'm wondering . . . And that obviously is the best way to go, for sure, and so that'll . . . I've got some questions about hot spotting for that reason. Are they working that way in Saskatoon now or how have things changed in . . . I can tell you they hadn't changed a year ago, but how would they be functioning now?

Mr. Hendricks: — I would have to follow up on that question with the region as whether they've started implementing some of the protocols that they're developing in the context of the 3P, just given the stage of the project. And we can check. I know they've been doing a lot on the children's hospital side in terms of following those flows and actually working those flows, but I'm not sure about the emergency room.

Hon. Mr. Duncan: — As Mr. Hendricks has indicated, he'll follow up with the region on that specifically. But we are doing a number of initiatives, and I know you've mentioned hot spotting and I think we'll talk about that a little bit later.

But certainly through what will be this year's portion of the emergency department patient flow initiative, one of the things that we'll be providing support to is a partnership between Saskatoon police, Saskatoon Crisis Intervention Service, and the region's mental health and addictions to implement a police and crisis team model in Saskatoon. So this would be teaming up two teams — a police officer with a mental health professional — that'll be available for the peak 12-hour period when we'd certainly see clients accessing services either through the emergency department or in some cases through the police services.

We know that mental health visits in Saskatoon constitute about 5 per cent of our emergency department activity. And this is one of the ways that we're going to be we think addressing the specific needs of these clients in a better way, as well just even initiatives like the Lighthouse where we are funding some additional spots in that facility specifically for intoxicated people that don't necessarily need the emergency room, don't necessarily need the police services. They're not a harm to themselves or to others. So this is also an opportunity that we've taken to partner with a community organization.

Ms. Chartier: — So the pilot is in Saskatoon then with Saskatoon police, crisis intervention unit, and mental health and addiction services. Is that correct?

Hon. Mr. Duncan: — Yes, that's correct. So it would be Saskatoon Police Services, the Saskatoon Crisis Intervention Service, as well as mental health and addictions. And the intent is that we will roll this out first of all in Saskatoon, and if it does prove as a useful concept, then we would look at perhaps Prince Albert and Regina.

Ms. Chartier: — What is the cost of that?

Hon. Mr. Duncan: — That's a part of the $2 million that is dedicated to the emergency department and patient flow initiative. So that portion of that is $250,000.

Ms. Chartier: — And what will those services include? So I know, again looking at some of the literature on the third door option, what they've done in Sydney and what they're doing in Toronto, in Toronto they have a mobile unit that comes out I

believe to someone's home to help assess, stabilize, and support in home. I believe that that's the way it works, but how will this pilot work?

[14:45]

The Chair: — Before you start, please introduce yourself for the Hansard.

Mr. Wyatt: — Hi, I'm Mark Wyatt. I'm acting assistant deputy minister. The concept is that rather than having police respond and oftentimes either bring an individual into either custody or deliver them to the emergency department, that the response is provided by a combination of a social worker along with a member of police to respond to complaints that would typically come in through emergency services, either police or ambulance. And a lot of times those cases don't necessarily require a medical intervention. They don't necessarily require a police intervention but a lot of I guess the combined assessment of both social work and police to determine how to resolve a situation.

Obviously where it's necessary that you need either medical attention and some emergency medical care, that would clearly result in an emergency admission. But I think based on some initial testing of this concept that was done in Saskatoon and I think has been done in other jurisdictions, there was a clear indication that many of these cases don't either require somebody being taken to cells or an emergency department but really require some referral to community services or some immediate counselling or intervention that doesn't lead itself to an emergency room admission.

Ms. Chartier: — Thank you for that, and I actually have to apologize. I think the Toronto model . . . Your model sounds very similar to the Toronto model. I think the model that I was referring to was a wish list of someone saying that they wished that there was a crisis team that would come to your home, assess, stabilize, and possibly medicate if necessary — those kinds of things. But the Toronto model, I think at St. Michael's, the mobile crisis intervention team sounds very familiar to what you're doing here. What is the anticipated . . . With the $250,000, how many people do you expect to work with?

Mr. Wyatt: — I'm not sure I can fully answer the question. What the $250,000 budget that we're providing does cover is the budget for three FTEs [full-time equivalent]. What I don't have the answer for you today is to also understand . . . from the police service or whether there are any other resources that are covered by the health region. So our funding will cover the cost of three FTEs.

Ms. Chartier: — As in social workers? Is that the thought?

Mr. Wyatt: — I would expect so.

Ms. Chartier: — Okay. And when do you anticipate that the pilot will be up and running?

Mr. Wyatt: — We were waiting for budget approval to go through, and I know that there have been some follow-up discussions. Because this had been tested previously in the region on a smaller scale, there was a sense that it could be started up fairly quickly. And I just don't know whether that would be before the summer months or whether it might take until fall.

Hon. Mr. Duncan: — If I could just add, I think it would be fair to say that there's a lot of crossover between some of the things that we are trying to do both as the Ministry of Health and working with organizations like the Saskatoon Police Service as well as what we're doing together with ministries of Corrections and Policing and Social Services on the hot-spotting concept. I think it's fair to say that, you know, there may be a lot of overlap in terms of the programs or perhaps even the types of services that they provide.

As the assistant deputy minister has indicated, this is to fund full-time equivalent positions. I think we will, as we get further along with both this concept as well as the hot-spotting, I think the hot-spotting one will be one where it will be more defined in terms of the number of clients and who those clients actually look like. This would be more of working in the community, and we'd probably get a good idea from the police of, you know, who some of the individuals that we'd be working with through this type of program. But the hot-spotting would be more defined in terms of an actual list of clientele that would accept services that we would be providing services around.

Ms. Chartier: — Okay. Thank you. Just out of curiosity, do you know in terms of the model, will the police receive any special training? Not necessarily sensitivity training, that's not the right word, but training? Obviously police officers deal every day with individuals who have mental health challenges, but sometimes that is a bit more difficult. So do you know, in this particular pilot are the police officers who will be involved in this specific or designated police officers who would be receiving special training?

Mr. Wyatt: — I don't know the answer in terms of what training would be provided, but I think the idea is that it would be, that it would be dedicated teams responding. And so I think the expectation is that they would be working with a different model than the traditional police model, but I can't speak to what training comes with that.

Ms. Chartier: — Okay. Thank you for that. Sorry to jump all over the place here again. I'm looking at my list here, and I'm going to go back to 3Ps. My apologies about that.

In terms of the costs of the 3Ps, can you tell me with respect to the children's hospital the number of 3Ps? I think you said three, three 3Ps. But what would the cost of the 3Ps be both in terms of . . . Obviously there are many costs because there is equipment or materials used. I understand there's mock-ups that are done. If I could get the cost of the 3Ps, that would be great.

Hon. Mr. Duncan: — [Inaudible] . . . perhaps at this moment, Ms. Chartier, because there were three for the children's hospital . . . sorry, two for the children's hospital. I think I misspoke last time. There was two for the children's hospital. We're just trying to track that information down. They would have been prior to 2012, so we don't have that offhand right now.

Ms. Chartier: — Okay.

Mr. Hendricks: — We would have to confirm that with the region because one of the things with Saskatoon is, because their project was already approved and funding was provided to the region ahead of time, they've been using that as their design funding. So we would have to confirm the exact figure with them.

Ms. Chartier: — That would be great. So there were two 3Ps, and if you could confirm what the cost of those 3Ps were, that would be great. How about for North Battleford and Moose Jaw, the numbers of 3Ps and the cost of the 3Ps?

Hon. Mr. Duncan: — So with respect to the Saskatchewan Hospital at North Battleford, there were three 3Ps, and the cost for the three was 895,000.

Ms. Chartier: — Total.

Hon. Mr. Duncan: — Total.

Ms. Chartier: — Okay. And what does that 895,000 include?

Hon. Mr. Duncan: — So that included supplies, the project management, the architect that was hired, as well as the work that JBA [John Black and Associates] provided.

Ms. Chartier: — And who provides the project management?

[15:00]

Hon. Mr. Duncan: — In this case it was ZW consulting.

Ms. Chartier: — ZW consulting. Are they a local firm?

Hon. Mr. Duncan: — They're based in Ontario.

