STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Mr. David Forbes, Deputy Chair
Saskatoon Centre

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Saskatoon Eastview

Hon. Nadine Wilson
Saskatchewan Rivers

Ms. Colleen Young
Lloydminster

Published under the authority of The Hon. Dan D'Autremont, Speaker

[The committee met at 13:29.]

The Chair: — Good afternoon everyone. Welcome today. I just want to introduce our members. We have, sitting in for Mr. Forbes, Ms. Chartier. We have Mr. Marchuk, Mr. Parent, Mr. Tochor, Ms. Wilson, and Ms. Young.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will be considering the estimates and supplementary estimates for the Ministry of Health. We now begin our consideration on vote 32, subvote (HE01). Minister Duncan is here with his officials. Minister, please introduce your officials and make your opening remarks.

Hon. Mr. Duncan: — Thank you, Mr. Chair. Good afternoon to the committee members. We're pleased to be here to have an opportunity to speak about the Ministry of Health's 2015-2016 budget. As you can see, we have a number of officials that are joining us from the ministry today. I will take a moment to introduce a couple of officials, and then if anybody else comes to the microphone, we'll just ask that they identify themselves at that time.

Minister Ottenbreit and I are joined, to my right, Max Hendricks, the deputy minister of Health; behind us, Mark Wyatt, assistant deputy minister; Kimberly Kratzig, assistant deputy minister; Tracey Smith, also an assistant deputy minister; and Karen Lautsch, assistant deputy minister. As I said, we have other officials that have joined us here, and I want to welcome them. We look forward to discussing the '15-16 budget, and we look forward to your questions today.

Before I begin, I'd like to provide some context and highlight some of the government's key health investments this year, investments that will provide Saskatchewan people with the responsive, quality health care that they deserve and need. This year our budget theme is keeping Saskatchewan strong. We know that Saskatchewan's economy is diverse and resilient. We're strong in many sectors — the agriculture, manufacturing, and resources such as potash, uranium, and oil. But even with this advantage, there are many competing priorities in the health system and elsewhere. We're always challenged to ensure that we're balancing the support for those who need it.

Each year our government develops a fiscal plan and budget with careful attention to all areas of revenue and expenses. Our solid track record of sound fiscal management helps us face the challenges of volatile resource revenue. We're committed to ensuring the long-term sustainability of health care services through innovative approaches, careful stewardship of resources, and the pursuit of system efficiencies.

So to the specifics of the '15-16 Ministry of Health budget, this fiscal year a commitment to quality patient and family-centred care continues with a record health budget of $5.12 billion. This is an increase of $135 million or 2.7 per cent over last year. This record investment represents the largest budget among provincial government ministries, and it demonstrates our firm commitment to health care.

Target investments will support key priority areas such as health infrastructure, 127 million will support capital improvements in the health sector; seniors' care, 10 million will enhance supports and services to seniors at home or in long-term care facilities; and the emergency department waits and patient flow initiative, $3 million will go towards helping reduce waits in our emergency rooms.

More specifically, Health's budget increases include $61.4 million or a 1.2 per cent increase for cost growth in base programs including health sector salary increases, drug and medical cost growth, and program utilization changes; $63.1 million or a 1.3 per cent increase for capital equipment and facility investments; and 14.1 million or a point three per cent increase for new initiatives programs and service enhancements.

The health system and the ministry have reduced funding by 3.5 million in 2015-16 through a $455,000 reduction in ministry administrative programs for tenant improvements, and a $3 million saving related to the change for the seniors' drug plan income threshold. The seniors' drug plan change will help offset increased utilization and drug price increases. It means that starting July 1st, 2015, the income threshold for coverage will decrease to 65,515 from the current 80,255. Of the 137,000 seniors eligible for coverage, about 6,000 seniors will be affected. The drug plan will continue to provide a range of programs to help individuals and families with the cost of their medications.

In total, government's investment in health care has increased by $1.7 billion or 49 per cent over the last eight years. Better care, better health, better value, and better teams will continue to be a focus as we support the transformational change under way across Saskatchewan's health care system.

Saskatchewan residents will benefit from $3.31 billion in funding for regional health authorities. This represents an increase of 55.7 or 1.7 per cent. The province's regional health authorities are responsible for much of the day-to-day delivery of health care in the province. We continue to look to them to practise sound fiscal management of these resources. Base funding for individual regional health authorities, excluding the Athabasca Health Authority, varies from 1.3 per cent to 6.1 per cent. The variations are a result of differences in the regional health authority collective agreements, new program funding for seniors, transfer amounts from other program areas to the regional health authority base, and specific reductions.

Over the past eight years, our investment in regional health authorities has increased $1.14 billion or 53 per cent. The government is committed to helping seniors stay in their homes as long as possible and improving the quality of long-term care for those who need it. This commitment is underscored by our budget's investment in support for seniors.

We're providing $10 million in new funding for seniors for a total of $14.5 million in '15-16. This includes $3.5 million in additional funding for the Home First/Quick Response program to support seniors to remain at home as long as possible while

reducing the need for acute care admissions. This will allow existing pilots to continue and enhancements be made to the pilot projects that are ongoing in Regina Qu'Appelle, Saskatoon, and Prince Albert Parkland Health Region. In addition a pilot project in the Prairie North Health Region will be expanded to include an additional site. This brings the total annual funding for Home First/Quick Response to $8 million.

2.8 million in capital renovations to develop specialized units for individuals with dementia and challenging behaviours in both Regina Qu'Appelle Health Region and Saskatoon Health Region; $2 million in individualized funding to provide increased choice and flexibility for home care clients to choose their care provider. This will help provide more services and eliminate the current wait-list for funding in the Five Hills, Prairie North, Regina Qu'Appelle, and Saskatoon Health Regions.

One million dollars annually to implement purposeful rounding in all health regions. This is the practice of regularly checking on residents' needs, focusing on the four Ps: positioning, personal needs, pain, and proximity to personal items, with the promise to return within a prescribed amount of time. This will help improve resident safety and outcomes in long-term care.

And $700,000 to develop a new geriatric program in the Regina Qu'Appelle Health Region and recruit a geriatrician to Regina to provide a range of services to seniors, including support for quality in long-term care. These targeted investments will help ensure that seniors can continue to live healthier lives and remain independent in their communities.

In the past five years, there's been a 19 per cent increase in the number of patient appointments at Saskatchewan's two cancer clinics in Regina and Saskatoon. Recognizing the critical work done by the Saskatchewan Cancer Agency, we've provided $157.3 million to the agency this year to deliver and enhance cancer care services. This is an increase of $1.58 million from last year.

We're also seeing more patients accessing cancer services in or near their own communities. Between 2010 and 2014 there was a 48 per cent increase in treatment visits through the community oncology program. This program provides cancer patients with care, treatment, and support in or near their home communities through centres located in 16 regional hospitals. There are many competing priorities across the health system, but cancer care remains a key focus for the government.

One of the government's proudest accomplishments in health care is the success that we've achieved in surgical wait times. As members will know, we inherited some of the longest surgical waits in the country. The success of the Saskatchewan surgical initiative has demonstrated that health system transformation is possible. Since the initiative began in 2010, the efforts of thousands of health system staff and physicians have transformed the care experience for Saskatchewan surgical patients. Remarkable progress has been made in improving access to surgery and reducing the surgical wait-lists. There are 13,255 fewer patients waiting more than three months for surgery than when the initiative first began. Back on April 1st 2010, 15,290 people were waiting over three months for surgery. As of January 31st 2015, 2,035 people are on the wait-list and none have waited over three months. That's an incredible reduction of 87 per cent, and it's because of the efforts of so many across the health system.

The budget includes $4.7 million or $3 million in new funding to advance the work on reducing waits in emergency departments. This is one of the health system's top priorities in the coming years. Addressing ED [emergency department] waits will directly improve patient care and enhance the quality of life for those needing emergency care. To be successful we need to make innovative changes in multiple areas where people receive care. We need to address areas where the bottlenecks occur. This includes pre-hospital primary care, emergency departments, acute care, and community-based services that support early discharge.

In 2015-16 funding will be allocated to sustain initiatives implemented in the '14-15 fiscal year by the three largest health regions: Saskatoon, Regina Qu'Appelle, and Prince Albert Parkland. I'd like to share just a few examples with the committee. We're expanding the police and crisis teams to Regina. This program, which is already under way in Saskatoon, pairs a mental health worker with local police units that respond to calls with an identified mental health component. The goal is to enhance public safety and care for individuals, families, and households with mental health issues. By beginning at the point of contact in the community, these individuals are supported with the most appropriate assessment, triage, and intervention. This will help eliminate inappropriate emergency department visits and costly hospital admission.

Funding will support the continued redesign of the in-patient model of care in Saskatoon. This will help to ensure that services are available on weekends and after hours to support timely transition for patients that are leaving acute care facilities.

We'll also see an expansion of the patient treatment and assessment in Regina Qu'Appelle. This work addresses the emergency department provider workflow at the General Hospital. It'll also help to improve the time for an initial patient assessment.

There's also more support for long-term care facilities with nurse practitioner coverage to increase preventative care and avoid transfers to the emergency departments. This allows patients to receive care in their place of residence for routine conditions.

As well there will be an assessor co-ordinator weekend coverage in the community and at the General Hospital in Regina and the Pasqua Hospital to ensure patients' care plans are delivered seven days a week, allowing for a timely discharge home, and continued expanded physician coverage at the Victoria Hospital emergency department in Prince Albert during peak times so that patients can receive timely assessment.

These are just a few examples of initiatives, innovations that can make an immediate difference to patients who need health care services.

Saskatchewan is investing in facility and equipment

improvements for the benefit of our patients and the staff who work across the province in health facilities. In 2015-16 we're making a $127.4 million capital investment, an increase of 32.4 million from last fiscal year. This includes 71.1 million for the construction of the Swift Current long-term care facility and the Leader integrated care facility; $7.8 million to complete the new hospital in Moose Jaw; $4.5 million to continue work on the Kelvington integrated care facility; $500,000 for facility planning for a new hospital replacement in Weyburn; 27.8 million for critical infrastructure repairs; and $15.3 million for diagnostic and surgical equipment.

I'll also note that 8 of the 13 new long-term care facilities are complete and work is still under way on the new children's hospital, as well as the Saskatchewan Hospital at North Battleford.

In the last eight years the government has invested approximately 1.1 billion in health infrastructure, approximately three times the investment made over the previous six-year period.

Effective March 31st, our contract ends with John Black and Associates. Saskatchewan has now acquired the skills and knowledge needed to continue improving care through the health system without external support. We know that this work is crucial in the future sustainability of the health care system.

Through continuous improvements in quality and safety, by thinking and acting as one system and by focusing on improving access, we are supporting better health for residents, better care for patients, better teams of health providers, and better value for taxpayers. There are many examples in the health system of lean improvements that have made significant improvements in patient care, and I will just highlight just a few of those.

In Moose Jaw, patients are being seen faster at the emergency department. The wait times to see a physician at the Moose Jaw Union Hospital ED are down 46 per cent from, on average, 50 minutes down to 27 minutes for patients with a medium urgency issue or classified as a CTAS [Canadian triage and acuity scale] 3. Staff improved triage of patients, introduced a rapid admission process, and consolidated supplies to save providers time.

In Saskatoon, operating room processes are making care safer for patients. O.R. [operating room] health care providers have the surgical instruments they need in less time at Royal University Hospital. Operating room technicians are taking 55 per cent less time to generate and post lists of instruments that they need for an upcoming surgery. Errors have been eliminated, and that means that staff and providers can focus on direct patient care. The hip and knee patients in the Regina Qu'Appelle Health Region now get all non-surgical services in one location; 100 per cent of osteoarthritis patients get everything they need when they need it at the new Hip and Knee Treatment and Research Centre here in Regina.

[13:45]

They no longer have to visit multiple sites for assessment, diagnostic tests, and education. Patients receive information at the right time to prepare them for surgery. Those who don't need surgery are connected with the appropriate community supports. Parking is convenient and right outside, which is especially important for patients that have limited mobility. This in Regina is located in what was the old Superstore downtown.

Patients are now receiving more timely lab services in Kelsey Trail Health Region. Patient wait times for lab collection services are down 73 per cent during peak morning times, which is 8 to 9 a.m., and down 55 per cent overall. As staff improved the patient registration process, they also eliminated data entry errors. This is a significant positive effect on patient safety and quality of care.

These are just only a few examples of the many, but an indication of the promising early successes that we've achieved through continuous quality improvement processes. We continue to be committed to this approach to enhancing patient and provider experiences while creating a more cost-effective, sustainable health care system.

The budget also includes $550,000 in funding for the Little Tots autism spectrum disorder program in Saskatoon. Little Tots program is a pilot project funded by the Saskatoon Health Region and delivered by Autism Services of Saskatoon. The original funding was temporary. The funding being provided will allow this evidence-based program to become permanent.

Since 2009, 7.55 million has been invested annually in autism services. This has resulted in health regions being able to offer specialized services through 15 autism spectrum disorder consultants; 18 support workers; increased seasonal programming and respite funding; and province-wide education and training for service providers and caregivers; additional speech language pathologists, occupational therapists, psychologists, behaviourists, developmental consultants, and para-professionals in areas of high demand; as well as diagnostic assessment and intervention services for the adult population; and enhanced therapeutic programming for pre-school children.

In closing I hope that this overview has provided a good sense of the ministry's direction, the strategic focus for the next fiscal year. This year's budget is framed around our government's principle of keeping Saskatchewan strong with a focus on building for the future in a fiscally sustainable and responsible way. We're funding areas and initiatives that we believe will best meet the needs of patients and families, and our investments also allow, also acknowledge the pressures that we're seeing in areas like long-term and acute care.

Across the health system, putting patients first remains our goal. We continue to search for opportunities to improve services and identify innovations that will help us do better for our residents. We're giving health system leaders the flexibility to innovate, encourage them to explore new ideas that will support long-term sustainability of the system.

This is an exciting and inspiring stage in Saskatchewan's health care transformation journey. I applaud those who want to continuously improve, those who are willing to think differently and try new approaches in the interest of better serving our

patients. We've just begun to realize our quality improvement potential. It's essential that we continue to help preserve the health system and to ensure that it's here for our kids and our grandkids. With that, we would be pleased to take any questions.

