STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Moose Jaw Wakamow

Mr. David Forbes, Deputy Chair
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Regina Douglas Park

Mr. Roger Parent
Saskatoon Meewasin

Mr. Corey Tochor
Saskatoon Eastview

Hon. Nadine Wilson
Saskatchewan Rivers

Ms. Colleen Young
Lloydminster

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[The committee met at 13:30.]

The Chair: — The time being 1:30, we're going to get started here. I'd like to welcome our members: Mr. Marchuk, Mr. Parent, Mr. Tochor, and Mr. Hart sitting in for Ms. Wilson, and we have Ms. Chartier sitting in for Mr. Forbes.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — So today we will resume our consideration of the estimates and supplementary estimates for the Ministry of Health, vote 32, subvote (HE01). Minister Duncan is here with his officials. Minister, if you would please introduce your officials and make your opening comments, please.

Hon. Mr. Duncan: — Thank you, Mr. Chair. We have a number of officials with us again this afternoon. To my right is Max Hendricks, the deputy minister of Health. To my left is Greg Ottenbreit, the Minister of Rural and Remote Health. If we do have further officials come forward during the day, as we normally do, we'll ask them to identify themselves for members of the committee before they give their answers.

Mr. Chair, I don't have an opening statement for this afternoon. I think we covered that off in our first meeting, but I do have some follow-up answers for Ms. Chartier and members of the committee on some outstanding questions from the last committee. So I'll maybe just move through those relatively quickly. I'll also identify, Ms. Chartier, some of the answers that we're still endeavouring to collect the information, just so that you know kind of where we're at in terms of providing that information.

With respect to your question about the head count for continuing care aids in Saskatchewan, we are in the process of gathering that information about employee counts. For CCAs [continuing care assistant], members, just keep in mind that CCAs are employed both in long-term care but also outside of long-term care, and so we don't have that information today, but we are compiling that information.

We're also ensuring that we have an accurate count, not only from those within the regional health authority but also those that would be employed by affiliates that wouldn't necessarily be captured under, say, our payroll account or payroll system. We want to make sure that we're providing a full picture to the members of the committee. I hope to have that before our next or at our next committee meeting, at some point for members of the committee this spring.

The CEO [chief executive officer] tours of long-term care facilities in 2014, we are reviewing those documents. We are wanting to ensure that we're putting the right confidentiality and privacy lens on this information and redacting things of a personal nature, so we will be providing the 2014 CEO tour information to the committee in the future. It won't be today, but we will be providing that information to the committee for members' perusal.

As well, I will note that that will be the 2014 information. We have also sent . . . I believe I mentioned this at the committee that we have asked for the CEO tours to continue, and so those are under way. My expectation is that those tours would be done for 2015 by the end of June. And so we'll have the 2014 information for committee members, and obviously 2015 will take a little bit longer after we can compile that information.

With respect to the program guidelines for special care homes, Ms. Chartier, you'd referenced that a staffing ratio in chapter 9 was removed from earlier drafts of the documents. When the guidelines were being developed and reviewed, policies were shared with RHA [regional health authority] long-term care directors for review and feedback, and at times with others such as the dietitians regarding nutritional programs, etc. All drafts have been reviewed within the ministry, and staff ratios were not included in any draft or in anything shared with RHAs or others. Chapter 9 in each draft refers to assessments, the MDS [minimum data set] system, and not specifically to staffing. The 1986 version of the guidelines also did not include mention of staff ratios.

Further on a similar topic, we had a discussion about the case mix index or the CMI dating back to 2007, and we had a discussion whether or not that could be provided due to changes in how the CMI was calculated over time. So I will be tabling with committee members today a document that goes back eight years to 2007. Eight years is the most that we can provide because prior to 2007 the CMI was in research development and was not included in CIHI [Canadian Institute of Health Information] specifications. So I will be tabling though that document, that table with the committee today. I believe I have my copy here at the table.

I'll just go further. There was a question as it related to the increasing number of beds at Oliver Lodge and whether or not it increased the number of beds provided specifically for dementia care. Prior to the expansion, Oliver Lodge in Saskatoon had 17 dementia beds. After the expansion of 63 beds, there was an increase within that 63 beds of 15 beds dedicated for patients diagnosed with dementia. So it went from 17 to 32 beds in total, a net increase of 15 beds at Oliver Lodge dedicated for dementia care.