Ms. Chartier: — Okay. And how many people participate in these 3Ps?

Hon. Mr. Duncan: — So each of the 3Ps would have been somewhere between 85 and 100 people at each one of them. I attended the third one and, just going by memory, there was probably, it would have been somewhere between 85 and 100 that would have been there. And that would be a combination of a couple of board members, senior officials from the health region, patient family reps, front-line staff.

The third one that I attended was largely around the, I think I said this before at the last committee, but it was largely around the supply, the services around the facility. So it was the laundry staff, it was the maintenance staff, those types of employees. That would have been a big part of it.

Ms. Chartier: — Okay. Just on a tangent there, I was thinking about that last night as I was reviewing the laundry staff. Will staff at the Saskatchewan Hospital . . . Are you not contracting that piece out or will there also be laundry staff there?

Hon. Mr. Duncan: — So the laundry that's currently provided and that will be provided in the hospital, so this would have involved the employees that are responsible for collecting the soiled laundry, and then the housekeeping, the general type of housekeeping that takes place in the facility, as well as receiving the clean laundry. They don't do laundry at the facility.

Ms. Chartier: — Okay. So preparing it to be shipped out and received.

Hon. Mr. Duncan: — Yes, that's correct.

Ms. Chartier: — Okay. With respect to Moose Jaw, the Moose Jaw Hospital, how many 3Ps were there and what were the costs?

Hon. Mr. Duncan: — At Moose Jaw, for the Moose Jaw project there were three 3Ps as well. We'll have to get back to you with the total number. We don't have that with us today.

Ms. Chartier: — Okay, thank you. Just with respect to some concerns that's been raised with me about the site, the RUH site, and I'm wondering if you've heard this as well. Have there been any concerns raised around the Royal University Hospital site?

I know that we have the parking garage there that is not stable and it's been closed. And I've been told by someone who works in construction that the substrate isn't stable and they couldn't even put a zoom boom on the decking because of the instability. So those are all new terms for me, but I've been told that it's incredibly unstable, but the hospital is just a short ways, like 75 yards away from that. Have there been concerns raised about the site on which the children's hospital will be built?

Mr. Hendricks: — With respect to the RUH site, we . . . The Saskatoon Health Region have had issues with the 1984 parkade. So in about mid-2013, the ministry provided $3.8 million to the region to address the parkade issues at children's . . . or sorry, well it's adjacent to the children's hospital site at RUH.

And based on some initial work and some initial analysis that's been done, the original thought was that that would have been adequate to repair the parkade. But now we're finding that this is maybe not the amount that will be required. So that study is still ongoing. Regardless of the children's hospital and its location, this work would have had to have been undertaken with respect to RUH as well. It's an older facility, or an older parkade and has had some challenges.

Ms. Chartier: — There's no concern in the close proximity that you've got problems in a certain area, there's no concern then that it's, as you said, it's adjacent to the children's hospital site. There's no concern with the building?

Mr. Hendricks: — No. The intent is to fix the parkade, to renovate it and renew it.

Ms. Chartier: — Okay, so the intent is to fix the parkade. But I'm wondering if there's any . . . Had there been any concerns flagged around the possibility that, as I've said, this individual told me that, again the substrate is not stable. And I don't know much about substrate — nothing at all actually — so I'm wondering if that has been raised as an issue.

Mr. Hendricks: — I would have to trust . . . And I presume

that the engineers who are constructing and doing the early works for the children's hospital — as you know, that site is already under construction — have accounted for an adequate substrate foundation for the building. So I think that these repairs would be independent of those and wouldn't affect the children's hospital.

Ms. Chartier: — Okay, thank you for that. On a totally different topic here, with respect to tanning beds, I'm wondering . . . I know, and I don't have the media article in front of me right now, but I do know that we are outliers here in Saskatchewan when it comes to Canadian indoor tanning legislation. We've got Alberta and Saskatchewan as outliers and Manitoba as well; Alberta and Saskatchewan with none and then Manitoba that allows for parental consent. And everybody else has banned youth tanning.

And the literature that I've read, and that I know you've seen, I think, supports that. So I'm wondering what your rationale has been for not implementing a youth tanning ban.

Hon. Mr. Duncan: — Thank you for your question. So certainly this is something that has come to my attention and to the ministry's over the last number of months and over the last year certainly since I became the minister. And we continue to look at what other jurisdictions are doing in terms of restricting the access to tanning beds for youth but all ages in fact.

I know that while in Canada most provinces have moved towards restricting tanning to youth — and you're right, Manitoba continues to have in place parental consent that would allow youth to use a tanning bed — there are examples though of other jurisdictions around the world that are actually banning tanning beds for everyone. I think Australia has already announced that or announced that they're intending to go down that road as well as I believe Brazil has made some moves to restrict tanning for all ages.

You know, it's something that we, that I continue to think about and evaluate. Any time that government makes a determination to restrict an activity . . . The choice of somebody to partake in an activity is something that, you know, I don't take lightly, and the ability of the state to outlaw that.

We do continue to fund Sun Smart, the Sun Smart coalition. We've provided nearly $100,000 over the last two years for them to continue to raise awareness of the health risks associated with tanning. But at this point we don't have plans to make a change in policy.

Ms. Chartier: — And I'm wondering sort of the policy rationale for that. And you've said you're continuing to look at other jurisdictions. So we have here melanoma, which is the deadliest form of skin cancer, on the rise in Canada. In 2009 there were 165 new cases of melanoma in Saskatchewan and more than 2,950 cases of non-melanoma. And so it's the most common skin cancer in Saskatchewan. We've got youth who are particularly vulnerable. The costs of treating skin cancer are rising. We have every other jurisdiction except for Alberta making some restrictions. So I'm wondering what is keeping you from moving on this and what continuing to look at other jurisdictions looks like.

[15:15]

Hon. Mr. Duncan: — Again thank you for the question. I think this is something that, with respect to other provinces and the work that other provinces have taken on the regulatory front, I think just, you know, if I as minister were to indicate that we were going to be moving in this type of direction . . . One of the things that is of interest is Manitoba, which I think tries to strike the balance between parents being able to make decisions for their children with also trying to restrict an activity.

I think that for me, first and foremost, education and awareness needs to be the first approach that government takes in this type of area. I think that from other types of prohibitions, you know, it's clear to me that it may sound like an easy response or an easy answer, but I think that it does show that that doesn't necessarily remove what is seen as a problem. And so, you know, I would want to ensure that we still continue down the road of education and awareness.

You know, I want to ensure that people, especially young people know that there are risks to any type of overexposure, whether it be UVA [ultraviolet radiation of relatively long wavelengths] or UVB [ultraviolet radiation of relatively short wavelengths] rays not just associated with tanning but just associated with spending too much time in the sun. And so I wouldn't want to necessarily send a signal that prohibition of this type of nature would simply remove any of the problems that I think you have rightly raised.

Ms. Chartier: — Do you think that children should be able to smoke with parental support or permission?

Hon. Mr. Duncan: — No, I don't.

Ms. Chartier: — It is the same thing, something that has been proven to cause cancer. In all seriousness, do you think it's all right to give parental approval for smoking cigarettes?

Hon. Mr. Duncan: — No, I don't.

Ms. Chartier: — And the reality is the organizations that you've funded, Sun Smart, has argued that public education is not working. Twenty-seven per cent of young women are using tanning equipment despite health education on the dangers of indoor tanning.

You said it was $100,000. Do you think that $100,000 is doing the work that it needs to do?

Hon. Mr. Duncan: — I think the Sun Smart coalition have done a good job of raising awareness as well as raising attention to me and to the public with respect to their views on these types of issues. But again I wouldn't want to necessarily move in this type of direction without knowing, you know, what that exactly means. I think that the government, the state has, you know, an incredible ability to regulate and to restrict the activities of people to make their own decisions, and it's something that I don't take lightly.

Ms. Chartier: — What is the recommendation of people who work in this area in your ministry? What is the recommendation of the ministry, of public staff, not political staff but people

within your ministry who are working on this? What is the recommendation?