The Chair: — Ms. Chartier, you have the floor.

Ms. Chartier: — Thank you and thank you to the two respective ministers here and to all your officials. I look forward to the next 10 hours or so of chatting about health. I will likely, I will ask some broad questions, but I also have some very specific number questions. And undoubtedly, like last year, I will be all over the map over the next 10 hours. So bear with me here on that.

I'd like to start with mental health. So almost two years ago, Minister Duncan, you had announced hiring a commissioner to look at mental health and addictions here in Saskatchewan. She spent a year and a half doing a review and this fall reported out. I'm wondering why there was no mention of her work in the budget?

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So I'll maybe just back up to say that we've had I think a number of conversations about, you know, a shared interest in seeing that mental health and addictions, the way that we provide services are improved for our clients, for the people of this province.

You know, I would say that first of all, the work that the commissioner did was extensive, but it also was done in a way that would help to provide a framework and a road map for the province, not in a single year or a two-year picture, but we're looking more at a 10-year time frame to roll out some initiatives over that time.

I would say that as with any, you know, any decisions that we have to make in trying to put together a budget, there is always competing priorities. I think this year, as we've mentioned often, this was probably a more difficult year to accomplish that. I would also mention that there are a number of ongoing initiatives that the commissioner had noted in her report around continuing to do the work that we're doing, and that we're seeing in reducing wait times for mental health and addictions services, improving responses in the emergency departments for individuals with mental health and addictions issues.

Certainly there is a collaboration that is ongoing through government working with other health, other human service organizations, ministries, around anti-bullying strategy, early learning strategy. Certainly we see regions working closely with other stakeholders in things like the Hub and COR [centre of responsibility] model for at-risk people. This budget did include dollars, not only to continue with the police and crisis teams in Saskatoon, but to expand that program into Regina. And I know that that certainly has been a program that, through the successes in Saskatoon, that indicated that it was being seen as a successful program. That's why we wanted to launch that into Regina this year.

So you know, I would say that while the commissioner may not have been named specifically in the budget or in the budget speech, certainly the work that she has done is guiding us in this year and will guide us over the next decade when it comes to mental health and addictions for the province.

Ms. Chartier: — In terms of guiding you this year, when we talk about new initiatives and things that came out of the report, obviously there was not, like there wasn't anything around mental health. But we have quite an abysmal record here in Saskatchewan. But in terms of, you've talked about the PACT [police and crisis team] team in Saskatoon, which is basically one police officer and one mental health worker. So are you saying the new initiative, the one new initiative, will that be the same model in Regina then, one police officer and one mental health worker over the course of . . . It's only one police officer and one mental health worker working with each other at any given time. Is that the only new initiative around mental health coming out of her report?

Hon. Mr. Duncan: — Thank you for the question. In terms of what Regina's going to do, working with the police services here in Regina, it will be similar to what has been operating out of Saskatoon. That's not to say it will be identical. They may have, between the health region and the Regina city police, they may have some different ideas compared to what Saskatoon is currently operating. But you know, it is I think something that has seen some success in Saskatoon, and certainly we want to see it be successful here in the city of Regina as well.

Ms. Chartier: — Thank you. What was the total cost of the mental health review? If that's going to be a couple of minutes, I'll just make a note that we'll come back to that. But also I'm wondering how many people participated in it, so both in terms of individuals who in the online . . . individuals and stakeholder organizations.

Hon. Mr. Duncan: — So we're just trying to find the amount in terms of what was spent on conducting the commission. In terms of the number of stakeholders, both individuals and organizations, we will find that as well. There was a time not that long ago where I could come up with some of those numbers off the top of my head.

But I know in terms of the individual responses that we had from people that took part in the online survey, I think I've mentioned this before in the past, that we did a similar type of survey process through Tony Dagnone's review of the health care system back in 2008-2009. We did have more people responding to the online survey through the mental health and addictions review than we actually did for the entire health care system review. But we'll be able to find those. We'll provide those numbers when we get them.

Ms. Chartier: — I just think it's important to point out that the PACT team is great, but one of the things around mental health is the need for community services. So you might intervene and keep someone out of the emergency room, but if you don't have the support services to support them after that point, it's a huge problem. So you intervene, but what are you intervening to?

So I have to say I was incredibly disappointed in the budget. We had a long conversation last year about housing and some work that had already been done by your government several years ago in residential housing. And so I'm wondering, you'd

talked about, in conjunction with the development of the North Battleford hospital, were there any discussions about . . . Housing was one of her recommendations, supportive housing, and I, from speaking to people, that was something that came out loud and clear. Obviously there were many recommendations, but that supported housing piece was imperative, and there's nothing on it. And I'm looking at our notes and our discussion last year and you said, hang tight for this review. And there's nothing in this budget.

Hon. Mr. Duncan: — Yes, again I would just point to the fact that what we were looking for from Dr. Stockdale Winder, and what I think she did a good job in providing, is looking at what was working well in the province and some of the gaps that did exist in the province. I think she notes in her report and commends the work that's being done by the ministry as well as a number of our health regions in trying to reduce our wait times for accessing services.

You know, we were able to make a commitment to expand the police and crisis teams to the city of Regina. Certainly we've talked about the housing aspect, about that in the past and how that could be a complementary service to the Saskatchewan Hospital at North Battleford redevelopment.

You know, I guess I would just say to the committee, I would leave with the committee that, you know, we haven't moved away from the concept of the residential support. Unfortunately we weren't able to move ahead with it in this budget but, you know, we've tried to make that balance in terms of providing some additional support to our emergency department waits because we do know that a number of individuals, that's their interaction with the health system when it's looking for mental health services. We see a commitment and I see a commitment from our health regions, from leadership in our health regions to continue to reduce the wait times both on the in-patient and the outpatient mental health services.

I know that Regina Qu'Appelle Health Region has done a tremendous job in ensuring that people that are being discharged from in-patient mental health services are getting appropriate follow-up care immediately after they're discharged, and that follow-up care does take place over a number of weeks, several weeks.

You know, I guess I would just go back to . . . It's not lost on me, all the things that have been recommended by the commissioner. Certainly this is an area that I'm very interested in and have a personal interest in. There are areas that she pointed out that frankly we were not able to move on this year. But it wasn't my expectation . . . You know, I made sure that cabinet and the government knew that this wasn't a one-year report, that we were going to have to make improvements over a number of years, and that's why we look at this as a 10-year plan.

Ms. Chartier: — Sorry, a 10-year plan that doesn't start yet for another year at least. Do you have the numbers?

[14:00]

Hon. Mr. Duncan: — Just to maybe jump back a little bit, so the commission itself, the commission itself cost $800,000 to conduct. There were 150 meetings that did take place through that. Much of that was face-to-face meetings. Some of that was using different technology. Over 4,000 individuals responded to the online survey portal.

I guess I would just maybe not agree with your premise, Ms. Chartier. I think that there is, obviously there's a lot of great initiatives that are outlined in the commissioner's report, and I think if people would look through the commissioner's report, there is a great deal of commendation in terms of what work is being done to make improvements in the system. Certainly I took the position that we didn't want to just wait until the commissioner had reported her work. I'm very encouraged by the work that regions have been doing to try to reduce some of our waits that we do have for people that are waiting for mental health and addictions services.

We did provide funding in last year's budget for a hot-spotting pilot, and I know that Saskatoon has started to . . . They've identified some of their first clients that will be a part of that program, and many of them have a history of being clients of the mental health and addictions services. So, you know, I think while one of the bigger items in that report was a residential piece, I wouldn't agree with the characterization that we are not starting to action the work of the commissioner until next year. I think that that work had already begun during her work but does begin in this budget as well.

Ms. Chartier: — Do you think those 4,000 people who participated in the review would agree with that?

Hon. Mr. Duncan: — Well I can't speak for 4,000 people, but I think that what has been shared with me by a number of people that I've had an opportunity to talk with is a recognition that the government takes this seriously, a recognition that we were among the last provinces, if not the last province without a mental health and addictions plan for our province. And so I think that there has been a recognition that, through the substantial redevelopment of the Saskatchewan Hospital at North Battleford, well over I believe now . . . Well it is over a 100-year-old building because I attended the anniversary I believe it was last year.

Through the commitment that the government has made to moving that project forward as well as to having a commissioner, having a plan, and being able to give people an idea of what the direction of the government is in making these improvements, I would be the first to say to those 4,000 people that this wasn't going to happen overnight. It wasn't going to happen in one budget year, but certainly we have a road map of where we want to make improvements in the system and where we want to improve the services that we do provide to people.

Ms. Chartier: — I would contend from all the people that I've spoken to in the mental health and addictions community that they feel like nothing has been advanced in this budget, so they feel like this report will end up sitting on a shelf, as many reports do, which is incredibly disheartening. I mean these are people who work in this area but also happen to have lived experience with mental health and addictions services. But we'll move on from here. Thank you for those numbers.

I'm wondering if you can explain to me, I'm just looking at a

project consulting for medical claims modernization initiative, competition for a contract. I just have a few questions about it. Can you explain to me what an advance contract award notice is?

Hon. Mr. Duncan: — It's a process to determine whether or not there is any interest from potential vendors before deciding to go towards a request for proposals.

Ms. Chartier: — There's this particular one that I'm looking at. As I said it's titled, project consulting for medical claims modernization initiative — HEA-DPEBB001, and it was opened on December 18th and it closed on January 5th of 2015. Can you explain in particular what that one is about?

Mr. Hendricks: — Max Hendricks, deputy minister of Health. One of the challenges that we do have within the ministry is that our medical care insurance processing system is built on a 1962 platform. It's supported by a language, COBOL [common business oriented language], that really isn't used anymore. As part of, you know, in terms of trying to improve service and turnaround time but also to ensure the stability of the system, we began some work to look at modernization in claims processing, not only in our medical care insurance branch claims but to integrate that with our drug plan claims.

As part of our work, we engaged Deloitte to do some work with us, to look at scoping that project to see what it would look like, what the best alternatives were worth, what was the business case, you know, in terms of rebuilding that system. And so we've done some preliminary work on that, but at this point we're kind of debating about where it should go in the future.

Ms. Chartier: — So Deloitte expressed some interest? Or forgive my ignorance here. Was that contract awarded?

Mr. Hendricks: — Deloitte did have the contract for the initial work which was basically the scoping work. We've not continued or awarded any additional contracts on this project because of fiscal restraint.

Ms. Chartier: — Okay. So Deloitte did the initial work and then you posted this competition?

Mr. Hendricks: — For a part-time resource, yes.

Ms. Chartier: — And did you get any potential bidders or takers?

Mr. Hendricks: — We discontinued the ACAN [advanced contract award notice]. We didn't actually source it. We didn't give it to anybody.

Ms. Chartier: — Can I ask you why you would do it over the Christmas, over the December 18th to January 5th break? From talking to people who work in different regions, I've been told that that's a highly unusual practice to run anything over, a competition over Christmas.

Mr. Hendricks: — I don't believe there was anything intentional or untoward about it. It was probably just the timing and sequencing of the project. But at the end of the day, the contract wasn't awarded. It was cancelled because of fiscal restraint.

Ms. Chartier: — Okay. Thank you. All right. I think this will be a bit of a broader, this will be an open-ended discussion here with some numbers that I'm looking for as well. I know, Minister Duncan, in the House you've talked about a 40 per cent increase in LPNs [licensed practical nurse], the 11 per cent increase in CCAs [continuing care assistant], and the 6 per cent increase in RNs [registered nurse]. I'm wondering, I'm just trying to get a handle on what those numbers mean in terms of numbers of those respective professions and what time frame.

Hon. Mr. Duncan: — Using 2006-2007 as a starting date, and the most recent numbers that we'd have would be for 2013-14, the number of CCA full-time equivalents — this is in long-term care and our integrated facilities, say like in a smaller rural community where it's a joint facility — CCAs, 4,487 full-time equivalents in '06-07. In '13-14 that's 4,981. That's the 11 per cent increase. LPNs, 521, and in '13-14 it was 730 which is 40 per cent increase. And for RNs, 1,211 and that is now 1,289 which is a 6.3 per cent increase. When you combine all of those FTEs [full-time equivalent] together, overall it's a 13 per cent increase.

Ms. Chartier: — Okay. And that's just in long-term care and integrated facilities.

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Okay. Wondering in terms of sort of the breakdown across the province, not just in long-term care and integrated facilities, but do you have a number of how many care aids there are working in the province right now?

Hon. Mr. Duncan: — Ms. Chartier, because the CCAs primarily work in long-term care, the numbers that I gave you would be the majority of CCAs. The breakdown, we wouldn't have a breakdown further than that outside of long-term care. We could endeavour to provide that to you. We have an overall list, but it's based on the different provider groups, depending on which region you work in. So it gets more difficult then, today, to discern whether or not that's in long-term care or if that's in another part of the health system. So we could . . .

Ms. Chartier: — Regionally you can provide that though?

A Member: — It can be broken down in a variety of different ways.

Ms. Chartier: — And you know, I don't need it broken . . . I'm looking for an overall number of CCAs, LPNs, and RNs practising in the province here today.

Hon. Mr. Duncan: — So I can provide that for the nursing profession. The CCA profession, we'll have to provide that at another time. So RNs went from 9,049 to 10,864. That's an 1,815 difference. Registered psychiatric nurses went from 914 down to 893. That's a decrease of 21. LPNs went from 2,558 to 3,287, so a 729 increase. And registered nurses . . . Sorry, nurse practitioners is up from 102 to 178, so a 76 increase. Overall that's a 2,599 increase in total of all the nursing professions.

Ms. Chartier: — Okay. And so just making sure that I've got

the right comparators, 2006-07 was the start, and 2013-2014 was the . . . so those are the right years?

Hon. Mr. Duncan: — I think these are more on the calendar year. I think these are probably the numbers from the nursing profession that may not be on a fiscal calendar but a calendar year, as a regulatory body. So these would be 2007 as the start date, and 2013 as the end date that I gave you.

Ms. Chartier: — Thank you for that. In terms of breaking down the numbers, you'd given me the number of care aids who are working in long-term care and integrated care facilities. How many of those are permanent full-time positions?