Hon. Mr. Duncan: — The Ministry of Health continues to promote public awareness and education of the risks of indoor tanning bed use and supports Sun Smart coalition's efforts in this regard. We continue to review approaches of other jurisdictions with respect to indoor tanning. We believe that with collective action, the goal is to protect the health of people and to make it easier to make healthy lifestyle choices. And we continue to support Sun Smart coalition financially.

Ms. Chartier: — In terms of the specific . . . I know that you support education and public awareness, but I'm wondering what your ministry staff, what the recommendation is specifically around a youth tanning ban.

Hon. Mr. Duncan: — I would just say to Ms. Chartier, in answer to your question, and members of the committee, you know, certainly there have been times in the two years that I've been the minister where I have asked for information with respect to what other provinces, other jurisdictions are doing, whether it be on this issue or other issues related to public health policy. But at this time, there isn't . . . I'm not at this time looking at a change in policy than what has already been stated.

Ms. Chartier: — Have you received a recommendation to support a youth tanning ban from the medical and health professionals in your ministry?

Hon. Mr. Duncan: — Thank you for the question. So there have been, I think it's fair to say, information that's been provided, briefings that have been provided to me that do lay out what other jurisdictions are doing, that lay out the approach that the government has taken in the past in terms of the support of the Sun Smart coalition and other types of support that has been provided. I know that, yes, I think it's fair to say that the Saskatchewan Medical Association has passed a resolution with respect to this, but in terms of recommendations that I've received from the ministry, I think that that's not something I'm going to get into.

Ms. Chartier: — Having seen briefing notes before, and at the little line that says recommendations, I'm wondering again, I'm going to ask again, have the medical and health professionals in your ministry encouraged you or recommended supporting a youth tanning ban?

Hon. Mr. Duncan: — Again, Ms. Chartier, just with respect to the question, whether it be the Sun Smart organization or other organizations, Cancer Society, certainly there's a lot of information and input that is received. I think at this point though in terms of recommendations on this or any other topic that I receive from the ministry, I think that that's advice for me to consider as minister. And you know, I think I would just leave it at that.

Ms. Chartier: — I'm wondering what, as you continue to look at other jurisdictions, what evidence you're waiting for to be able to make this decision.

Hon. Mr. Duncan: — Well I think there would be a number of things that, before any decision would be made, would be first of all to look at the provinces that have implemented these such bans, whether or not it has actually translated into a reduced incidence of melanoma or any other type of skin cancer that you referenced; I think because a lot of these bans are still fairly early in their development and implementation, what those jurisdictions do to regulate and ensure that the bans are being adhered to by businesses and by consumers; I think as well the lengths that these bans are going to go to.

While in Canada, the experience so far for those jurisdictions that have implemented a youth ban are limited to youth, it hasn't taken long for other jurisdictions across the world to see that translate into not just youth bans, but in fact bans for entire populations regardless of age group. So I don't think any other province is at that point where they are contemplating limiting the availability for any person in their province, regardless of age, to not access the services of a tanning bed. But certainly that's not the case outside of Canada. And you know, my worry is that we creep along towards that eventuality.

Ms. Chartier: — Your worry is that by implementing a youth tanning ban here in Saskatchewan that that will lead you to implementing a complete tanning ban. Aren't you the one who makes the decisions for that though?

[15:30]

Hon. Mr. Duncan: — Well, I mean just in general, in terms of debate within society, that these types of bans eventually lead to an outright ban, as we're starting to see in other countries.

Ms. Chartier: — But if it's harmful, particularly when you've got exposure for young people and early exposure causes cancer, is that not something that should be addressed?

Hon. Mr. Duncan: — Again, thank you for the question. I guess I'm not sure how much more I can provide on this but to say that as a government and certainly as minister, I believe first and foremost that education and awareness need to be at the forefront of this type of public health message that we deliver.

Again, we continue to monitor what other jurisdictions are doing, seeing how they police it, how effective it is at actually bringing about the change that organizations believe that this type of policy can put in place. And we'll continue to do that. But at this point, there has been no decision to enact this type of ban.

Ms. Chartier: — I think it's important to put on the record here that indoor tanning is problematic and youth are particularly vulnerable. In 2012 a review of evidence published in the *British Medical Journal* found that using tanning beds before the age of 35 increases a person's risk of developing melanoma skin cancer by 59 per cent. So usually I often appreciate the minister's answers and have a great deal of respect for you, but I think that none of those answers were particularly satisfactory on this topic.

Hon. Mr. Duncan: — Sorry, Ms. Chartier. Could you just, could you . . . I don't have that in front of me, the data that you referred to.

Ms. Chartier: — The *British Medical Journal* found that using tanning beds before the age of 35 increases a person's risk of developing melanoma skin cancer by 59 per cent. And this was information provided by the Canadian Cancer Society just a short while ago to all of us. So I will . . .

Hon. Mr. Duncan: — I just want to be clear, the position that you're bringing forward is a tanning ban on youth under 18 or under 35?

Ms. Chartier: — Under 18. But I'm drawing attention to a piece of literature that points out that young people are particularly vulnerable or exposure to tanning can be difficult. So moving on here. Just one moment please.

With respect to, in terms of looking at the funding of health regions, with the $51.9 million efficiency money this year, and there was the similar money clawed back last year, I'm wondering if the minister is aware how hirings in health regions, particularly in the Saskatoon Health Region, currently take place. The position optimization oversight committee, are you familiar with that?

Hon. Mr. Duncan: — So with respect to the original health authority budgets, we have, as we have in the past, asked regional health authorities and the Cancer Agency to find efficiencies within their budget based on their previous year budget and a percentage that we ask them to find.

A part of what they are trying to do is look at a couple of areas, particularly around their workforce. One is attendance management. So this would include looking at lowering their premium costs, whether that be sick time or overtime. These are I think interrelated, as unplanned sick time often will result in a shift being filled at an overtime premium. So better sick time management along with improvements in staff scheduling is some of the areas that the regional health authorities are looking at.

The other is workforce optimization. And that's something I think that you're referring to in Saskatoon. This is really looking at the demands, whether it be a particular ward or a particular facility, but really doing, I think, a deep understanding of what the service level that is being . . . the demand on the service level. So it's looking at whether or not shifts need to be filled. The example I think would be if a ward has 30 beds in it, do we need to staff it for the 30 beds for that day if there are only 15 patients? So do we staff it for the demand that is on that ward? And so those are two of the areas that they're looking at.

Ms. Chartier: — I think, and the minister may or may not be aware of this, but some of the concerns that I've had flagged for me is that, first of all, you start out with a deficit. So you've got units or departments in the Saskatoon Health Region having to make up efficiency. So in essence you're penalizing already good managers who have found lots of efficiencies. And not to say that you can't always improve, but what ends up happening with this position optimization oversight committee, a manager can't post a position without going to the broader group.

So I don't know if this is every day or not, I was told that every day every vacancy you have, there's a group meeting, and the group approves or rejects the ability to post a position. So it's not just about managing overtime and sick time, that attendance management, but it's about managing positions and actually filling positions. So it's forced vacancy management when the question comes up, when you've got a broader group who isn't involved in that area saying, well do we really need to fill that position?

So the concern that I've heard reflected back is what it boils down to is that you don't trust your colleagues at your management table that they know how to staff. And what happens if you're a good manager and already have met the efficiency targets? These concerns have been reflected to me from folks in the Saskatoon Health Region, and I'm wondering if you've got any thoughts about that?

Mr. Hendricks: — I think what . . . You know, the minister described it very accurately when he said what some of Saskatoon is doing is they're challenging a little bit their straight-time payroll. And as you know, in the Saskatoon Health Region, which is a $1 billion or more operation, that your payroll is going to be about $800 million of that. So it's a significant chunk of their expenditures.

And I wouldn't say that it's not trusting their front-line managers. I think that they've been involved in some healthy discussions in Saskatoon about things like the minister mentioned, is that when you have a 30-bed unit that's operating with 15 patients currently on it, do you need to call back everybody and staff it for 30 beds?

With respect to vacancies, I think it's good management practice actually to look from time to time as to whether a unit is continuously functioning below ADC [average daily census] or below its ADC, or capacity, sorry. And if it is, then you should review the staffing levels for that unit and not continue to staff it in a manner . . .

So yes, they are vacancy managing. Actually I do have to commend them in the diligence, that that's required at all levels of management and working with our teams. And I wouldn't say that this is a big top-down thing, that they're actually working with their managers to try and address this issue.

Ms. Chartier: — That's not the sentiment that's been expressed to me. The sentiment that's been expressed to me is that you meet your efficiency targets, you've been meeting your efficiency targets, and more are foisted upon you even though you have been managing well. Every single vacancy that gets posted goes to this committee, from my understanding, and so you're at the mercy of your colleagues — who may or may not understand the particular needs in your department, which you understand intimately.

So the sentiment that has been expressed to me is exactly what I've put on the record, that managers feel frustrated and feel like you can only reach so many efficiencies before you start impacting service. And anecdotally I think we've heard in the legislature here stories around hospital cleanliness. We've heard stories around pain medication management — story after story. Some have come here; some of them haven't. I can tell you I've spoken to people who aren't comfortable having their name come forward, but that anecdotally, services are being

impacted.

Mr. Hendricks: — So in response to those questions, a couple of points. You know, over the last couple of months there have been several issues raised with respect to vacancy management and whether that has had any impact on patient care. And you know, we've heard about examples that people have said exist through complaints, that sort of thing, and we've asked for those specific examples so that we can investigate them.

You know, what I've suggested to at least one of our unions is that, if they are concerned about the model of care in a specific area, that we do a deep dive on it. We look at whether we have the right number of providers, right place, right time to provide the best patient care possible, to provide safe care because that is the overarching goal of the Ministry of Health and of our health regions. And to date we've not had any, I'll call it substantiated evidence that a model care change or a vacancy management decision has resulted in compromised patient care.

I don't want . . . You know, at the end of the day, patient safety trumps budget every time, and so I wouldn't want care decisions that affect the safety of patients to be made purely on budget. And so we've offered the complainants in this case the ability to actually look very closely and scrutinize this, and if there needs to be a process in place for determining that, be it through lean work or just daily management of a unit . . . sorry, within the hospital, we're prepared to look at that.

[15:45]

Ms. Chartier: — I'm not talking about stuff that's been on social media or . . . I'm talking about one-on-one conversations that I have had with health care workers in the Saskatoon Health Region, so conversations . . . I can't table conversations people are concerned about for whatever reason. And you may think it's justified or not, but people are concerned about publicly bringing their issues forward. I can tell you, I have heard these complaints. And that takes me to a particular issue when we talk about patient safety actually. This is a bit of an airing of the grievances here.

At St. Paul's Hospital, I know that the operating room staff has had some huge concerns around the surgical initiative. I've spoken to LPNs [licensed practical nurse] and RNs [registered nurse] around their concerns about this push for the surgical initiative. I understand that the OR [operation room] nurses brought it to their management and raised these staffing concerns, and they were told . . . And I will show this to you afterwards, but this is from their communication log that "It was clear my conversation with . . ." This is from management communicating to staff on the OR: "It was clear in my conversations with Jenny that closing of the OR theatres or counselling cases is not an option."

The nurses, not just the nurses but staff in ORs are running short. I've heard of one occasion where there was one OR nurse available which, looking at the OR nurse recommendations, that isn't what is supposed to happen. At one point at St. Paul's Hospital, I understand there used to be three OR nurses at a given time and they never function that way. The OR staff, not just at St. Paul's but in the other locations in the Saskatoon Health Region, are frustrated, but this particular issue came from St. Paul's. So there's pressure and understaffing in our operating rooms, and the push for the surgical initiative means that surgeries are not being cancelled. Come heck or high water, those surgeries are going forward.

And I've had OR staff tell me that they are working . . . they fear that they're breaking sterile protocol, that they're rushed and not . . . They have said to me that they, every time they walk into the OR, they hope for the positive outcome on the other end because they are feeling so pressed. I'm wondering if any of that has come to your attention.

Hon. Mr. Duncan: — Thank you for the question. Certainly this is something that, with respect to the surgical initiative, issues that have been identified and brought to my attention and the ministry attention around these types of issues would be related to the situation that happened in Regina in the last year and a half, two years, where there was a lack of operating room nurses which really, I think, has put Regina in a position where they didn't reach their target by March of 2014.

Certainly in that situation there was no push to ensure that surgeries were done at a level, a staffing level that wouldn't be considered a safe level. The surgical initiative is guided by the principles that . . . sooner, safer, and smarter. And so safer is obviously a big part of that. So in a case like that, the experience that we had in Regina certainly didn't indicate that surgeries were being forced or pushed.

In Saskatoon, I mean we'll certainly follow up with the health region, but this isn't something that's come to our attention. We do know that in Saskatoon surgeries are still being cancelled for whatever reason. So to me that would indicate that, while we do want to see Saskatoon reach the goal of three months and we hope that they'll do that later this fall, that it wouldn't necessarily indicate, because we do still see cancelled surgeries in Saskatoon, that that may not be the case. But we certainly will look into the concerns that you've raised.

Ms. Chartier: — The initial part of that again is the communication log between staff. And the first part of it says, as of February 7th, 2014: "As per our discussion in our daily huddle yesterday, I spoke with Jenny Bartsch [sorry, it's handwritten here], director of surgical services, OR, regarding your staffing concerns. I raised the fact that staff are feeling stressed, tired, and overworked and that we need to look at solutions."

And then there's more. I won't read the whole communication piece again, and just the part that is of concern to the staff there: "It was clear in my conversations with Jenny that closing of OR theatres or cancelling cases is not an option."

And again, the conversations that I've had with staff has been . . . They've used the terms, we're worried that we're breaking sterile protocol. And forgive my lack of knowledge of language around here, but on one case — I've not been in an OR other than as a patient — but I was told that on one occasion where there was the one OR that the assisting physician, or the second physician, ended up serving as the scrub nurse on one occasion because they were short-staffed.

So I don't know if that's exactly correct language, but in my

recollection of the anecdote that that's how it was explained to me. So there is . . . When it comes to vacancy management and staffing issues and not having enough staff and being pushed on the surgical initiative, I am telling you that I'm hearing from people that it is a problem and patient safety is a concern. And that is why it was brought to my attention. I don't have information from RQHR [Regina Qu'Appelle Health Region] about this in particular other than what you've talked about, but this is coming out of the Saskatoon Health Region.

Hon. Mr. Duncan: — Again, we will be happy to look into that. It's not something that has been raised to my attention. It's not something that we're familiar with, so we'll follow up with Saskatoon Health Region on that.

Ms. Chartier: — Okay. Thank you for that. I'm going to just take a moment here. In terms of midwifery, the midwifery rollout, which has been going on since 2008, so far we have midwives available in three health regions. Is that correct? Saskatoon, RQHR, and Cypress?

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — The number of midwives available to women?

Hon. Mr. Duncan: — Currently in the province, there are 14 midwives licensed to practice.

Ms. Chartier: — And how are they distributed between those three, or actually it's four sites I believe?

Hon. Mr. Duncan: — So currently the distribution of the positions: six in Saskatoon, two in Cypress Health Region, five in Regina Qu'Appelle, and two in Fort Qu'Appelle.

Ms. Chartier: — There are two in Fort Qu'Appelle?

Hon. Mr. Duncan: — Fort Qu'Appelle.

Ms. Chartier: — Okay. That number has sort of ebbed and flowed over the last few years and it's not moved beyond the three health regions. What are your plans for ensuring that all women have access, if they so choose, to midwifery services?

Hon. Mr. Duncan: — So we do continue to support the growth of midwifery services in the province. We do provide the annualized funding of $2.2 million to support the service. We also have return-in-service bursaries available for recruitment and training. To date, 12 candidates have received the bursary. Ten students have done clinical placements in Saskatchewan, and six of those are currently employed by the regional health authorities.

Ms. Chartier: — But those numbers, it's not moved beyond the three health regions since implementation, or perhaps I think in 2009 it might have been in Cypress. It started out in Saskatoon, then Regina, then Cypress. So we haven't gotten any farther than that. And I know in Saskatoon and Regina, there are often wait-lists. So I'm wondering . . . I know what you're doing, but I want to know what you're doing to ensure that more women have access to midwifery services.