Hon. Mr. Duncan: — We will ask for a head count. That's what you're looking for. The number that I'm giving you is a full-time equivalent, so that doesn't break, it doesn't determine between full- and part-time. It just lumps them together to create a full-time equivalent position. So the number I've been using is a full-time equivalent, but we would have to provide you and the committee with an actual head count that we could then break down into full- and part-time positions.

[14:15]

Ms. Chartier: — Okay. I'm really trying to wrap my head around this because I know you've given numbers and you've said the complement in long-term care has stayed the same, although I know acuity level in long-term care has risen in recent years. But honestly, what your numbers and what you're saying don't match with what I'm hearing from folks who both work in long-term care and who experience long-term care. So I really, really am trying to wrap my head around all of this.

And we talked today about Providence Place in Moose Jaw, and Mr. Broten in the House had referenced a letter that he had gotten from an RN in Moose Jaw. I wouldn't mind reading this letter into the record and maybe have a discussion, because I really can't wrap my head around there being more staff and seeing what is happening. So I'd like to have a bit of that discussion here.

So this letter from an anonymous RN, and she explains, she says:

> Dear Mr. Broten,
>
> In light of the recent news release in regards to the death of the patient at Providence Place, Moose Jaw, I'd like to enlighten you on what we encounter on a regular basis. I've been a staff member at this facility for many years. In the past, this building had a wonderful reputation and people wanted a position in this facility [and then there's ampersand — I can show you this letter at some point]. Never in my work career at Providence have I encountered such an understaffing or replacement of staff with other staff not within the same professional range. Registered nurses are being replaced with LPNs or continuing care aids on a daily basis. LPNs are also being replaced with continuing care aids. Staff are being pulled from units to work on units they have never been oriented to. Overtime is a common practice.
>
> The most common problem we are now encountering involves hiring untrained people off the street to provide care with the understanding they will pursue a CCA course within the next two years. This has resulted in a person with no experience or training looking after as many as 32 residents alone or, on the geriatric rehab and assessment unit, looking after up to 14 patients that can be subacute, alone. This is a recipe for disaster. Staff are overworked, and most recently registered nurses and registered psychiatric nurses were informed no holiday time would be approved for the next year due to staffing shortages.
>
> Residents and patients often have to wait long periods of time for care, or needs are prioritized on what can be done that day and what will wait for another day, such as tub baths, vital signs.
>
> On the GARU, staffing levels have dramatically decreased. It is a common practice for one CCA to be left alone for up to four hours, looking after up to 14 patients at a time. Many of these patients may be new strokes, dementia, or post-operative hip or knee surgeries.
>
> [It goes on to say] For the government to say that the below statement is hard to believe, it is true. "The provincial government said funding to the facility has increased by 46 per cent since 2007. Staffing has increased by 9 per cent." As we, the front-line workers, have not witnessed this, the only change we have seen in the past few years is a four-hour LPN position added on the evening shift in long-term care. This was accomplished by pulling the LPN from the geriatric assessment unit, replacing her with a CCA pulled from Maguire Centre, leaving both units not staffed appropriately.
>
> Many of us that are nurses have said that it will take an incident such as this to make management realize the crisis we are facing at Providence, and what a tragic way for them to realize this.
>
> Due to the fear of retaliation by management, I prefer to remain anonymous in regards to the above matters. In the past, those who have spoken out have lost their jobs. Job workplace bullying by management seems a common practice at our facility in regards to not speaking out about the present problems the building is having.
>
> Thank you to yourself and Eunice Blanchard for bring this sensitive subject to the forefront.

So we have this letter. I have another note from someone who points out, and you've cited payroll numbers . . . Sorry to read that whole thing into the record, but these are these things that I hear on a regular basis. Some people are willing to come forward and others are uncomfortable. These come in the form of letters, emails, and phone calls. This is not a one-off experience. I have another phone call from Providence Place where someone alleges that your numbers are baloney, was the exact quote, because people leave positions and are rehired as part-time or casual, often refusing offered work because of their work environment.

I'm trying to get a handle on . . . So you've got these full-time

equivalent positions. Does that, if you've got a full-time equivalent position, does that mean that that position is . . . And you said it was based on payroll. Help me understand this. Does that mean that that position is definitely staffed?

Hon. Mr. Duncan: — Thank you. And I just want to say, while we were trying to prepare for the answer, it wasn't that I wasn't listening to you read that. I have a copy in front in me, so I'm familiar with the letter. And I appreciate the opportunity to be able to respond to this.

So in terms of the staffing levels and the increases that we've seen, I can tell you in Providence Place, and this is based on payroll, so this is based on payroll data so it's . . .

Ms. Chartier: — So when you say based on, and you've said that in the House — I don't mean to interrupt there — but you've said that same term, it's based on payroll data. So when you say it's based on payroll data, what does that mean?

Hon. Mr. Duncan: — It's based on paid hours.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — So in Providence Place, the full-time equivalents for RNs has not changed, in fact it fluctuated a little bit, back in 2011, 2012. So it was about 25 full-time equivalents back in '06-07. Today it's, or in '13-14 based on the data, it was 25.42. So very small change. It had increased up to 27, 28, came back down.

LPNs, the starting year was 6.94. In the last year that we have information, it's 7.91. And the CCAs was 85.17 full-time equivalents, and last year it was 94.81. So that's where the nine, little over 9 per cent increase comes from. And that again, that's based on hours that are paid hours.

With respect to, I think some of the other comments that have been made, I can provide and elaborate on some information. So the facility, in terms of a care aid being responsible for 32 residents, the facility, they've shared information with the ministry that, supported by their nursing team and their staffing model, that they never provide for a 1 and 32 ratio. So they disagree with that assertion.

They've also been able to provide us with information as it relates to, and I think I shared this in the House, so the concern was raised in question period yesterday about a deliberate strategy of short-staffing by not filling shifts. So in the three months from January to the end of March 2015 there were 8,365 shifts that were scheduled at the facility. Only 46 of those shifts went unfilled, so that's 0.54 per cent of shifts that went unfilled. In part those were nursing, on the nursing side, but that also did include environmental as well as nutrition. So that wasn't just straight on the front-line nursing side.

As well there was an assertion about — in the letter and if I can find it here — about, I think it was about excessive use of overtime. Sorry I didn't make a note in here. I thought it was highlighted but it wasn't. Overtime is common practice. According to the information of the 8,365 shifts in the last three months, 165 of those were filled by somebody that was in an overtime position. So less than 2 per cent of shifts were filled using overtime.

Ms. Chartier: — Why do you think staff are coming forward and . . . So we have this issue of Providence Place where we heard 1 and 32 in this letter. We have Oliver Lodge where we have someone who came forward on Monday who had said he's left alone with dementia patients to the tune of 1 and 32 at night. I've toured long-term care facilities where at night there are two CCAs for 55 residents and an LPN who's in charge of. obviously, paperwork and meds, those kinds of things. Why do you think, like why do you think this is happening?

Hon. Mr. Duncan: — Well I can't speak on, I can't really speak on, you know, why individuals want to come forward. I don't have a problem with that. I think Minister Ottenbreit has mentioned to me that you've met with the gentleman the other day from Oliver Lodge, and I think the ratio that he was talking about didn't necessarily match up with the ratio that was in the public. I think it was more of 1 to 22 was the ratio that he had used, so it wasn't . . .

Ms. Chartier: — Just to interrupt though, he said there was a period during a shift that it was 1 to 32 for a couple hour period. So the shift on paper is something different than he says happens in practice.

Hon. Mr. Duncan: — Okay, and fair enough; I'm just relaying in terms of what was shared with Minister Ottenbreit at the meeting.

But again in that case in Oliver Lodge, you know, I can say that in terms of the staff increase in that facility, while we have allowed for a significant expansion in the number of beds at Oliver Lodge, in 2010-2011 I think you'll recall or you'll know that government provided funding for 63 additional beds in that facility. So in that one facility, as an example, government or the expenditures of that facility are up 126 per cent in seven years. The beds are up 63, yes, so that means that there are a little over 50 per cent increase in the number of residents. But the total number of staff increases was double the number of resident increase. So . . .

Ms. Chartier: — Can I just . . . Wasn't — I'm sorry; sorry, I just want to jump in here — but wasn't that, those increase in beds, wasn't that the development of the dementia unit? Or am I mistaken about that? So you'd think that there would be increased . . .

Hon. Mr. Duncan: — No, this was 63 beds. We'll try to find exactly if there were a number of those that were dedicated for dementia patients, residents with dementia. But my understanding is that this was just a general increase in the overall number of beds of 63. I don't believe it was a dementia unit. Certainly it wouldn't have been a dementia unit of 63 beds that were added.

Ms. Chartier: — I'm again, a little baffled. I had a constituent come into my office two days ago to get help with her GIS [Guaranteed Income Supplement]. Her husband has moved into Oliver Lodge, and they are in the process of separating their finances to make that work. But she's at Oliver Lodge three times a day to feed her husband, who's had a stroke because he needs help, and she's noticed the staff aren't . . . don't have the

time to be able to do that.

So you can cite numbers, and you have cited small increases. I mean when you look at sort of number-over-number increases, they're not huge. But I'm wondering what you would attribute to these issues that are coming forward, and not because staff are grumpy but people are concerned, like genuinely concerned whether it's families or staff, and staff who are worried about losing their jobs but are willing to come forward.

As the Minister of Health and responsible for long-term care here, you can cite numbers, but does that not set off some serious red flags for you?

Hon. Mr. Duncan: — Well as I've said in the past, this is an area that is, I think the record of this government, we've demonstrated that this is an area of priority. Have we addressed all of the issues or all of the problems within long-term care, or even those issues that we need to address for older adults in our population that aren't in long-term care? No, I would say that work, there is still work that needs to be done.

But I will say this, and I will maybe just correct myself and perhaps correct you as well, Ms. Chartier. The number of beds in this province have remained relatively stable over the last seven years. And I know in terms of redevelopment, I've talked a little bit about the 13 rural, mainly rural long-term care facilities, as well as a couple of other additional facilities that we are working on, in large part they haven't been a . . . I'll talk about the experience in Radville, which is close to my hometown.

So Radville had an aging facility. The number of beds that were opened in the new facility, and this was with community consultation and it was based on demographics of the area, but it actually saw a slight decrease in the number of beds in that facility. So what has actually happened despite some record development when it comes to long-term care facilities, we're actually about 100 beds less than we were when the government changed in 2007.

So my position has been that what we have done over the last number of years is we have added and . . . it's based on payroll but it is full-time equivalents, people that we're actually paying, whether they work full-time or part-time, but we look at it as a full-time equivalent, up nearly 800 full-time equivalents to care for about 100 less residents. That's not to say that that fixes all the problems, but I think it shows that the government does take this, does take this issue very seriously.

In terms of the 1:32 ratio that has been bandied around, we would be nothing more than pleased to look into where that would have happened, those types of situations. I think that, you know, one thing that is a possibility of what happens is, in an evening shift, if somebody is saying that they're being left with 32 residents to care for themselves or a greater number than would be normal, you know, we would have to look in to see, what are their circumstances? What happens if a co-worker is sick and leaves halfway in their shift? If it's 4 in the morning and there's whatever number of hours left before the next shift starts, will they try to fill the shift? I'm sure they'll try to, but how realistic is it in such a short time frame to actually fill that?

So are there circumstances where that will happen? I'm sure there probably are. But if this is more of an ongoing issue then we would be more than happy to look into these types of serious situations.

[14:30]

Ms. Chartier: — And I think Peter came forward because it wasn't a one-off. But talking about an occasion where a staff member goes home and so you're short-shifted, are you familiar with the fact that . . . and this is what I've been told by CCAs, that shifts will get filled but only for a portion of the shift, if it's like four hours of a shift, not a full shift. So I'm wondering how that all shows up in payroll.

So when you say, when you say this is all based on payroll, on paid hours, there are occasions where I've heard repeatedly that people are only called in . . . someone calls in sick. They're burnt out. They're stressed or they are sick, sick with the flu, whatever it might be, but they're not replaced for their whole shift. Are you familiar with that happening?

Hon. Mr. Duncan: — So we will endeavour to provide you with additional information but certainly our facilities and our regions, we have to follow labour law. You know, we can't just call somebody in for an hour and pay them for an hour. There's certain labour legislation that would apply to how many hours somebody will be paid for. As well as within the collective bargaining agreements, there are provisions within the agreements in terms of if there's some premium time that is paid based on the hour of when somebody is called in or other extenuating circumstances. So our numbers are based on straight time pay. We'll try to provide you with some additional information if we can and kind of pull out what exactly, kind of tease out what that looks like, but it's based on paid hours. It's based on straight time pay.

Ms. Chartier: — Okay. Yes I think I need to sort of ponder all of that and mull that over here but I think I'll come back there in a little bit or next time once I look at my notes here again.

So still keeping with long-term care, with respect to the Urgent Issues Action Fund, I know that looking at the initial news release that went out on October 1st, 2013, one of the things you were doing was requiring a 60-day, a 90-day, and 120-day report directly to the minister on the outcomes achieved in facilities that received money through the Urgent Issues Action Fund. Obviously we're well past those time frames. I'm wondering if you could give me an update on the $10 million and how and where that's flowed and what's still remaining.

Hon. Mr. Duncan: — Thank you for the question. Perhaps if I could maybe just jump back, just to add a little bit more information. I know in the letter that was written by the nurse with respect to Providence Place, it talked about hiring of untrained people off the street with the understanding that they could do a CCA course within the next two years. So just for the committee's information, that is not a new change, so that's something that has been in place for some time.

In 2008 there were three additional programs that were added so that we now have four different programs that somebody could choose from. But there always was a component that somebody

could, they could start work if they made a commitment that they were going to continue or finish the program within a two-year time frame. So I know that that was a concern that was raised, but that's not a new change. We haven't made a change that this would be a result of.

Ms. Chartier: — And I'm familiar with that, having spoken to long-term care facilities in rural Saskatchewan who've said it's incredibly hard sometimes to find CCAs. But the red flag that jumps up or stands up for me there is that maybe that's . . . If you've got one or two untrained CCAs per shift or when all your staff is untrained or hasn't finished their schooling, and that might be a problem then. So if that's what regions are relying on more and more often, that could be a problem even though it's not a change. And I know recruitment and retention can be a very difficult issue because of stress and workload, and that's what I'm hearing so . . .