Hon. Mr. Duncan: — We are in a position now, after several years as the program has been developing, where the positions that are available are filled. There has been some interest from some other health regions, but at this point we haven't moved forward beyond the regions that we do currently have services.

Ms. Chartier: — What health regions have showed an interest, other health regions?

Hon. Mr. Duncan: — There's been interest expressed by other health regions, certainly Cypress in terms of expanding the current positions that they do have. There has been I think conversations with P.A. [Prince Albert] Parkland Health Region. I believe at one point too, and I'm just going off memory on this, that Kelsey Trail had expressed some interest in staffing, having funding to staff a midwife position. But at this point, we're not in a position to expand at this point.

Ms. Chartier: — Can you tell me how that would work? And forgive my not full understanding of how this works, but is the money that goes to the regions allocated specifically for midwifery? So if you've got five midwifery positions, that money is dedicated for midwifery positions.

Hon. Mr. Duncan: — Yes, that's correct. The model that we have in Saskatchewan is largely based on the Manitoba model where the midwives are employees of the regional health authorities, and so the dollars would be attached specifically for those positions.

Ms. Chartier: — Okay. So how do you, if you're . . . So the regions that have expressed an interest in midwifery services, how would they go about getting these midwifery services then? So you said you're not expanding the program at this time, so these health regions either have to find it in their own budgets, which with efficiency targets and such isn't going to happen. So how do you ensure that women in Saskatchewan have equitable access to midwifery services?

[16:00]

Hon. Mr. Duncan: — Well certainly within each health region and the Ministry of Health's annual budget allocation, certainly there are competing priorities for where dollars will go to. Typically what would happen is a region would, in the case where they would be looking for the ministry to fund a position or additional positions, they would put forth a proposal for us to fund those positions, always in balance with not only the competing priorities within the existing health budget but as well as issues related to recruitment and retention because we know that these can be difficult positions to fill.

As I said before, we're just now to the point where we're in a position to fill all the positions that are funded within the regional health authority, and that's been several years in the making through bursaries and other types of programs. So it would really be driven by proposals that would come forward from the regions.

Ms. Chartier: — Of those who've expressed an interest either in expansion of the program, like Cypress or P.A. Parkland or Kelsey Trail, have any proposals come forward and been rejected?

Hon. Mr. Duncan: — No. At this point there has only been some interest being expressed by health regions but no formal proposals that would have been rejected by the ministry.

Ms. Chartier: — Is the ministry providing any supports for those who have expressed an interest in providing midwifery services and to get to the stage where they put in a proposal? Is there any work that happens between the health region and the ministry?

Hon. Mr. Duncan: — We would certainly assist the regional health authorities in further outlining and expanding on what that type of proposal would look like. We would certainly provide that support, but at this point we haven't gotten to that point.

Ms. Chartier: — Out of curiosity, has the ministry, since the implementation of midwifery in those three health regions, done any number crunching or evaluation of the effectiveness of midwifery both from a woman's perspective on the outcome of birth or any cost effectiveness?

Hon. Mr. Duncan: — At this point the ministry, you know, we haven't done anything like a patient satisfaction type of survey. The regional health authorities might have done some of that work that do provide midwifery services. As of the end of the calendar 2013 year, we're just under 1,400 births that were delivered by a midwife.

With respect to whether it would be a cost-benefit analysis or a type of financial analysis, we wouldn't have that information. I think it's fair to say that the physicians, that the OB/GYNs [obstetrician-gynecologist] would, even with these births not on their . . . With them not having done them, you know, they would fill their time with other work, with other patients. And so we don't at this point, we wouldn't have, you know, be able to put a number on what . . . the analysis that would take place.

Ms. Chartier: — Do you and your ministry feel like it's a cost effective or a useful program?

Hon. Mr. Duncan: — Yes. Absolutely.

Ms. Chartier: — I think some of the challenges around the expansion of it . . . I know for example there's a woman here in Regina who our province has paid for her to study midwifery, and she's come back to Saskatchewan to no position in which she can work. So I understand there's a mat leave here in Regina that is being left vacant. And so you have a woman who we've paid for her education. She has roots in Saskatchewan. She wants to stay in Saskatchewan. And she has nowhere to work. And I'm wondering, I suppose there's some concern on her part too. Not only does she not get to stay in Saskatchewan and practise the profession, but what happens with respect to someone like that who has their return-to-service expectation?

Hon. Mr. Duncan: — We certainly are aware of the particular situation. We are in a position now, unlike previous years where there would have been unfilled vacant positions where it was a lot . . . You know, I think it was probably easier for the system to be able to accommodate those types of return-of-service bursary commitments and obligations on the part of the midwife, whereas now we're pretty much at full positions. So we are working with Regina and Saskatoon to see if there is a way to accommodate this situation that we're now in this year.

My understanding with respect to the Regina position is, based on the . . . It's a fairly short-term leave that the person is going on, not even a full year, and yet the licensing process and all the process for licensure and going through that process can in some cases extend up to a year. And so there really wasn't a good fit in terms of putting a person in that position because that position was going to be filled when the term was ended. But with respect to that specific case, we are working with Regina and Saskatoon to try to find an accommodation.

Ms. Chartier: — So that mat leave is not being filled then. Is that correct?

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — And how long . . . I know you've said it's less than a year, but how long less than a year?

Hon. Mr. Duncan: — My understanding is that it goes until September.

Ms. Chartier: — And it started?

Hon. Mr. Duncan: — My recollection of that situation was that it was a nine-month leave. And when the region looked at it can take up to a year for the licensing process for a new midwife to come into a position, it didn't make sense to go through that process first of all to find a midwife and then to go through that process if that would actually take longer than the position would be vacant because of the leave.

Ms. Chartier: — Okay. Help me understand that. With this particular individual with whom I've not spoken . . . I've spoken with other people who are involved in the midwifery community who are quite upset about it all. But she's a graduated midwife. What has to happen with licensure then for her?

Hon. Mr. Duncan: — So, Ms. Chartier, just to the specific case that you're talking about, so I think there's . . . I'll hope to be clear with this, or perhaps you have some additional information. So the position in Regina was a term. There was a leave that was being taken for one of the Regina positions.

So there's two kind of issues. One is the return-in-service bursary individual. Our understanding of that is that that was, the educational component of that would be finished in the spring.

With respect to the Regina position there wasn't, to their knowledge, an individual in the province that would be able to fill that position. So that would leave the province in the position of having to recruit from outside of the province, and by the time the orientation and the licensing would all be finished, that that would have most likely taken them beyond the September return date that they were expecting for that position that was to be filled or was vacant because of a leave.

Ms. Chartier: — Okay. And I think you're correct around her education finishing right about right now. But I understand

she's got a mat leave that she's doing in Alberta or BC [British Columbia] quite possibly this summer. But of course you've got . . . There's some concern when we're paying for someone's education. And we want to recruit these health professionals and it's been hard to recruit homegrown midwives. And we've relied on foreign-trained midwives which are wonderful, but there's many local individuals who'd like to practise their profession here.

Hon. Mr. Duncan: — And if I could add to that, certainly I think, you know, we acknowledge that we're now in a situation where over the last number of years it's been a combination of homegrown with return-of-service bursaries; it's also been some out-of-province recruitment that's taken place to try to match up the positions that are available with the supply of midwives.

We're now to a point though where in the past it may have been easier to match that up because we were always consistently having vacant positions, we're now in a position where, you know, we're pretty stable in the positions that have already been created. And so, you know, we acknowledge that, with the continued work of the return-of-service bursaries, that we need to be mindful that we're going to have students coming back and we need to match up some positions. So we do recognize that.

Ms. Chartier: — Is there a will on your ministry's part and your part . . . I know you've said proposals come from the health region, but I see this midwifery as a cost-effective and very good way for women to give birth in a normal pregnancy. That is the reality. Evidence shows that, and that is one of the reasons your government implemented midwifery, following all the work that had previously been done.

So I would like to see the ministry take the lead on that, on the expansion of midwifery services. We have return-to-service students who are training and want to come back here. We have women who want access to midwifery across the province. And I think relying on already stretched health regions to say, we'll come up with a proposal for midwifery isn't . . . I think it's doing a disservice to Saskatchewan women who want the benefit of midwifery services.