Hon. Mr. Duncan: — So with respect to your question on the Urgent Issues Action Fund and our update, so the information . . . This is as of December 31st, 2014. So when we have additional information from the first quarter of this year, I'll be happy to provide that. So as of December 31st, 2014, if you'll remember the 10.04 million to RHAs [regional health authority], 9.3 million of that was one-time funding with . . . the rest was related to some ongoing dollars.

So of the 9.3 million in one-time funding, 7.2 million of that had been spent by December 31st, 2014, and I'll maybe just briefly provide the committee with some information. So as of that date, there were about 700 pieces of equipment that were identified for purchase through the fund. As of December 31st, approximately 680 pieces of equipment had been received. The remainder had been ordered and we expected that they would be received within the next several months. So I suspect that when we get an update further to this that there will be very little outstanding in terms of equipment that has yet to be received by the health regions.

Ms. Chartier: — Then does received mean installed, or does received mean received?

Hon. Mr. Duncan: — No, received. I'll maybe go a little bit further into what that looks like. So six of the RHAs had targeted funding for staff training as it relates to gentle persuasion approach. So they are currently implementing some education sessions and they continue to train staff throughout the year.

And I'll maybe just . . . In the Athabasca Health Authority, electrical upgrades to link the tub room to the backup generator have been implemented, as well as they have fall prevention sensors, alternating pressure mattresses, mechanical lifts, slings. They've been purchased and are being used as needed. So the funds that they received, as of December 31st, they didn't have any funds remaining to be received from the ministry.

The majority of Cypress funds had been received and spent by December 31st, so this was filling a temporary recreation coordinator and long-term care facilitator position. I know that that was one area that they wanted to ensure that they were able to offer some weekend recreational programming in their facilities, as well as they have something that is called a dementia walk virtual program and that's being developed, is being provided to their staff.

Five Hills Health Region, 11 bathtubs have been replaced and five track lifts with scales have been installed, and that's the majority of their dollars.

Heartland Health Region, they're one of the regions with the gentle persuasion approach training. So that training continues and they also had dollars to purchase electric beds, wheelchair cushions, pressure support mattresses, sit stand lifts. Those have been purchased and are being used as needed. So the majority of Heartland dollars had been spent by December 31st.

Keewatin Yatthé, their vital signs machine and stethoscope has been purchased and it's being used as well as part of . . . The other concern that we have addressed in the funding was that the facility at La Loche didn't have an outdoor space for the residents and so a little I guess a gazebo, so to speak, was being constructed to give them some outdoor space. That was what was requested by the residents and their families. So most of that has been already finished. There may be some construction that has to wait until the weather changes. I'm not sure on that but I could find out.

Kelsey Trail, gentle persuasion approach training is being provided. New lifts, tubs, and slings have been purchased and are being used, as well as their weekend recreational programming. They've enhanced their weekend recreational programming in all of their facilities. So as of December 31st, they were to receive about . . . They have spent almost $400,000, and they have about 150,000 remaining.

Mamawetan Churchill River, I guess the issue that we tried to address with their funding was with the background of the residents. There was a desire to have more traditional food, a special on special occasions, and so they've incorporated that into some special occasions, having some more traditional food for the residents that live in that facility.

I'll quickly go through the list here. So Prairie North Health Region, they've spent about $400,000, a little over 400. As of December 31st, they had about 100,000 remaining. So they are one of the regions doing gentle persuasion approach, so that continues. Mechanical lifts, slings, mattresses, fall prevention alarms, and mats have been purchased, and they are being used. And there was a capital improvement at Jubilee Home, and that was around replacing some windows, doing some painting and some restoration in the home, and that work has been completed.

Prince Albert Parkland, they requested funding to provide some training in the Eden Alternative. So that training is being provided to staff. There has also been some training provided to their staff when it comes to First Nations language and culture based on their resident population, and 51 rooms have been equipped with ceiling track lifts. So the majority of Prince Albert Parkland Health Region's dollars have been spent.

Regina Qu'Appelle is one of the gentle persuasion approach regions, and they are providing that to their staff. As well, they've had a temporary food service position that's been filled, and they are developing standard policies and procedures as it

relates to their food services at all of the LTC [long-term care] sites, and so that's under way as well. And I've had an opportunity to speak with a number of dietitians that work in the region that have been engaged by the region to do some work around menu planning and alternatives to food planning, and they were pretty pleased to be involved in that.

I believe Regina is doing, as well, purposeful rounding. They were one of the regions or the one region to do the purposeful rounding, and so that's under way as well. And I had an opportunity to speak with their VP [vice-president] about a week ago who indicated that they have a schedule of all the facilities as they roll out the purposeful rounding training.

Saskatoon received a little over $2.5 million. They've spent 2.2 of that as of December 31st. They have about 300,000 remaining. One hundred rooms have been equipped with ceiling track lifts, and 56 mechanical lifts have been purchased and are being used as needed.

Sun Country is implementing gentle persuasion approach. They also have new mattresses, sleep surfaces, bath slings, and food preparation equipment that has been purchased and being used. They also requested dollars for three facilities to have their nurse call systems upgraded, and so they have been upgraded. I believe Sun Country as well — it's not on the list here — but I believe that they were also going to be implementing some recreational programming on weekends in a couple of their facilities. And I'm just going off memory of reading it in the local newspaper. I might be wrong on that.

Sunrise, finally Sunrise, gentle persuasion approach is being provided to their staff, and ceiling lifts and food preparation equipment that they requested has been purchased and is being used in a number of their facilities. They've spent about $600,000 as of December 31st and have about 100,000 remaining. We should be . . . I'm hoping to get an update, more up to date. When we have that, we'll provide that, whether or not the committee's still sitting at that time or not. I'll talk to you about that.

Ms. Chartier: — Thank you. In that same news release of October 1st, 2013, you'd also committed to annual CEO [chief operating officer] visits to their respective long-term care facilities to provide updates to the minister on improvements. I'm wondering: has there been one of those annual visits to their respective facilities? Tell me what's come of that commitment please.

[14:45]

Hon. Mr. Duncan: — Thank you for the question. So the CEO tours of long-term care facilities will continue. We have sent a reminder out as of about a week and a half ago to the CEOs. And I will mention that just based on the volume, the number of facilities I think were 156. That's one number that I won't forget, 156 facilities across the province. The intent is to have the CEOs to tour the facilities, but in many cases it will be the CEO or a senior leader in the region, so a VP, other senior managers. So I don't want to leave the impression . . . While the concept is the CEOs will get out and meet with the residents and the staff, it's not going to be in every single case that CEO is going to see every single facility, but they do take part in these and they do work through their senior management, senior leadership to do these. We did send a reminder out of the 2015 tour, so our expectation is that they will complete those tours by the summer, and this will be the third year in a row that the CEOs and the senior leaders will be touring their facilities.

Ms. Chartier: — And what kind of reports do they provide you in terms of . . . Like is it a written report? How do you hear back from the CEOs with respect to what they're seeing and hearing?

Hon. Mr. Duncan: — The CEOs do report back to the ministry. They will look at a number of different areas as they tour, meet with residents and family members as well as staff and the administrators of the homes. They're looking at areas of resident and staff safety, resident comfort, care for residents with dementia, engaging residents and their families so, you know, how regularly are we seeing the resident family council meetings taking place? What are the results? What is the feedback that you're receiving from residents and families? They look at menu quality and selection, transportation, recreational activities of the residents. What they will also do is . . . And through those broad areas they will be asking questions about what is working well, what isn't maybe working as well and then that information is then used. We'll essentially go back to them, especially in the areas that aren't working so well. What are the plans to make improvements in those areas?

Ms. Chartier: — What kind of things are you hearing back? So if this is the third year, obviously we know what happened in the first year. How have things changed since that first year?

Hon. Mr. Duncan: — Based on the previous tours including the 2014 tours, you know, the reports that we received back . . . especially in light of the investments that were made through the Urgent Issues Action Fund, 2014 would have been the first real year to, I think, get a sense of some of the improvements.

So certainly there will have been noticeable improvements, both by residents and staff and resident family members now seeing things like the mechanical lifts and the slings and fall prevention monitors, the electric beds, the nurse call systems, so those changes have been noticeable, as well as specific to resident comfort — replacing of a number of mattresses, and purchasing pressure ulcer prevention mattresses, wheelchair cushions — as well, what has been noted as some quality improvement activities related to staff training as it relates to preventing pressure ulcers.

There has also been notes made, or notes . . . It's been noted that improvements have been made, particularly through the Urgent Issues Action Fund, for those regions that have received the gentle persuasion approach. I think it's about six regions that I mentioned. So the training has enhanced the staff's ability to respond in a compassionate way for those people, especially in those challenging circumstances.

What has been I think noted by all the regions is the improvements in engaging family and residents, so knowing that we do have regular family, resident family council meetings, that we do seek that feedback through the surveys and focus groups, and have very engaged families.

Further work does remain on . . . although there has been identified some gains that have been made with respect to menu quality and selection. There were some action plans being put in place back in 2014 that include some dietary audits, some meal experience surveys so, you know, we'll be looking forward to having that information.

I think it's interesting what you hear out of these types of reports, everything from . . . While we were able to expand on some of the weekend recreational programming in some facilities, obviously that's not going to be everywhere. You know, there still is an interest to see some of that expand further as well as ensuring that there is some . . . You know, I think that there is interest from residents and their family members to, depending on where you live, community group visits to your facility. That happens a lot. But, you know, it's all around that issue of trying to relieve the boredom and loneliness that can be present in long-term care facilities.

Things like staff name tags, that's been something that's been identified. There have been improvements made to ensure that residents and their family members know who the staff are. As well as — I think that's been raised before, I think — one of the challenges that we do have in long-term care is ensuring that residents and their family members, as much as possible, have some consistency when it comes to staff members, those people that are interacting with them on a daily basis.

I know — this is just anecdotal — but I know that in some cases a resident will have a particularly good relationship with one or two staff members. And you know, it's important, if possible, for that facility to ensure that, as much as possible, especially for personal hygiene, that if that connection can remain, that's certainly very important. So those are some of the themes that we do here.

Ms. Chartier: — Are they written reports?

Hon. Mr. Duncan: — Yes, what we do is we essentially give a template for the CEO, so basically the date of the visit, who attended on the visit, what facility that they attended obviously — that's important — who else from the RHA was present, and then just a series of I guess prompting questions about, what did you hear on the tour? Who did you interact with? What are the things that were seen to be working well? What were the things that weren't seen to be working well?

Ms. Chartier: — Obviously that first CEO tour highlighted, sort of across Saskatchewan, staffing issues, people being left on toilets, people not being able to be fed, those kinds of things. So I'm wondering if these reports are as detailed as that initial CEO report.

Hon. Mr. Duncan: — I think just in a general sense I would say that they are detailed reports for as much as you can in a very short kind of, you know, just a couple of lines here for improvements and areas of concern. I think where the 2014 reports would differ from the 2013 reports is that because a lot of the Urgent Issues Action Fund dollars would have been in the hands of regions and some of it would have been spent by that time, I think that the 2014 reports would have obviously highlighted some of the changes that would have taken place through the $10 million Urgent Issues Action Fund that obviously wouldn't have been in place in 2013.

Ms. Chartier: — The 2014 report, obviously I haven't seen it, but I'm wondering if there were some of the same concerns highlighted. Obviously the money that flowed wasn't an instant fix and was, by some measures, a drop in the bucket when you look at what the requests actually were. But I'm wondering if some of those more serious concerns that were highlighted around staffing were highlighted in 2014 as well.

Hon. Mr. Duncan: — I think it'd be fair to say that some of the issues that were identified in 2013 wouldn't . . . You're right. I mean the $10 million Urgent Issues Action Fund wasn't, you know, I wasn't under any illusions that it was going to make all the issues go away or correct all the problems that are in long-term care.

You know, the 2014 report and survey would indicate issues, in some cases around staffing, would indicate the challenges that present themselves just in dealing with some aging infrastructure. You know, certainly there's a great deal of demand for renewing infrastructure across the province, and long-term care would not be any different. And I think, you know, the VFA [Vanderwiel Facility Assessors] report, we've talked about that in the past, that would certainly speak to that. So there would be some of those issues that would still be present in 2014 that we would've seen in 2013.

Ms. Chartier: — Would it be possible to get those . . . Sorry, did every region file a report with you?

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

Ms. Chartier: — Would it be possible for you to table those reports with the committee?

Hon. Mr. Duncan: — Yes, we'll be able to provide that information to the committee. The deputy minister's just going to follow up on one of my answers.

Mr. Hendricks: — Yes, in terms of the work that's going on in long-term care homes and the CEO reports, in addition to the Urgent Issues Action Fund, we have been actually implementing things like daily visual management in our long-term care homes. This is where staff get together and they actually look at how they're improving care. They measure improvements to care, and they're doing so on things, looking at things about . . . or looking at safe and timely, faster medication distribution, whether patients were developing pressure ulcers, looking at whether there are care plans in place for high-risk patients and then the usual things — the number of falls in a long-term care home, the use of restraints, that sort of thing.

So if you visit a long-term care home today, staff will gather at a wall on a regular basis and will actually look at these measures. And if they don't see it improving, they are to take corrective action plans to make sure that they are actually providing care. And I think that's one of the issues is that it wasn't universal before that we were necessarily tracking the care that was provided at each individual care home. And so we see that as a definite improvement as well in terms of the care that seniors are being provided. And probably there's still more

work to do for sure.

Ms. Chartier: — It is possible though to get those reports tabled with the committee?

Hon. Mr. Duncan: — We'll provide those reports. We'll make sure that if there's any personal information, we'll want to make sure we redact that. I think we've done that in the past.

Ms. Chartier: — Yes, okay. No, fair enough. Would it be possible to have those — I'm sure that they're probably in one of your binders there — would it be possible to have them tabled today? Or obviously if you have to redact, possibly at, well at the next committee?