Hon. Mr. Duncan: — We would certainly . . . I mean, obviously the province has a role in this, but we will continue to work with the regional health authorities as they identify proposals and opportunities to expand the services. So we're certainly willing to work with the regional health authorities in that.

[16:15]

Ms. Chartier: — I think I need to flag just a bit of a concern for you that a midwifery consumer group, who has been very proactive in this particular health region anyway but would like to see equitable access to midwifery across the province, met with the human services, I think it's your human services committee of your caucus. And they were told that they needed to make a business case for expanding midwifery, which is odd in light of the fact that your government has supported midwifery. You got to proclaim and implement midwifery in February of 2008. And so to be told very recently by your caucus' human services committee that a consumer group needs to make a business case for expanding midwifery, I think is not acceptable.

Hon. Mr. Duncan: — I will certainly . . . It wasn't a meeting that I was a part of, so I don't know what the discussion was but, you know, certainly follow up with my colleagues on that.

Ms. Chartier: — Thank you for that. Changing topics here again, I realize I'm taking you back to the start of the day here, a little bit further back here. In terms of long-term care and the numbers of individuals who are awaiting a long-term care bed — whether it's in the transition unit at City Hospital, wherever it may be — do you have a number of how many individuals are awaiting a long-term care placement in Saskatchewan right now?

Hon. Mr. Duncan: — If you'll just give us a few moments to get the right people and the right information up to the table. Thank you.

Thank you very much, members of the committee, Ms. Chartier, for your patience. So just with . . . In terms of the waiting list for long-term care placement, so we typically receive that information at two points — one is September and one is March. So the information that we have today is the September 2013 information. We will be receiving, or have received and just are putting together, the information for March. So when we do have that, we will obviously provide that to you.

Knowing that wait-lists fluctuate and they're not static, that there is often transfers between lists, so for the September 2013 report by regional health authorities, at that time there were 418 people waiting for long-term care placement. Between April of 2013 and September of 2013, the average wait time went from 34 days on average that people were waiting down to 26 days on average for people waiting. And at that time, at the September 2013 date, there were 590 people on the transfer list that were . . .

Ms. Chartier: — Sorry, what's the transfer list?

Hon. Mr. Duncan: — Sure. So that consists of clients that are in a facility, but it's not the facility of their choice. And so they're waiting for a transfer to their facility of choice.

Ms. Chartier: — Okay. So 418 waiting for long-term care and then 590 waiting to be transferred from one long-term care facility to another.

Hon. Mr. Duncan: — Yes, that's correct. And that's the September 30th, 2013 report. And as I said, they report September and March — at the end of September, the end of March — and so we'll provide you with the end of March numbers as soon as we can.

Ms. Chartier: — Have there been, in terms of trends or numbers, do you have the previous year, the previous couple of years perhaps?

Hon. Mr. Duncan: — Yes, so we would have the . . . So in terms of people waiting for long-term care placement, so the

September 2013 of 418. The previous number that we do have, I don't have a year-over-year comparison, so I don't have September of 2012. But I have the March of 2012 and, at that time, there were just over 350 people on the wait list.

And I don't have . . . In terms of the average wait, I gave you that number from September 2013 versus April of 2013. I don't have it year-over-year from September 2013 versus September 2012. If you would like that number, that's certainly showing a decrease in the amount of days that people are waiting. And the transfer list, I only have it for September 2013. I don't have a previous number to base that off of at this point.

Ms. Chartier: — Okay, and with respect to the transfer list, so that might be I'm in Parkridge in Saskatoon and I want to go to Sherbrooke. And I'm patiently waiting for a spot at Sherbrooke. I suspect that that list doesn't . . . Are people always waiting for their first or second choice? Or with respect to the transfer list, I suppose I'm wondering how often people get moved off of that transfer list.

Hon. Mr. Duncan: — So with the transfer list, we don't have kind of an average time, that wait, because different facilities, different circumstances. But typically what happens is people are . . . They go on the list chronologically based on when they are assessed and then go onto a list.

So when a bed opens up in a facility, they'll look at the transfer list first to see whether or not there's somebody on that transfer list. If that's the case, then the individual will move from the facility they're currently in to the facility that they are wanting to transfer to, and then a person would then obviously go into that bed that they would then be vacating. But we don't have . . . We can certainly provide, as I have, the number of people on the transfer list, but it would vary region to region how long people would wait on that transfer list.

Ms. Chartier: — That's okay. With respect to the 418 currently waiting or as of September 2013 waiting for long-term care places, can you tell me about . . . Are generally people always in transition units like at City Hospital or other facilities? Where are those 418 people waiting generally?

Hon. Mr. Duncan: — So that would be a combination of people that would be waiting in either a community setting, whether that be . . . I think there's, you know, a variety of different options that people would have. It also could include those that are in hospital waiting for placement.

We do keep track of the percentage of acute care beds that are occupied for people that are waiting for placement. That number typically ranges between four and a half to 5 per cent. So it looks like we're trending down. So October of 2013, we were at 4.8 per cent. That 4.8 per cent continued into November of 2013. It went up a little bit in December of 2013 to 4.9 per cent, and then as of January 31st, 2014, it's down to 4.6 per cent. But it does seem to range between that four and a half and 5 per cent.

Ms. Chartier: — So individuals who are waiting in an acute care bed is about four and a half to 5 per cent of that number. Okay.

Hon. Mr. Duncan: — It's four and a half to 5 per cent of the acute care beds.

Ms. Chartier: — Okay, sorry. Four and a half to 5 per cent of the acute care beds are occupied by someone who is . . .

Hon. Mr. Duncan: — Waiting for placement in long-term care, correct.

Ms. Chartier: — Okay. And my overall sense of long-term care is that it is getting more difficult to get into long-term care, and anecdotally just stories that I've heard from people, getting a better understanding in the Saskatoon Health Region around CPAS [client/patient access services]. We had the conversation about Ron Caron who initially didn't even make it onto the long-term care list because he had too many needs.

Can you give me a little bit of a picture of long-term care here in Saskatchewan? I know we don't, I don't think we typically use levels anymore like one, two, three, four. But can you give me a picture of what long-term care in Saskatchewan and the level of acuity looks like?

Hon. Mr. Duncan: — Thank you for the question. Just generally speaking, access to long-term care, I would say that there would be some specific cases, and not to, you know, get into specific individuals cases, but there may be circumstances that would create some challenges to providing long-term care in some cases.

I think there are certainly pressures, especially in our larger cities. We recognize that. But I think that overall, based on I think a couple of indicators, that I wouldn't say, I wouldn't generalize to say that it's getting harder to get into long-term care. I know the average time that people are waiting to actually access a bed in long-term care is trending down, as well as they indicated that while it's fairly stable in the recent months, the percentage of our acute care beds that are being taken by people who are waiting for long-term care, that's trending I think in the right direction as well.

So we acknowledge that there are some specific situations or circumstances that challenge the system. We work hard with the regional health authorities and families to address those situations as best we can. There are pressures within the cities, as I said before, the major cities. But I think overall, you know, we're certainly in a position where some of the trends I think are going in the right direction in terms of, that indicate access to long-term care.

[16:30]

Ms. Chartier: — I'm wondering what . . . My grandmother was in long-term care for a very long time, quite some time ago now, and it changed over the course of her . . . She had spent 20 years in long-term care. As a matter of fact, she was 99 when she passed away, and I saw in that time it changed. But I'm wondering, just paint me a picture of what long-term care needs generally look like in Saskatchewan. I've heard from front-line staff who've said needs of individuals have intensified.

Hon. Mr. Duncan: — I think as a general comment, certainly I have the same experience with a great-uncle that went into

long-term care and, you know, somebody very close to me in my family. And you know, he was in long-term care for a significant number of years in the later part of his life.

I think overall it's fair to say that within long-term care, people are entering long-term care later in life than they used to. The average stay within, living within long-term care is certainly not what it would have been in years past. I think right now we average about a year and a half. One to two years is the average that somebody will live in long-term care, which I think is certainly quite different than what it would have been, you know, 10 and 20 years ago where it was a number of years that somebody would be living in long-term care. So I think that, you know, certainly we are seeing that trend that people are coming in later in life and for a shorter amount of time though.