Hon. Mr. Duncan: — Despite the fact that we have reams and reams of paper and binders and briefcases, we don't have them here today. But we'll provide them.

[15:00]

Ms. Chartier: — Okay, thank you for that. That's hard to believe, all those binders. Anyway, with respect to the purposeful hourly rounding and the $1 million, I know how I've . . . Obviously you rolled that out or have been rolling out, rolling it out in Regina. Can you tell me how that, the $1 million of purposeful hourly rounding money, will make it into every health region?

Hon. Mr. Duncan: — So the $1 million that is in the '15-16 Health budget for purposeful hourly rounding . . . so I'll maybe just provide a little bit of, if I could provide a little bit of context for you. So the goal of rounding, the purposeful rounding initiative is to ensure that caregiver interacts with the resident in a meaningful, purposeful way every hour while they're awake. Each long-term care facility begins by observing current resident-staff interactions. Front-line staff then design a strategy specific to the needs of those residents. This is the practice of regularly checking on the residents' needs using the four Ps: positioning, personal needs, pain, and proximity of personal items such as a call light, with the promised return in a prescribed amount of time.

Purposeful rounding has been adopted to help improve resident satisfaction. It also has an impact on patient safety, quality outcomes, workflow efficiency improvement, and staff satisfaction.

So it's $1 million in this year's budget, but it is annualized. So this isn't just kind of one training and we're done; this would be ongoing, especially as we know that there's turnover in staff in long-term care.

So I'll maybe walk through a little bit of . . . I'll give you some details on where that million dollars is going. So Cypress Health Region will receive $56,000; Five Hills, 60,000; Heartland, 58; Keewatin Yatthé, 3,000; Kelsey Trail, 54,000; Mamawetan, 2,000; Prairie North, 57,000 — and I'm just rounding them; they're not exact numbers — P.A. [Prince Albert] Parkland, 64,000; Regina Qu'Appelle, 216,000; Saskatoon, 250,000; Sun Country, 79,000; and Sunrise, 94,000.

So just further to hourly rounding, hourly intentional rounding enables patients not only to anticipate when next they will see their nurses or their care aids, but also to anticipate what interactions will occur during the rounds. So according to studies, hourly intentional rounding improves patient safety, so a reduction in patient falls and skin breakdown; improves patient satisfaction; reduces the number of call lights; and improves staff satisfaction.

So there was a study conducted in 2006, the Meade study in 2006. Hourly intentional rounding reduced the number of call lights by 38 per cent, patient falls reduced by 50 per cent, and patient satisfaction increased by a mean of 8.9 points on a 100-point scale. As well, there is something called the Studer Group estimated that a reduction in the number of call lights for non-urgent requests led to 166 hours of staff time saved per month.

Ms. Chartier: — So I'm curious then how . . . So it'll be for training every year to ensure staff know how and what they're supposed to be doing. Is that the gist of it? That you get around to see every resident, so that money going to each health region is to ensure staff is trained to know what they should be doing each hour?

Hon. Mr. Duncan: — So there is rounding that does take place now. This is different in that it's really more focused on these four areas. There's a process that is undertaken. But as well it's to provide the resident with the knowledge and the comfort that at a designated time somebody's going to be looking in on them. So you know, if I'm a resident and I don't know if the next care aid or the next nurse is going to come see me in an hour or four hours, you know, that can cause . . . especially if I'm bed-ridden or if I have limited mobility. So this is really more of a, as it is called, it's more of a purposeful type of rounding system.

Ms. Chartier: — So again though I'm just not quite sure how I understand what the money to health regions will be used for. It's training of all CCAs in each health region?

Hon. Mr. Duncan: — So the dollars will be used for the training, specific training around the four Ps, and kind of what the staff should be looking for during the purposeful rounding. It could also be used for if that training is going to require some of the staff to be away from the floor for backfilling some positions. So that's the intent of the dollars.

As I've mentioned before, because this has been in place in other jurisdictions, the evidence that's been gathered by, again I think I've referenced the Studer Group, but in the studies that they've done it's shown it reduced the number of call lights, reduced the number of complaints related to pain, increased employee satisfaction, increased staff productivity, increased nurse staff satisfaction and gave them more control over patient care, increased patient satisfaction. Residents were happier and feel staff were always accessible. Families were happier with the care. They reduced patient and family complaints, and issues could be resolved immediately.

Ms. Chartier: — Who will all be trained?

Hon. Mr. Duncan: — It'll be for all staff, so it'll be for the CCAs, the LPNs, the RNs.

Ms. Chartier: — So the goal is in every health region to have all staff in long-term care trained.

Hon. Mr. Duncan: — So the intent is that, as I said, this is annualized funding. So it's our intent that in this first year we'll have, about a third of our facilities will have this training. But the intent is that for all of our staff, that they would have this training in all of our facilities. But it will take time to get to every facility.

Ms. Chartier: — So after the end of this fiscal year, a third of facilities and a third of staff and . . . sorry, a third of facilities, all the staff will be trained. Is it a third of staff across all the facilities or is it a third of facilities? Do you know what I'm saying? Like, is it . . .

Hon. Mr. Duncan: — It would be across the regions. So the $1 million, as I mentioned, it's going to be apportioned to each of the regions. So each of the regions will be able to begin this this year. So overall we suspect it'd be about a third, but it'll be based on the size of the region; how many, you know, the dollar amount you received as a region. So everybody will start this this year, but we won't have every facility complete by the end of this year.

Ms. Chartier: — And I'm assuming it'll be three years then, or depending on next year's budget, it'll be three years. And obviously you said it's ongoing and it's been annualized and there's turnover, but would the goal be within three years to have, hypothetically, the existing staff complement trained?

Hon. Mr. Duncan: — So the intent is that this will be ongoing. I just want to be clear. So it's one-third of facilities that will begin this year rather than one-third of staff. It wouldn't make sense to have a few staff in this building know purposeful rounding but not everybody, so it'll be rolled out by facility in the regions. Our intent would be, I think it's fair to say, depending on budget levels next year, whether or not we move this out further more quickly.

But what we also want to do is we want to have some feedback from staff and from residents and their families after the first year. We know that there is data, there is evidence that supports this, but obviously we want to know how it's actually working on the front lines. So we want to have some feedback after the first year just to confirm that we want to continue with this.

Ms. Chartier: — Obviously you've cited some literature. And it's been rolled out now in RQHR [Regina Qu'Appelle Health Region] for a little bit. What kind of feedback are you getting at RQHR?

Hon. Mr. Duncan: — So Regina Qu'Appelle, their VP that's responsible for this area has indicated, and I'll maybe just quote. This is from Michael Redenbach from Regina Qu'Appelle:

> We've come to believe that purposeful hourly interactions will be foundational to our ability to improve resident care. One of the basic metrics that we expect to improve is resident falls. Resident falls very often occur when a resident is attempting to get to the bathroom. With hourly interactions, we can offer assistance. But perhaps more basically, we're wanting to improve the personal connection between residents and their caregivers. It's important that they know each other as individuals and hopefully this will help that and translate into other aspects of the care experience.

Ms. Chartier: — Not working in health care myself, and obviously you've said that rounding happens or doing rounds happens, can you describe for me . . . I'm just in my mind thinking about an evening or a night in a long-term care facility, how this would roll out. So you've got staff who go . . . They have a schedule where they go from resident to resident to resident. Call bell goes off; they get called to a different resident. Just help me see what a night in a long-term care facility looks like and how hourly rounding will look different.

Hon. Mr. Duncan: — So with purposeful rounding, so I've talked a little bit about the four Ps. So I think, you know, what we're trying to get to is a more intentional type of rounding. So this could even comprise of a little bit of a checklist of the things to look for and ask for. So it's asking the resident, are you having any pain? Do you have to use the washroom? Are you comfortable? Do you have everything that you need in reach?

Purposeful rounding also looks at checking, just scanning the room, checking the environment. Are there fall hazards? You know, checking things like the room temperature, if the resident needs a blanket, ensuring that the bed alarm is plugged in. And then before either the aid or the nurse leaves, just asking, is there anything else that you need? Let them know that somebody, and if possible try to say who, is on the next round. So they will be back in one hour or whatever the time frame is, but just let them know that somebody's coming back to them at a time. They log the round and then chart anything that they find in the round.

It's important to note, so this would be done during the waking hours. So the intent is not to wake somebody up in the middle of the night and do an hourly rounding. This is just during the waking hours.

Ms. Chartier: — How do rounds . . . Okay, so when RQHR introduced that last year, it was called purposefully hourly rounding. Are we calling it purposefully . . . purposeful rounding or . . . I know you've said in your answer there whatever time frame it might be. So what are the expectations for staff to get to residents on a regular basis?

[15:15]

Hon. Mr. Duncan: — So purposeful rounding, I think, is a better way to describe it. I know it has in the past and in other jurisdictions been described as purposeful hourly rounding, but it really is intentional around the resident. So for some residents it may be more often than an hour. For others it may not be as frequent as an hour. So it's more around the intention of what the rounding is about, so that's why we're referring to it as purposeful rounding.

Ms. Chartier: — Is there a goal or an expectation over the course of the day when you think about residents in long-term care, how often staff should be connecting with residents?

Mr. Hendricks: — So purposeful rounding is not exclusively all the contact that the residents will have. This is in addition to other things that will happen. The residents will have, you know, obviously they will come down to the dining room and they'll have supper or lunch and then they will also have contact with cleaning staff when they're cleaning their room. And there will be activities and other things that they'll be doing. The purposeful hourly rounding is, or purposeful rounding, is when they're in their room. And I think, you know, our intent here in calling it purposeful rounding would be that if a patient is very high needs, their care plan might actually determine that they need more frequent rounding, so we want to be flexible to that.

And in certain cases where you have a fairly high-functioning patient who is down for recreation and is being . . . is in another area of the facility where they're being monitored or with staff and other residents, it might not be every hour. It's intended for when they are in their room.

Ms. Chartier: — Keeping with long-term care here, and we've talked obviously about minimum-care standards and staffing ratios and the current document that the ministry is working from, that as we've said in question period . . . it's been referred to as general guidelines, but I'm curious. I understand in previous drafts, in early drafts of that document, it did in fact have reference to staffing ratios and that was removed. So I'm just wondering why that was the case.

Hon. Mr. Duncan: — So with respect to when we would have made changes and moved towards the program guidelines for special care homes and away from what had existed and which were frankly outdated, there wouldn't have been a draft that would've contemplated a staff ratio.

Ms. Chartier: — I actually spoke with someone who is very pleased with the program guidelines and thinks it's got very good content in it. And I was actually asked, they'd thought maybe I'd know why in early drafts that was . . . I was told very explicitly that there were in fact references to staff ratios and it was removed.

Mr. Hendricks: — To our knowledge, when the 1966 regulations were updated, there was no draft that we know about that included staff/resident ratios. And in fact it seems a little bit odd that it would, given that part of the goal of redrafting the regulations was to recognize the different care needs of different patients and not having it mandated so that there wasn't any flexibility for a long-term care facility manager to provide more care to a resident that needed more care. So I would find it odd that that would be part of it. You know, we can certainly check, but it would just seem against kind of where we were trying to go with these new guidelines.

Ms. Chartier: — I'm simply relaying what I heard from someone who in fact had an opportunity to review the early draft and, like I said, was very pleased with the content. There's some really important things in there, but she was quite definitive that . . . She'd asked me why those would be removed, and I say, I've got the same question.

Mr. Hendricks: — Well we can certainly have a look at what . . . We did share the drafts and we consulted with, at the time, health regions, and so we'll have a look. I don't know if somebody in the health region misunderstood the intent of the guidelines and suggested a staff-to-resident ratio that this person might have picked up. I don't know the specifics about what he or she . . . We can check.

Ms. Chartier: — Apparently this is in chapter 9 particularly. This person was referring to chapter 9.

Mr. Hendricks: — We'll follow up.

Ms. Chartier: — That would be very much appreciated. Just moving . . . I think we'll move away from long-term care here for the moment, and I want to just ask a little bit about year-over-year numbers back to my earlier discussion about . . . You know what? Actually, no. I'm going to stick with long-term care. Sorry. I'm going to stick with long-term care.

In terms of funding long-term care facilities, when the ministry funds RHAs, are you providing block funding to regions and then they decide how to fund their long-term care facilities or can you explain to me how that works?

Hon. Mr. Duncan: — Yes, that's what we do. We provide regions block funding and then make determinations of where they're going to allocate that funding.

Ms. Chartier: — Can you provide me a bit of a breakdown in terms of how different regions fund their, both . . . well, their own facilities and affiliates?

Would you mind if we recess for five quick minutes, take a quick break if that would be all right?

The Chair: — So we'll take a five-minute recess. The time is 3:27. We'll be back at 3:32.

[The committee recessed for a period of time.]

The Chair: — The time being 3:32, we'll get back to work here. Ms. Chartier.

Ms. Chartier: — Well I'd asked a question of how long-term care is funded. Yes.

Mr. Hendricks: — So to answer your last question before the break — and sorry about that — the total '15-16 budget for long-term care for regions we estimate is going to be $828 million. $690 million of that would come from the ministry and then about an additional 133 million from resident fees.

Now in terms of how we calculate that, when we develop regional budgets we look at their total staff complement, which unions they have, what those union agreements say, and we provide increases corresponding to the collective agreements. In addition, in most fiscal years, we provide funding for inflationary increases on material goods, and so that's provided to the regions. They make a determination of how to allocate that.

In addition, there are specialized programs that we provide funding for. So in the case of Parkridge where they have some specialized clients, there was some unique funding that was

directed towards that facility. Similarly in this year, this year's budget with our $2.7 million that we're dedicating to the development of geriatric assessment units in Regina and Saskatoon, that would be specific targeted funding towards a program.

Ms. Chartier: — When it comes to funding, when it comes to regions funding long-term care, do they all do it the same or is it a patchwork? What does that look like? So when a region is . . . like do they fund it per resident? Do they fund it per bed? How does that work?

Mr. Hendricks: — So typically, obviously, they have to compensate each long-term care home for their compensation costs, so their staff costs, and that would likely be based on their existing staff complement. So that's provided as a flow through.

Now there will be some discretion on the part of the regions. Over the last couple of years, we've had efficiency targets for regions. Not all have shared those with their affiliates, so not all affiliates have been expected to come up with efficiencies. It might have been more centred on acute care facilities, that sort of thing. There would be some discretion in regions and also, you know, the ability of long-term care homes to bring in specific pressures. So if a home is feeling, you know, that their residents are specifically challenging, they could bring that to the region who would then decide whether they required more funding.

Ms. Chartier: — In terms of the efficiency targets of the last two years then, you said the regions had some discretion. Do you know that there are facilities that had to meet the efficiency targets?

Mr. Hendricks: — To my knowledge, long-term care in most regions, and in particular affiliates, were spared by this.

Ms. Chartier: — In most regions or all regions?

Mr. Hendricks: — In most regions, I will say at this point. I don't know if there were some adjustments made in specific long-term care homes in certain regions, but certainly I don't think that's been a broad-based practice. Most of the efficiency targets have been met through reducing sick time, premium time, through shared services, savings through lean. So it hasn't been really about going into a specific acute care facility, an integrated facility, whatever, and saying, you know, you have to reduce X number of staff, that sort of thing. That just hasn't been part of it.

Ms. Chartier: — The way I've understood it was rolled out as, say you'd go to a department or an area or a unit, and you'd have X number of dollars. This is where you start. And those units were starting in a deficit position, is what I've been shared with by folks, that with the efficiency targets, people were already starting in a deficit and had to find and make up the difference.

Mr. Hendricks: — I wouldn't say that that was the approach used in all regions. And I think you're probably referring to the way it might have been done in Saskatoon, where they looked at the total amount of dollars available and they issued their managers and vice-presidents targets to say that, you know, we expect you to work within this envelope of funding, and so the idea . . . and when the ministry issues our accountability letters to regions, we say specifically that you are to do nothing that has an impact on patient care, safety, quality, those sorts of things. So those managers are challenged to look at other ways to save money without reducing care to clients. So they'll look at a variety of options.

You know, to give you an idea, as a health care system we spend tens of millions of dollars on premium time and sick time in any given year. So it's looking at strategies to reduce the utilization of premium time, to use more effective callbacks, to make sure that you're trying, if you can, if it's possible, to pay someone at straight-time pay. But at the same time our direction to them would be, if a position must be filled or if a staff must be called in regardless of whether it's straight time or premium time, if it's for staff safety, they should do it.

Ms. Chartier: — I think some of the challenges that I've heard from folks is areas that were already meeting their targets being pushed to already go below the targets that were already set. So you have an efficiency . . . So even prior to the budgets a unit might be meeting its targets already when it comes to use of sick time and overtime and is doing what they . . . like they're hypothetically a high-functioning unit or one of the . . . and then they're told that they have to do even better. And obviously we talk about improvement, but what I was hearing from folks is that it was very difficult to come up with some of those savings without impacting residents or patients in this case.

Mr. Hendricks: — Yes, I think that in certain cases as regions, you know, as they move through the year and they see fiscal challenges develop, they may go back to high-performing units and say, can you look at the way you're doing things? Are there ways that you can, you know, look at the care model that you're currently using and still provide effective and efficient and safe care to patients while reducing your budget?

And so I think where, you know, in a system such as ours where cost escalation has been a huge issue over the last years, we do have to challenge our system to do things as effectively as possible. But certainly our goal . . . well not our goal, our specific direction to the system has been not to do this at the patients' expense.

Ms. Chartier: — We digress here because we're talking about long-term care, but I just want to ask one more question around the efficiency targets. So we had the efficiency targets the last two years and those were spelled out very clearly in both budget documents, but I just wanted to double-check to make sure that there are no efficiency targets this year. Or is that part of this budget as well?

Hon. Mr. Duncan: — So this year we're going in a little bit of a different direction than we have in the previous years where we actually spelled out, identified a dollar amount. The mandate that we'll be giving to the health regions is to live within their means, within their budgets, but there won't be a specific dollar amount that they, as a group, have to find.

Ms. Chartier: — Thank you. So back to funding of long-term care — we digressed a little bit there — so we talked about

Parkridge or having some special services that are offered. Is there a formula that you'd fund . . . I just want to get a better handle on how long-term care and the affiliates are funded.

Mr. Hendricks: — It's based on historical values for the facility. There's no formula per se. As I said earlier, they will look at the staff complement and the staffing needs of the particular long-term care facility and they'll make adjustments based on collective agreements maybe for inflation and, you know, where we would line item certain things for special purpose units or a special purpose, like I mentioned at Parkridge. Those would be specific allocations that would come from the ministry through the region to that facility.

Ms. Chartier: — So in coming up with the staffing complement though . . . So I've been told that in Five Hills they're funded at 2.5 hours of care per resident. So that's what I'm getting at. Like when you talk about the staffing complements, is it based on funding a certain amount of care per resident or X number of staff per resident? Like, how does that work?

Mr. Hendricks: — No. You will see variants in the number of staff per resident across our long-term care homes, and it goes back to the earlier line of questioning on the minimum care guidelines.

There's certain homes that generally provide care to lower acuity residents, whereas if you have a facility . . . Certain facilities tend to take in higher acuity residents with special needs, and so accordingly you would expect in those facilities to see a higher staff to resident ratio. So there's no formula that's straight across the board like that and, as I said, you know, it's based more on the history and the recent experience of the facility.

[15:45]

Ms. Chartier: — Okay. When we talk about acuity levels across facilities on average or generally, I'm sure that there are always anomalies. But generally speaking when we look at long-term care . . . And we had a bit of this discussion last year, Minister Duncan, when we talked about I think it was your great uncle or your uncle who'd been in long-term care and my grandmother who'd been in long-term care for a very long time. My grandma I think was in long-term care for 20 years, and obviously her needs changed over that time, but the level of acuity has increased. Do we have facilities . . . On average where would you rank, if we were looking at level of care, where would we rank most of our long-term care facilities?

Mr. Hendricks: — So the tool that we use to assess the acuity and develop care plans for seniors who may be eligible for long-term care is called MDS [minimum data set]/RUGS [resource utilization groupings]. They're assigned a score which is basically their case mix index, and what we've seen over the last several years is that this case mix index has stayed relatively constant across regions. So for example in Regina Qu'Appelle, it has been around 0.64 and in Saskatoon slightly higher at 0.67. But there hasn't been a substantive change in that index in the last few years, and so that would seem to suggest that the acuity of patients, at least over the last few years, has remained relatively constant.

Just to give you an idea on the index, a .64 . . . A 1 would be the most high-needs client, patient or resident, that you could have.

Ms. Chartier: — Could you say that again?

Mr. Hendricks: — A 1 would be the most high-needs client or resident that you could have, so .64 would be accordingly right.

The average length of stay in our long-term care homes is about two years, five months. That varies between regions: from one year, nine months in Athabasca to three years, five months in Mamawetan at the other end of the spectrum.

And you know, I think that one of the differences you'll see between regions in terms of accessing long-term care and the length of stay, there will be access to things like personal care and supportive housing, privately delivered or whatever, as well as home care supports. And we're doing work with home link, Quick Response to try and . . . because we've heard from seniors that the ultimate goal is to remain independent and in their home as long as they can. And so we're trying to develop programs that will actually address that need and that desire, that expressed desire. So the goal of long-term care is that in the future, hopefully not so long . . . that people remain outside of an institutional setting for as long as possible.

Ms. Chartier: — Oh, for sure. I couldn't agree more, but we have to make sure that the residents who are in our long-term care facilities, that they're well cared for.

When you say, Mr. Hendricks, RQHR and Saskatoon, that acuity level has been relatively stable over this last several years, can you give me a context for that? When you say several years, what does that mean?

Hon. Mr. Duncan: — So I think it's fair to say that, based on the data that we collect, it's been relatively stable over the last five years. Certainly I think when the prevalence of personal care homes came online, when there were a number of long-term facilities that would've been transitioned to personal care homes, obviously those residents would've been leaving our system. So that would've seen a pretty significant jump in the acuity, not having all of those residents in our care anymore. But the last five years has . . . The chart that I've seen, we don't have it with us but we can provide that. But I know that I've seen the chart, and I think it was about a five-year span where it was a fairly consistent CMI [case mix index].

Ms. Chartier: — How far back does the chart go?

Hon. Mr. Duncan: — Yes. So the information that I would've received that I know that I looked at would've been a five-year period. We'd have to see if we go back further. It just kind of depends on how much information we would've been collecting, like when we would've started using MDS. I'll check here.

Mr. Hendricks: — So going back historically, the MDS/RUGS tool, I'm led to understand that the algorithm in terms of how the case mix index has developed has changed over time and the comparison is quite difficult. Similarly there are changes that are being contemplated to the MDS/RUGS system nationally right now, or a newer version of it, that take less time

to fill out and are more directed to, you know, directly meeting the care needs and assessing the care plan for the patient and reducing staff time to fill those out. So we think it's comparable over the last while. Going back would require a lot of assumptions and that sort of thing that we haven't done.

Ms. Chartier: — How do we know then when we talk about staffing complement and numbers of residents that . . . Talking to people in long-term care who have worked over a long period of time, I've been told the level of acuity has risen. I mean and we talk about personal care homes, and I know in personal care homes, again we had this conversation last year where we had firefighters being called out to do two-person lifts because people are falling. So personal care home acuity has increased as well. So you've got that. How do we know then, when we talk about staffing complement and seniors, that we're comparing apples to apples when we talk about acuity level?

Hon. Mr. Duncan: — I think because of the information that the MDS system collects. While anecdotally we also hear that acuity is going up, the last five years the information would suggest that, while there may be some changes, it hasn't been a dramatic change in that five-year period. That's the information that we, you know, need to rely on. But you know, we certainly would hear anecdotally that care levels have gone up. The challenge we have is that the information that's collected through MDS doesn't necessarily match the same what we're hearing anecdotally.

Ms. Chartier: — Okay. When we talk about comparisons here, I think obviously one comparison that often happens is staffing levels and number of residents. And we pull out time frame because politically we are partisan politicians. But that I think would be the point, is that the level of acuity in many of these facilities has gone up. And if you've pulled out a five-year number and say that there's nothing, you can't really compare to previous years. How do you know that you're not dealing with something completely different than you were eight years ago?

Mr. Hendricks: — The algorithm has changed. They've said that it's not directly comparable, but it's not radically different, and so it does give us, you know, some idea of what's happening.

The minister is correct. Like anecdotally we do hear and maybe even, you know, we do know that neurodegenerative diseases such as Parkinson's and dementia amongst our elderly population, those in long-term care, we're seeing more of that. But that is also why we're targeting funding to developing specialized dementia units and geriatric assessment in both Regina and Saskatoon to deal with those most complicated patients. The gentle persuasion is about teaching staff in long-term care homes how to better manage with those residents, and so I think that's been an identified need that we are seeing. And so we can't do a direct comparison, but we have an order of magnitude, I would say, to look at this.

Ms. Chartier: — Would it be possible to get a longer time frame or a bigger snapshot for next committee then to get a sense of level of acuity and how that's changed over the last decade even perhaps?

Hon. Mr. Duncan: — We can provide that information going back further than a five-year period. Yes, absolutely.

Ms. Chartier: — A decade would be great.

[16:00]

Hon. Mr. Duncan: — Ms. Chartier, I can give you a comparison going back to 2007 today. So this goes back to the fourth quarter of 2007. That's the starting date. And I'll maybe just, as way of comparison . . . So Sun Country, the CMI for the fourth quarter of '13-14 was 0.60, and back in the fourth quarter of 2007 it was 0.62.

Five Hills Health Region, 0.65 in this last, in the fourth quarter of '13-14, and it was 0.67 in '07. Heartland Health Region, 0.62 in '13-14 fourth quarter, and it is 0.64 in the fourth quarter of '07. Kelsey Trail, 0.60 is the '13-14 fourth quarter. Kelsey Trail in '07 fourth quarter was 0.67.

Keewatin Yatthé, 0.59 in fourth quarter '13-14; 0.63 in fourth quarter of '07. Regina Qu'Appelle, 0.64 in fourth quarter of '13-14, and it was 0.66 in '07 fourth quarter. Saskatoon, 0.67 in fourth quarter of '13-14, and it was 0.66 in '07 fourth quarter. And P.A. Parkland was 0.61 in fourth quarter '13-14, and it was 0.66 in '07 fourth quarter.

I don't believe I gave you Mamawetan Churchill; it was 0.73 in the fourth quarter of '13-14. But I'll just note on that one, over the fiscal year '13-14 it went from a low of 0.58, up to 0.82, down to 0.66, and then up to 0.73 in the course of four quarters in the year. So it jumped around . . . [inaudible interjection] . . . Yes, small bed numbers in La Ronge. So 0.73 in fourth quarter of '13-14, and it was 0.56 in fourth quarter of '07. But I note that it jumped around quite a bit too in '07-08, going up and down quite a bit in that year as well, and again back to the small bed numbers.

Sunrise, I don't know if I gave you this; sorry, I might be repeating myself. Sunrise was 0.64 in the fourth quarter of '13-14, and it is 0.66 in '07 fourth quarter. You know what, but I did make an error. I think I used 0.6. I used Sunrise Health Region number for Saskatoon. Saskatoon, I think I gave you 0.66 as the '07. Sorry. It was 0.71 the fourth quarter of '07, and it is 0.67 fourth quarter of '13-14. Sorry. I was bouncing all over; I'm not sure if I kept track.

Ms. Chartier: — Saskatoon, you gave me at 0.67 in '13-14 and 0.66 in '07.

Hon. Mr. Duncan: — Yes, sorry about that. In Saskatoon it was 0.67 in '13-14 fourth quarter, and in '07 fourth quarter, it was 0.71.

Ms. Chartier: — And are there . . . I don't know how many of those we got. I didn't catch them all. I was going to look at *Hansard*. My question then is around the algorithm. So, Mr. Hendricks, you'd said the algorithm had changed, not dramatically. But when would that have happened?

Hon. Mr. Duncan: — The challenge with collecting this data is that there's change every year, and they look at national kind of comparisons every year. This is a good comparison though

between the ’07 and the ’13-14 numbers that I gave you, because we actually asked CIHI [Canadian Institute of Health Information] to do an evaluation on them and give us a comparison between the numbers. So we’re confident with the comparison, but it does change frequently.