Ms. Chartier: — Where is that difference being made up? I know home care hasn't grown exponentially. And I know . . . So I'm wondering your sense of what kind of care people are receiving and where they're receiving it prior to entering long-term care?

Hon. Mr. Duncan: — Well I think that that's a good point. You know, I think it's, generally speaking, I think that people are . . . The experience is that people are staying in their homes longer. They're availing themselves of other options, whether that be personal care homes or within their own homes supported either by family or perhaps by the system, whether that be home care or other types of supports.

But certainly the experience has been, over the last number of years, there hasn't been a great change in the number of long-term care beds in the system. We're at about 8,700. That's changed, you know, ever so slightly as the 13 long-term care facilities for example come online — that's really more of a renewal of aging facilities — as well as 100 beds in Saskatoon that just opened up in the last couple of years. So overall the number haven't changed greatly in the last, you know, five or seven years. But you know, I think the trend is that across not just Saskatchewan but across Canada, people living in their own homes longer, or in other types of living facilities.

Ms. Chartier: — With respect to personal care homes, which I think again anecdotally more and more, and possibly with the numbers . . . I don't have the numbers. But people staying or calling personal care homes home . . . I think one of the things that's been expressed to me is the level of care in personal care homes has gone up.

So I've heard stories in Saskatoon anyway around the fire service actually, Saskatoon Fire and Protective Services being called to do lifts on a frequent basis. If you happen to live in Saskatoon Eastview or if you're the fire service that services that area, you get calls quite frequently. And I know the Saskatoon Health Region tracked this a little bit last year. And the fire service wasn't complaining. They were doing it as a matter of course. They would get calls to do lifts because of lack of staff or lack of staff who have the skills to be able to do the lifts. So I'm wondering if you're hearing the level of care or need going up in personal care homes as well?

Hon. Mr. Duncan: — Personal care homes first of all I think provide a tremendous service to the entire continuum of care for seniors in the province. And we're certainly pleased that the legislature and the committee saw fit to speed up the process to post those inspections online.

There is nothing to say that without the proper level of training and supports, that personal care homes, they are able to provide a higher service and a home to people with higher levels of needs. But that's dependent on the facility, the operator, and the family to make those types of arrangements. But there's nothing to say that if a resident, if their care needs are changing and they and their family don't necessarily want them to move, with the right amount of supports and training and so forth in place, there's nothing to say that that person couldn't stay in that type of facility.

We're not aware of the fire department personnel being used for lifts in personal care homes in Saskatoon. That's something that we're not familiar with.

Ms. Chartier: — From my understanding, it's quite frequent. I actually was on a ride along one night, and they got a call, and that's how the discussion started. And I understand that the Saskatoon Health Region . . . Actually at one point the fire department was getting called out quite frequently to help with lifts. Someone has fallen and there are some challenges. So firefighters are generally fit, strong individuals, and that's where the personal care homes have been calling for support.

Hon. Mr. Duncan: — So I just want to be clear because we've kind of moved from special care homes or long-term care to personal care. This was experiences in personal care homes?

Ms. Chartier: — Personal care homes, yes.

Hon. Mr. Duncan: — Again it's not something that's come to our attention, but we'd be happy to follow up with the health region, knowing that the health region . . . I mean obviously the health region doesn't own and operate them but, you know, if they have some knowledge of this, we'd be happy to follow up with that.

Ms. Chartier: — And as I've said, the fire service wasn't complaining about it. But I think it's an odd use of dollars for firefighters to be called out to do lifts in personal care homes. So it calls into question, our personal care homes, do they have the right staffing complement? Sometimes the equipment is lacking, and care needs have increased, from my understanding, in some of these personal care homes, thus necessitating additional help which has come in the form of firefighters.

In terms of long-term care again — sorry to go back and forth here — some of those individuals who are more difficult to find long-term care placements for, like Ron Caron or the CLSD [community living service division] clients who have been in the Dubé, what generally are some other options for them? As a minister who knows that this is a need, you've got complex cases, people who have very high needs. How do you propose addressing some of these individuals' demands or living needs?

Hon. Mr. Duncan: — Thank you for the question. So certainly there's a number of approaches that we're trying to take as a Ministry of Health working with the regional health authorities in trying to, you know, I think deal with some complex issues

and some trying circumstances for families and residents and for the health region as well because they're obviously trying to provide residents with a proper level of care.

So there's I think a number of things that we are trying to do. Certainly in certain facilities, there will be special supports put in place, for example dementia and Alzheimer's, where there's some additional precautions that are put in place. I can think of Samaritan Place in Saskatoon, which I've had an opportunity to tour.

There's also a great deal of training that's going on within the long-term system. I know that Saskatoon has accessed some dollars from the government through the Urgent Issues Action Fund to provide gentle persuasion training, which is really a training method of trying to de-escalate the situation, which has been seen to be effective in other jurisdictions that have employed it in trying to de-escalate those situations, especially when it involves individuals with dementia or Alzheimer's.

I know that there are certain circumstances and special circumstances that regional health authorities have undertaken to make some changes to the facilities themselves to be able to accommodate some of these complex issues. I know that I toured two of the three long-term care facilities in Swift Current just in the last six months or so. As you'll know, those facilities are being replaced.

But what the region has done in one facility in Swift Current where they had an individual, it was a gentleman with early onset dementia. He was relatively young but still was quite physically strong. And so they did have to make some retrofits to his room to put in some security precautions with some mirrors so that they could more easily, I think, just keep watch on him. They made some changes even, for example, to the bathroom, where they put in place a different toilet rather than a porcelain toilet because he was literally physically strong enough to break the toilet just by his strength. So they did make some specific changes to that facility.

And that does happen from time to time through the health regions, where they're able to make some changes to accommodate specific circumstances. But we know that it is a challenge. We know that certainly when you look at Alzheimer's or other related dementias with an aging population, with people living longer, longer life expectancy that we know that that is something we need to be mindful of going into the future.

[16:45]

Ms. Chartier: — Okay, thank you for that. I think my concern is that need to be proactive. In Mr. Caron's case, he will get what he needs but it wasn't . . . His daughter advocated very hard for him. She was involved and the people who she thought were supposed to be her team or her support weren't. She had seemed to hit a brick wall, and you don't always want to come to the legislature to raise your concerns. You want your parents or whomever your loved one is, their needs met. So that need to recognize that Mr. Caron is one of many people.

Being new to this portfolio, could you explain a little bit to me about funding of long-term care with respect to affiliates versus facilities owned by health regions. Is it the same across the province or do different health regions receive different funding? So if you could just describe for me how those are funded.

Hon. Mr. Duncan: — So the funding that regional health authorities receive is, it's a part of their global funding, global budget funding. So from the pool of money that they receive from the provincial government, they will make determinations on how they will fund long-term care facilities, whether they own them or whether or not they are owned and operated by an affiliate. So each region has a different approach in how they then allocate the funding to long-term care facilities, but it's not something that we itemize separately as a Ministry of Health. It's just a part of the region's global budget.

Ms. Chartier: — And as part of the global budget how, when you're deciding the global budget, when you're thinking about long-term care obviously, so you're not saying, this is for long-term care. But in the makeup of the budget, there would be some considerations of long-term care costs. Would that be the case?

Hon. Mr. Duncan: — So just generally speaking in terms of the global budgets that are provided to the regional health authorities, we'll factor in a number of things, generally speaking, and relate it to the global budget. So you know, it could be things like inflation. It could be the settlements to public sector contracts. Again that would be both long-term care, that would also be acute care — all sorts of types of contracts that would be included.

We also look at some specific programs. So for example, in long-term care what we did say, as I think you'll recall, through the Urgent Issues Action Fund, we did itemize out a separate 3.7 million based on what we had provided late last year for funding through that fund. So that would have been separate from the global budgets. We do also provide dollars, for example, for population growth which would then affect the global budgets that health regions receive. We also do provide specific dedicated funding when it comes to capital projects — so, for example, the $500,000 to begin planning an expansion of the La Ronge long-term care facility — that would be over and above the operational dollars that regions receive on a global level.