Ms. Chartier: — And, Mr. Hendricks, you said one is the highest level.

Mr. Hendricks: — Correct.

Ms. Chartier: — Okay. What’s interesting because obviously anecdotally, we’ve talked about anecdotally . . . Well, and this, that’s just a seven-year period there. But I’d be interested, is it possible to get a comparator . . . or with CIHI you’ve only gone back seven years?

Hon. Mr. Duncan: — So we would be able to go back prior to ’07, but we would have to do a special run on it because, unlike what we’ve done on the ’07 and having CIHI kind of do analysis on it to make it comparable, we wouldn’t have had that done prior to that. So we could get the information but it wouldn’t be a comparable . . .

Ms. Chartier: — Yes, I’d be very interested in that because again, anecdotally we’re both saying that we hear that acuity levels are going up, and obviously the numbers are not, the numbers here are not illustrating that. Or no . . . Yes, sorry, I have to look at them more closely. Anyway I’d be curious, but if they’re not compared, like if they’re not a direct comparison, that’s fair enough. So okay, we’ll leave it at that.

I was just thinking again back to chapter 9 and our discussion of a few minutes ago. I’m wondering if you could be so kind as to table those original or early drafts of chapter 9 of the special care home regulations.

Mr. Hendricks: — Yes. First of all I never acknowledged their existence, or I didn’t acknowledge their existence, but we’ll have to check for them. And if we find them, you know, I think that’s reasonable.

Ms. Chartier: — The ones that went out to the regions for input and approval, I’m specifically speaking of. So I don’t know at what point or what stage they went out, but again . . . Yes.

Mr. Hendricks: — We can look into it. Yes, we can look into it.

Ms. Chartier: — That would be great. Thank you. Okay, just thinking here to an earlier conversation about employee complements like LPNs, RNs, those kinds of things. When we talk about employee numbers of staff, health care staff, in-scope and out-of-scope numbers is what I’m thinking of year over year and how that has changed in recent years.

Hon. Mr. Duncan: — Specific to long-term care? Or just overall region, health authority, FTE, in-scope versus out-of-scope . . .

Ms. Chartier: — Health regions, yes. Actually if I could get a breakdown, that would be great. RHAs and long-term care.

Hon. Mr. Duncan: — Ms. Chartier, I’ll maybe begin by . . . if I go through like a total number of change in the FTEs for regional health authorities, that’ll include both their unionized and non-unionized. And then if you want, I can break it out by actual provider union, if that’s okay for you.

Ms. Chartier: — Sure.

Hon. Mr. Duncan: — So you wanted the change in . . .

Ms. Chartier: — Year over year, in-scope and out-of-scope.

Hon. Mr. Duncan: — Okay. So the overall annual change, this is a total number within RHA and affiliates. So this will include the unionized and non-unionized. I’ll maybe start with that.

So using ’07-08 as a base year, so the total number was 27,986. The following year it went up by 572. The following year it went up 1,292. The following year, 254. The following year after that, 625. After that was 659. The following year after that was 31. And then I have a year to date for ’14-15. So that was the number . . . the years were ’07-08, and now to ’14-15 year to date, so this is as of December 31, 2014: 489. So the total number went from 27,986, and that’s FTEs, to 31,908, an increase overall of 3,922.

So would you like it broken down by the unions, or would you just like the non-unionized staff now?

Ms. Chartier: — You know what? The number of non-unionized staff please.

Hon. Mr. Duncan: — Okay. So overall, the numbers went . . . I’m going to have to do some adding in my head here. So the overall number went from 2,523 back in ’07-08 to in ’14-15 year-to-date, so as of December 31st, 2014, 2,965. So an overall increase of 442 in that time frame.

Ms. Chartier: — And that’s non-unionized?

Hon. Mr. Duncan: — Yes. That’s right.

Ms. Chartier: — Okay. Thank you for that. Okay. Shifting gears here a little bit, we’ve heard, I think, in the news thus far, that I think it’s two health regions that are planning on running deficits. Thus far, have you heard from any other regions where they’re at?

Hon. Mr. Duncan: — So far I know of two health regions that have had preliminary discussions about their budget that have been public discussions. So I know Regina Qu’Appelle was obviously in the news, and they are going to be working very hard to ensure that they are able to manage their budget and balance their budget this year.

The CEO has talked about some of the initiatives that they’re going to undertake to not have a deficit this coming year. It’s going to take a lot of work on their part, absolutely. But you know, their commitment is that if they were to just run status quo, that yes, they would be facing a deficit. But they’re going to look at some initiatives to not have a deficit this year.

Ms. Chartier: — Can you talk about some of the initiatives

that they've discussed with you?

[16:15]

Mr. Hendricks: — So at their board meeting the other night, Regina Qu'Appelle Health Region executive talked about some of the specific areas that they would be . . . or some of the areas, broad areas, sorry, that they would be looking in to meet their budget challenge. So all things being held equal, if things were to continue at the current running rate, they would have a deficit of, I think they said $38 million.

What Mr. Dewar said is that within the broad categories of reducing overall or reducing overtime hours, he talked about $4 million; reducing sick day costs, $2.5 million; reducing orientation costs, and so that's related to turnover of staff, $1.3 million. And improving, and this is something that Regina has done a lot of really good work in, is reducing ambulatory care admissions for chronic conditions. And so they're looking at some pretty significant savings there, but this wasn't their detailed budget. Their detailed budget will not be approved by the board until May. And so what Regina Qu'Appelle has to do is add . . . be more definitive in terms of where they expect to see their savings and what specific actions they will have to do to produce a balanced budget.

Ms. Chartier: — I'm just wondering when, what calculations . . . so obviously the ministry gives block funding to the regions, and whether it was 1.8 it averaged . . . or what was the average in this budget again?

Mr. Hendricks: — So that in the estimates display, the increase, the total increase for health regions is $107.9 million, and that's a three and a half per cent average increase. But included within that are some transfers from regional targeted initiatives to their base budget. As the minister said in his opening remarks, the overall increase is about 55.7 million, which is a 1.7 per cent increase.

Ms. Chartier: — When the ministry looks at, or when the regions are looking at making budget . . . so never having done this before, what do you normally break out when you look . . . or allot? Like, if you were to meet demographic changes like our increasing diversity, aging population, dealing with collective agreements, what would be, what would you allot for each of those? Like when you're putting together a budget, what kind of numbers would the ministry expect regions to be using to take into account those kinds of things?

So you've got a status quo budget hypothetically, but if you've got those, like aging population . . . When you're making a budget, I guess the bottom line is, when you're making a budget, what do you factor in for all those kinds of things annually? Like in a perfect world, what would a budget look like? You would give 1 per cent for — no, I'm being serious — 1 per cent for, I've been told 1 per cent for aging population, or sorry, growing population. I've been given a few different numbers, but I'm wondering what the ministry uses.

Mr. Hendricks: — So there again, in a perfect world where the price of oil remains well above $100, what we would be looking at is obviously collective agreements. And so whatever collective agreement settlement cost we have, we would be looking at utilization, and utilization is tied to a couple of factors — or well it's actually tied to several factors, so it would be population growth, but also your demographics, the age structure of your population. So those are factors that ideally we would look at.

We've also seen, you know, with the proliferation of new technologies, MRI [magnetic resonance imaging], CT [computerized tomography], that sort of thing, there tend to be special allowances for those programs. And then as I noted earlier with long-term care, provide inflationary increases on material items — drugs, supplies, that sort of thing.

And so there are a variety of factors that we would ideally look to build what we would call a status quo budget for a region, and then decide in really status quo if you do have population growth or demographic changes. And so that represents the ideal state. Now from there, the reality is that when we look at health care spending over the last seven or eight years, it's been growing in the 6 per cent range. And at that rate of growth, what that effectively does is it crowds out other programs like social services and education and housing and such. And the reality is, is that many of those programs actually . . . or many of those programs affect people in a way and deliver programs that are determinants of health. And so I think the challenge in health, and it has been for several years, is that we have to look at our operations and look how we can fit within the fiscal envelope of government.

Now in this particular year that has been constrained somewhat due to the, you know, challenge with oil. And so we have asked our regions . . . They have to live within the target that was given to them. Allocations for all of those things were not made this year. But what we have seen is that regions have made considerable progress at not only living, and, you know, some regions will report deficits this year, but most overall living within their financial targets while at the same time addressing demographic and population growth, meeting surgical targets, that sort of thing.

And one of the ways that they have been able to do that is by realizing certain efficiencies. We've talked about shared services, sick time, that sort of thing. And so regions are looking at those specific baskets. We're seeing that we are able to increase capacity through the use of things like lean to avoid costs and the requirement for provincial funding to address service growth. So we have made a lot of improvements in terms of how we're doing this.

Actually you know, it's been several years I think since we would truly have recognized what a region would call a status quo budget, because status quo budget didn't take into account ever finding any improvements in the way you did things. And so now that is where our challenge is with regions.

Ms. Chartier: — In the past then . . . Or so this year, you've pointed out, was a more difficult year, but in that like . . . and you said you didn't give any for population growth or the age structure. What would you, like what would the ministry allot normally for population growth?

Hon. Mr. Duncan: — So in the past number of years, it's fluctuated. It's not a set amount. I think last year — we're just

trying to find the number — but I think it was about 24 million last year that we allocated. Now we didn't do that this year, but we have offset in part that, in not having an efficiency target, an actual dollar amount that regions have had to find. So that's a bit of the trade-off this year that we've tried to strike that's a little bit different than last year or previous years.

And not every region would have benefited from the demographic, from the population growth funding. It would have been heavily weighted for Regina and Saskatoon but there is . . . So even those regions that wouldn't have in the past benefited from population growth, targeted money for population growth, they're not going to have the . . . Even if they weren't getting money on the population side, they were still required to find the same savings on the efficiency side. So that's, you know, a little bit of a . . . going to be a better picture for some of them this year even without the population money.

Ms. Chartier: — In terms of age structure, what kind of allocation would be a normal allocation? So you'd give me a money number or 24 million last year. Is there a percentage that normally is used in terms of when you think about a formula?

Mr. Hendricks: — First of all to confirm. The minister, we have checked. Last year's number was 24 million to recognize population growth. Typically the way that we look at this is we have to look at both the structure of the population that is experiencing growth. So in Saskatchewan that's largely been located in our urban centres, and were you to actually take an average cost or whatever for the population or such, that wouldn't be an accurate reflection because generally they've been younger and so, you know, the costs are lower. They might not utilize as much, as many health services.

But typically we would look at, you know, the cost — the average age, sex — adjusted cost of a person. And in a kind of ideal workup to the budget, we look at our utilization, how that's translating, and arrive at a figure. And at some point we make some assessment about what, you know, capacity, the capacity of the provincial treasury to actually meet that need or that dollar value. And then, you know, like I said, for example in Regina, without any budgetary allocation they were able to increase the capacity of their MRI by 650 exams a year — no additional staff, no money, nothing. So there's a challenge to regions to do more with the same as well. So that's how we're meeting this population growth.

Ms. Chartier: — Okay, thanks. I think I'll probably have some more questions. I just want to ponder that a little bit.

Just switching gears here, family health benefits. So in the last couple of budgets, family health benefit numbers I believe have gone down and this year they're projected to go up, which I thought was odd because in light of the employment supplement being cut for families from that 12 and up, for children from 12 to 18, that will have an impact on the family health benefits numbers. So it didn't make sense for me in the last couple of years that the number had budgeted lower, and then this year when you were taking people off of the employment supplement that family health benefits would go up.

Hon. Mr. Duncan: — The increase is attributed to just increases in the costs of the contracts for the dental, chiropractic, and optometric contract. So we are forecasting a decrease in the number of beneficiaries, but the increases, that'll be offset by the increase in the contracts, basically the pre-negotiated contracts for the things that I've mentioned already.

Ms. Chartier: — Okay, thank you. Again, totally switching gears here, we'll talk a little bit about kaizen promotion offices. How much has been spent on KPOs [kaizen promotion office] or how much is budgeted to be spent on KPOs this year?

[16:30]

Hon. Mr. Duncan: — We don't provide a specific allocation for the region kaizen and promotion offices, so this would come out of their block funding. So we don't target the amount of money for that; it basically comes from their global budget.

Ms. Chartier: — Okay. Do you know the number of employees in each kaizen promotion office in each community or, sorry, in each health region?

Hon. Mr. Duncan: — Swift Current has 4 FTEs. eHealth has 5 FTEs. Five Hills Health Region is 10. Heartland is 4.3 FTEs. Keewatin Yatthé is 3. Kelsey Trail is 7. Mamawetan, 3. Within the ministry, it's 5. Prairie North is 7.9 FTEs. Prince Albert is 6, and Regina Qu'Appelle is 38. Saskatoon is 51.8. Sun Country is 5. Sunrise is 3. And there would be additional FTEs that would be assigned to the emergency department waits that work out of Saskatoon, as well as the stop-the-line safety alert system. So between those two out of Saskatoon, that's a five additional, so it's 190 in total, FTEs.

Ms. Chartier: — In terms of the position of kaizen specialists, how many kaizen specialists work in each region?

Hon. Mr. Duncan: — So Cypress is 2 FTEs. Five Hills is 2; sorry, it's 4 in Five Hills, but one is a vacant position. Heartland is 4, sorry, 3.3 FTEs as one of the positions is vacant. The smaller regions don't break out into titles with . . . Like Keewatin Yatthé, they just have three FTEs. There's no kaizen specialist denoted on the list.

Kelsey Trail is two; one is also a quality of care coordinator. That looks like a split position between a specialist and a quality of care coordinator. Prairie North is four. Prince Albert Parkland is three. Regina Qu'Appelle is . . . sorry, there's a number of different kind of subtitles behind a specialist for different areas. We'll just, we'll count that one up. I'll come back to that. We'll do the same for Saskatoon. Sun Country is two kaizen specialists and a lead specialist position. Sunrise is four. We'll just come back to Regina and Saskatoon in a moment. Regina Qu'Appelle is eight, I believe. Saskatoon is eight, yes.

And I'll just maybe clarify. So as an example, Sunrise, it's three FTEs for their KPO but it is seven staff. So they're not a full-time position. So when I gave you the number for their office, it's four specialists but one is a vacant position. So I just want to clarify that; I said four people but there's only three FTEs. It's because we're talking FTEs, but also an actual head count.

Sorry, SHR [Saskatoon Health Region] is 22.

Ms. Chartier: — SHR is 22 and Regina is eight? Okay. Just have to make a note here. In terms of the kaizen promotion offices in each health region, do you know what the budget is of each kaizen promotion office? Let's go back to maybe 2012, the first fiscal year, or when they became KPOs.

Hon. Mr. Duncan: — So I'll maybe just, Ms. Chartier, try to answer the question. So most of these positions were already internal positions within the regions that would have been focused on aspects of quality and patient safety and so forth. So for the most part, it's more of undergoing a kind of a renewed focus in their mandate. But for the most part, these would have been positions that would have been doing like work, a similar type of work within the regions. So we don't have a breakdown or a comparison today for you of kind of what regions would have been spending and what they are spending today.

Ms. Chartier: — So were they the policy . . . What were they called prior? Were they the policy shop? I can't remember what the original names of them were before they were converted to KPOs.

Hon. Mr. Duncan: — So prior to lean, there was a number of different names that these types of offices would have gone by over . . . different kind of iterations of them. So at one time they were called quality departments. And depending on the region that you're talking about, some of the names in the past were quality departments, quality improvement offices, quality and safety, and quality and efficiency management.

Ms. Chartier: — Would it be possible for next committee to have the cost associated . . . like a pre-lean and post-lean breakdown of what's being spent in each of those areas?

Hon. Mr. Duncan: — We could certainly be able to go back to the regions and find out today what the costs are. The difficulty is in going back because we base that information on payroll. Personnel would have changed, like individuals would have changed. Departments would have changed. And so it's harder to track back prior to when these offices would have been set up, to go back that far into the payroll information from SAHO [Saskatchewan Association of Health Organizations] to kind of find out who was doing what in different departments. We'll have a conversation about that, but that may be difficult to do.

Ms. Chartier: — I don't know how to make this simple. Maybe it's not. But then I . . . Was it 2012 that they made the switch to KPOs? Was that the year? If I could have that sort of year-over-year 2012, 2013, and the last budget year what regions spent on KPOs, that would be great. Thank you.

Sticking here with lean a little bit, following your announcement in December of the exit of the John Black contract, wondering how many 3P [production preparation process] workshops have taken place since that time. I'm going to amend my question actually. Instead of just having that three-month window then, if in terms of the lean contract, if I could get an outline of all 3Ps last year, but if I could get a complete picture of what's taken place for 3Ps to date and what their individual costs were. And I know we talked about some of them last year, but if I could a complete picture of what's taken place for 3Ps.

Hon. Mr. Duncan: — So, Ms. Chartier, there has been one 3P event since the December announcement that we were going to be exiting the contract. That took place in January, and that was with respect to the Prince Albert Victoria Hospital replacement. So I'll just go through.

The children's hospital involved two 3P events. We had one 3P event in March of 2013 with the Kelvington and district integrated health care facility project. For the Moose Jaw Hospital there were three 3P events: April 2012, June 2012, and November 2012. The Cancer Agency, Saskatoon Cancer Centre has had one 3P event. That was in November of 2013. And Prince Albert Victoria Hospital, I have mentioned the January 2015, but there was also a March 2014 3P event. Sorry, I'm missing a couple. Saskatchewan Hospital, North Battleford, there has been three 3P events: June 2013, July 2013, and February 2014. I believe I attended the 2014, February 2014 report-out. And Swift Current, there was one 3P event that was August 2013, and I attended the report-out of that as well.

[16:45]

Ms. Chartier: — Was there just one in Heartland in March?

Hon. Mr. Duncan: — So that was a design 3P around EMS [emergency medical services]. It wasn't around a capital project.

Ms. Chartier: — Were there other design . . . So you've just given me the capital 3Ps. Were there many other . . . No. Sorry. Yes, you've just given me the capital 3Ps. Were there other design 3Ps?

Mr. Hendricks: — Yes. So there have been a couple that I know about off the top of my head. There was the Heartland which looked at their emergency medical services. Saskatoon did one as well around staff scheduling a couple years ago. There have been events that certain regions may have held that they might have called a 3P to look at specific . . . Because 3P isn't just about capital. It's about processes as well. It's about a total redesign of a process, and so they might've done a more rigorous approach that might be used in a rapid process improvement workshop and called it a 3P, but I don't necessarily have all that detail. The capital ones have been the major ones, and the Heartland one was an important one as well.

Ms. Chartier: — Can you talk about the Heartland one?

Mr. Hendricks: — I don't have the report back from the region on the outcomes of that one yet.

Ms. Chartier: — Do you have the costs of the 3Ps? I don't know how you'd have it broken out if it's . . . Were the costs of all those 3Ps borne by the regions or borne by the ministry?

Hon. Mr. Duncan: — So the cost of the 3P, there will be costs that the ministry would have paid for as it relates to the overall JBA [John Black and Associates] contract, and that's part of what we were purchasing. The region then would have some of their own costs. The architect that's involved is contracted by

the region to do the architecture work after the 3P is complete. For Moose Jaw regional hospital — and these are just approximate numbers — so Moose Jaw would have been about $500,000 for the 3P events.

Ms. Chartier: — And is that the ministry's cost or the region's cost?

Hon. Mr. Duncan: — That's our total cost. I believe we . . . That's the total cost of that 3P, yes.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — Kelvington integrated health centre, $370,000.

Ms. Chartier: — And is it the same . . . Is that all ministry costs or was there region cost?

Hon. Mr. Duncan: — No, that would . . . For Kelvington integrated health centre, 370,000, that is a combination of the ministry cost as well as the region cost.

Ms. Chartier: — Sorry, sorry. Can you break that out to the ministry and region cost? Because the region cost wouldn't have been included in the contract, the JBA contract.

Hon. Mr. Duncan: — We'll try to get you more, a clearer answer on that. The problem though is that because much of this is proprietary in terms of like the architecture fee, the JBA, the proprietary knowledge, so I'm trying to give you as much as I can without kind of getting into blurring the lines of getting into proprietary knowledge.

Ms. Chartier: — You know what? With only seven minutes left here, why don't . . . I'll give you actually what I'm looking for, if you could aim to get that back to me the next time, and so there's not going back . . . So I'm interested in the cost of all of the 3Ps, both the capital and the process 3Ps that you know of that aren't just sort of extra special RPIWs [rapid process improvement workshop], so the 3Ps, the capital and the process ones, and the costs that were borne by the ministry for those and the cost borne by the regions for those. If you could do that for me, that would be great.

Hon. Mr. Duncan: — Sure. We'll endeavour to provide the committee with that information, but I will put in that, you know, we need to be mindful of the proprietary information in that.

Ms. Chartier: — For sure.

Hon. Mr. Duncan: — So we'll try to put that together as best we can.

Ms. Chartier: — That would be great. When it comes to the 3Ps, I'm curious what the average number of days is for each 3P. Is there a time that . . .

Hon. Mr. Duncan: — So the 3P event itself is a five-day event. Typically the first four days is most of the work. The fifth day is typically the report-out although there would be some work kind of leading into that day.

It's really hard to put an estimate. Each project is different. While the event itself is five days, there's a lot of information that has to be gathered going back for some deal of time prior to the event. There's also, after the event is over, there's always work done to kind of refine the work that's been done. There's reviews that take place I believe at 30, 60, and 90 days out after the event ends. So it's five days itself, but there's a lot beforehand and a lot afterwards.

Ms. Chartier: — Fair enough. In terms of the five-day event, is there usually an average number of participants? And I know a swath of different folks who participate, but is there an average number of participants?

Hon. Mr. Duncan: — So the 3P event itself, it would depend on obviously the complexity of the project that is being worked on. So Kelvington would have been a smaller event than say Saskatchewan Hospital at North Battleford. It also depends on what part of the 3P that particular 3P is looking at.

So I can share my experience in when I toured, I believe it was, the last of the three 3Ps for the Saskatchewan Hospital project. It was more focused on the support services, so in fact the people that were leading, the front-line staff that were leading the 3P work were the custodial staff, laundry staff, the other environmental services. It was really heavily focused on looking at that aspect of the project. And I think at that report-out, you know, there would have been, you know, close to 80 people there, closer to. You know, it was a very large group that were gathered.

It's important to note, for me, that from where I see the value in the 3Ps is that it is directly informed by the front-line staff in terms of what the current state is of how they operate and their ideas on how to make their jobs more efficient but also ensuring that the patient is always at the centre of it. And in fact at our 3P events, in all of our lean events, 3Ps, RPIWs, we always have a patient rep there. We always have the patient voice as a part of that. So that's kind of my experience at these types of events.

I've been at report-outs for the children's hospital as well as the Swift Current 3P report-out. And I'll maybe just mention that, and I know that there's been a little bit, it's been in the media a little bit, but at that report-out on the Swift Current, because they looked at changing the model of care that they provide at the three facilities going into a new facility, one of the things that was really encouraging for me to hear was to actually hear the front-line staff saying that there's good ideas in terms of the model that they want to attempt at the new facility, and they don't necessarily need to wait till the new building is complete. And so I know that they are piloting some work in one of the facilities in looking at how to transition smoothly over to the new facility, but the learnings that they have at the 3P, a lot of that can be utilized even in the existing facility while they wait for the new one to be built.

Ms. Chartier: — Thank you. In terms of 3P sort of going forward, are there any planned, are there any 3Ps planned?

Hon. Mr. Duncan: — The intention is to have a third 3P around the Victoria Hospital redevelopment in Prince Albert. That would take place typically . . . I think in June is what we're

looking at for that to take place. The region's determining how that's going to go forward.

Ms. Chartier: — Just with respect to the hospital there then, I know the planning dollars, it was $2 million dollars planning last year? Is that correct? In last year's budget?

Hon. Mr. Duncan: — It was $2 million.

Ms. Chartier: — Is that what the $2 million is being used for, is for the 3Ps?

Hon. Mr. Duncan: — Yes, it would be, the 3Ps would be a part of that $2 million. But there's other work that has to take place as we're planning a new facility. It's not just the 3P.

[17:00]

Ms. Chartier: — Well I'm curious though because from everything that I've read in the media, is it a new facility or is it a renovation or a refurbishment? Like that's . . . So I don't know how you'd do a 3P if you're not sure if it's a renovation or a new facility.

Hon. Mr. Duncan: — So during this process, we've asked them to look at both.

Ms. Chartier: — Okay. So they're looking at both refurbishing the existing hospital and designing a new one.

Mr. Hendricks: — So just to understand the 3P, they're looking at care processes, right? And so what they're going to do is look at optimal care processes, the way that patients should flow throughout the facility. That will actually help to inform whether that can be achieved within the existing infrastructure with a lot of renovation or whether it would be more cost effective to start greenfield.

Ms. Chartier: — So the architect who's participating in that will help inform it, either direction.

Mr. Hendricks: — At the end of the day, there would be a business case that was based on a renovation of existing or addition to existing facility or a greenfield.

Ms. Chartier: — I'm curious about the La Ronge . . . I know time, we're going to get called time here. But the La Ronge long-term care facility, the planning dollars for that, what's happening with those planning dollars?

Hon. Mr. Duncan: — So right now they are working on their functional program, their functional plan. After that, they would move to the 3P stage.

Ms. Chartier: — Thank you. I see that it's 5.

The Chair: — Ms. Chartier, because we had the break, we're going to go the extra four minutes. So you have time for another question.

Ms. Chartier: — Excellent. Thank you, Mr. Chair. So La Ronge, then, could you repeat that for me, please?

Hon. Mr. Duncan: — Sure, and I'll try not to take four minutes to say it. So La Ronge is working on their functional plan, their functional programming. Once that work is done, that's kind of the . . . that's a part of the information that's required to then move to the 3P stage. So the intent is that after that work is done that they would move to a 3P.

Ms. Chartier: — Is it expected that every new facility going forward will go through or every new facility or major renovation will go through the 3P process?

Hon. Mr. Duncan: — That would be our intention, yes.

Ms. Chartier: — With respect to La Ronge, how much of those planning dollars . . . Forgive me here, but I can't recall how much was put into the La Ronge for planning dollars.

Hon. Mr. Duncan: — So it's $500,000 is what they had been allocated in last year's budget.

Ms. Chartier: — And has that been spent?

Hon. Mr. Duncan: — No, not the entire amount. They have dollars to continue into this year.

Ms. Chartier: — When are you expecting their functional planning to be finished?

Hon. Mr. Duncan: — They've gone through a process to . . . They did an RFP [request for proposal] to find somebody to help them do their functional programming. They expect to issue the RFP late, mid to late April.

Ms. Chartier: — Okay. Okay, thank you for that.

Hon. Mr. Duncan: — And that should take, once they do award that RFP, that work should take about three to six months.

Ms. Chartier: — So the RFP is for . . .

Hon. Mr. Duncan: — The RFP is for support to complete the functional plan.

Ms. Chartier: — To complete the functional plan. So they've had money to work on the functional plan up to this point, and they're doing an RFP to be able to have support to complete the functional plan? Sorry. This is . . . forgive my ignorance here.

Hon. Mr. Duncan: — So the work to date has been around looking at the demographics of the area, identifying the needs going forward into the future. So they've been working with the ministry through that process.

In the last number of months, they've been working on actually drafting an RFP for somebody to hire for the functional plan. So that RFP will be going out later this month. Once they award that, then that consultant will work with them to develop that functional plan over the next three to six months after they start working on that. So it'll be later this year I suspect, depending on when the RFP's actually awarded, that they will be completing . . . doing the work, developing and completing the functional plan. And then from there then it can move forward

to the next phase which would be, a part of that would be the 3P process.

Ms. Chartier: — Does the 500,000 that they received . . .

The Chair: — Excuse me. The time now being 5:05, I would ask a member to move a motion of adjournment.

Mr. Parent: — I do.

The Chair: — Mr. Parent has moved. All agreed?

Some Hon. Members: — Agreed.

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

[The committee adjourned at 17:05.]