Ms. Chartier: — Okay. In terms of . . . So I just want to echo back to you to make sure that I've got this right then. Each health region functions differently. They get their global budget and will decide that an affiliate will get X number of dollars per bed. Is that normally . . . Is that a standard practice that they are funded per bed? Or how does that usually work?

Hon. Mr. Duncan: — So it really depends region by region. Some would do something similar to what we do with regional health authority budgets. So it would be an amount that would be based on the historical amount that they had provided to the facility and maybe make some adjustments for inflation or for some other reasons. Some would look more specifically at the case, the index mix of the residents within that facility and make determinations up or down based on the level of care that's being provided in that particular facility. Each region approaches it a little bit differently.

Ms. Chartier: — Okay, thank you. In terms of the urgent action money, the 3.7 million that was allocated last year, and then this year it now is part of the global budget and will be . . . the 3.7 million is just part of the global budget, or what is the expectation of that 3.7 million?

Hon. Mr. Duncan: — So the 3.7, it's nearly $3.8 million, so that relates back to the $10.04 million that was allocated to health regions. Of the 10.04 million that would have an ongoing cost — whether that be staff or otherwise, but for the most part it would be additional staff — what we've done is, we wanted to ensure that, especially as it relates to staff, that we wanted to keep the health region whole so they were provided the funding to hire the position. And when it comes to the case of staff, so the 3.7 million would be related to the ongoing costs of either those positions or other things that they would've purchased that would have an ongoing cost beyond just the one-time cost, the equipment and things like that would cost.

Ms. Chartier: — Can you give me some examples? It's easy sort of to wrap your head around ongoing staffing costs and the cost of positions, but the other things, the equipment, can you give me some examples of that?

Hon. Mr. Duncan: — So if it's helpful for you, I can speak about both the ongoing cost, but also the one-time cost if you're interested in that as well.

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — Okay. So in Saskatoon Health Region, 21 ceiling lifts have been installed in two facilities.

Ms. Chartier: — Can I just stop you for a minute? Is this pertaining to the 3.7 million?

Hon. Mr. Duncan: — No. So this is both the . . . I'll speak about the 10.04 million, but also I'll indicate where the 10.04 million relates to an ongoing cost that is then covered by the 3.7 million that's budgeted in this year.

Ms. Chartier: — Okay. Yes, I have some clarifications, but we'll start.

Hon. Mr. Duncan: — Sure, okay. Okay, so Saskatoon Health Region, 21 ceiling lifts have been installed in two facilities and 18 other rooms include installation to access to the bathroom. So the ceiling lift also has access to the bathroom.

In Parkland health, P.A. Parkland Health Region, the track lifts have been installed in eight facilities. That's currently under way. And 10 lifts at Mont St. Joseph Home which is an affiliate. Those 10 lifts have already been installed.

At Five Hills Health Region, 10 of the 11 tubs have been installed. So they're waiting on the 11th tub to be installed.

Athabasca Health Region, which received just a minor, small amount of money, the equipment has been purchased and is currently being used.

Kelsey Trail Health Region, their first priority equipment has been ordered. So that would be for lifts, tubs, and chairs for five facilities. And as they receive that equipment, installation will occur of that equipment.

Six health regions now have certified trainers in gentle persuasion, which I think we spoke about just a few minutes ago. So that's going to allow for the front-line staff to be trained now that there are certified trainers within those health regions.

In Regina Qu'Appelle specifically, 64 staff have been trained in gentle persuasion — sorry, 64 staff have been trained as gentle persuasion certified coaches. And that represents 20 facilities across the health region. And 600 care staff and 306 other staff have been trained to date.

Sun Country Health Region, expansion of weekend recreational activity has occurred and approximately 75 per cent is complete. Sorry, 75 . . . if I'm reading this correctly, 75 per cent of the expansion of the planned weekend recreational activities has been complete.

Prairie North Health Region, capital improvements are under way at Jubilee Home in Lloydminster; 50 per cent of the wall repairs and some painting, repainting is complete. And they also are replacing some windows in that facility.

Regional health authorities, so here's where the ongoing dollars relate to . . . So regional health authorities, through the action fund, received funding for 52 full-time equivalent positions. And so regions will be in various points of posting and filling those positions.

Ms. Chartier: — So just to clarify then the 10.04 million was not about positions at all, but the 3.7 million is.

Hon. Mr. Duncan: — So of the $10.04 million, approximately 800,000 of that would have been for positions. That would have covered those positions from the time the dollars were allocated to the end of the fiscal year. So the $3.7 million, the proportion of that that is staff related, would be for an annualized year, annualize that funding.

Ms. Chartier: — Okay. So of the 10.04, 800,000 covered positions.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — And then you had announced the 3.7 million as well. And so that . . . Sorry that I'm having trouble understanding that. So I know that, going forward, that that money is in the budget.

Hon. Mr. Duncan: — Right. So I'll maybe try one more . . .

Ms. Chartier: — Okay. One more crack at it.

Hon. Mr. Duncan: — No, no. Sorry if I'm not clear on this. So of the $10.04 million, when the dollars were allocated, approximately 800,000 of that would be for those staff positions that would take the regions from when the money was allocated to the end of that fiscal year, so the '13-14 fiscal year.

What we also wanted to ensure was that we didn't want to leave the health regions in a position where we would fund a couple

of months of a position, and then in the ’14-15 fiscal year say, now you’re on your own; fund that position yourself. So we indicated at that time that it was approximately 3.7 million or a large portion of the $3.7 million that would be required for annual funding for those positions. So we indicated at that time that the $3.7 million would be included in the ’14-15 fiscal year to cover those positions that are hired in the $10 million.

Ms. Chartier: — So that 3.7 million didn’t flow in the last budget year, but it was . . . You announced it to flow in this budget year to cover the new . . .

Hon. Mr. Duncan: — Right. So what I had indicated is that because a portion of the dollars, the $10.04 million would be dedicated towards adding staff in some long-term care facilities, that we were essentially making a commitment to the health regions, that we were not going to just expect them to find it in their budget, that we were planning to include it in our budget for ’14-15, of course pending approval. And thankfully we have the approval to do that. But the 3.7 million was intended to provide the funding for the health regions to keep those positions going forward.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — The point wasn’t just to add them for a couple of months and then basically say to the regions, now you find the money or lose the positions. It was, you create the positions and we’ll fund them ongoing.

Ms. Chartier: — That makes sense. I just wasn’t sure. I had thought the 3.7 million flowed last year. So no, that makes perfect sense to me. Just, I know that our time is just about up here for today, but I’m wondering where you are with your check-in periods? You had committed to check-ins to see how all this is going, and you’ve given me sort of some breakdown in terms of what’s been installed. But do we have any outcomes yet from any of that?

[17:00]

Hon. Mr. Duncan: — So the list that I ran down, that was the 120-day update. So there are still some pieces of equipment, some positions that still need to be installed and then used by front-line staff and residents. So we know that we need to go back to the health regions even beyond the 120 days, because not all of those dollars have been used yet. So we’ll be doing that when we get a better idea that the equipment has been installed, the positions have been hired, and then we’ll go back to them and get basically an assessment of, you know, whether or not the dollars have actually improved care.

Ms. Chartier: — Okay, well thank you. I think that that’s all for today.

Hon. Mr. Duncan: — Thank you very much.

The Chair: — Mr. Minister, if you have any closing comments.

Hon. Mr. Duncan: — No, Mr. Chair, other than to thank the members of the committee and Ms. Chartier for the questions this afternoon, and again to thank the officials for being here today and for helping us to prepare for today. And we look forward to what I hope will be one final appearance before the committee before the legislature adjourns. And Happy Easter to everybody.

The Chair: — Thank you very much, Mr. Minister. The time being now 5:01, I would ask a member to make a motion of adjournment.

Mr. Lawrence: — I make the motion.

The Chair: — Mr. Lawrence has moved a motion of adjournment. All agreed?

Some Hon. Members: — Agreed.

The Chair: — This committee stands adjourned to the call of the Chair.

[The committee adjourned at 17:01.]