Finally we are also putting together the information on the 3P [production preparation process]. That won't be tabled for committee members today, but it will be tabled with the committee I suspect in time for members to deliberate on that as well. So we will be providing that information as well.

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

Ms. Chartier: — Thank you. I'd like to thank you for that update, and I appreciate getting that. Sticking with long-term care here, I know that you said you'll endeavour to get the 2014 report, but out of the 2012 December meeting that took place with stakeholders and interested parties that came out of the Urgent Action Fund, that December 2012 meeting, I understand that many of the stakeholders received a summary of that discussion. I'm wondering if that would be possible to have the summary tabled. Was there a report that came out of that December 2012 meeting?

Hon. Mr. Duncan: — The two-day stakeholder engagement meeting took place in 2013.

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — I know you knew what you were talking about. But yes, 2013. There was no report that was generated from that, but we will table with the committee the summary of the two-day event. We don't have it here with us, but we will be providing it. We will provide it to the committee.

Ms. Chartier: — Can you tell me what actions have come out of that summary? I understand that people felt that it was a good consultation process, but it's been expressed to me by participants that they were concerned that there hasn't been action out of that process.

Hon. Mr. Duncan: — Thank you for the question. The two-day event that took place in 2013, December in 2013, followed upon the work that we had done through the CEO tours, the surveys that took place with resident family councils, as well as, I would say, one of the lead-out events from our Urgent Issues Action Fund that was announced prior to that.

So there was — I know from my time, the time that I did spend at the summit — there was a lot of discussion about, you know, the general concepts around ensuring that we're providing supports to seniors in their home longer, appropriate supports to keep them in their home longer. So you know, I would certainly point to what we have previously announced as it relates to the Home First/Quick Response program, the expansions that we're doing in this year's budget for that, as well as the individualized funding for those that are on the wait-list for individualized funding when it comes to services like home care.

I think it's fair to say that what we've tried to do in terms of some of the other programs around gentle persuasion, purposeful rounding, you know, focusing on the four Ps within long-term care . . . And I'll maybe just — I know members know about that — but the four Ps are around pain, proximity to personal items, personal needs, and their positioning. So some of those training programs that we're implementing in a number of regions and specifically purposeful rounding will be implemented across health regions, as we discussed at the last committee meeting.

But we will, as I said before, we'll endeavour to provide the actions that would have been a direct result, that would have come out of that summit, as well as kind of a summary of the discussions that would have taken place.

Ms. Chartier: — Thank you. Of that summary, was one of the emergent issues staffing? Did that come out at all in that two-day summit?

Hon. Mr. Duncan: — The way that the summit would have taken place, there would have been obviously some . . . I made some opening comments, and then there would have been a lot of kind of group work that would have been done, looking at the different aspects of long-term care.

I think it's fair to say that there would have been discussions at each individual table around a variety of different areas. I think it's fair to say staffing would have been among that. But I do know that, from our officials that would have attended the entire two days, that it wouldn't have been one of the overarching themes that would have come out kind of at the end, at the wrap up of the entire event.

Ms. Chartier: — I guess we'll see the summary, but did it make it into the summary?

Hon. Mr. Duncan: — We don't believe it did, but we'll share the summary when it comes to members.

Ms. Chartier: — Thank you for that. I'm still speaking of seniors' care here. I'd like to talk a little bit about home care. And I know we had a conversation about that last year, and I'm again looking to gain some of my knowledge of the different programs. Forgive me if I'm wrong here, but we've got supportive home care, palliative home care, and acute home care. Would those be the categories, or am I missing anything else there?

[13:45]

Hon. Mr. Duncan: — Typically it does break down into the different categories of supportive, acute, and palliative. There are other services that would be provided that would be more specifically focused. So it could be around therapy, it could be around some things like personal care, respite, that sort of thing. But generally the three themes are correct.

Ms. Chartier: — Okay. Obviously you give regions a global budget and then they spend their money on home care as they see fit, and then there's the targeted money for the Home First program. But aside from the Home First programs, can you tell me how much each region spent on home care?

If you have comparative, so not just the most recent fiscal year but take me back even a decade, if possible.

Hon. Mr. Duncan: — Sure. So I'll maybe start with just the overall total amount for all regions combined, the funding level for home care. We do have the breakdown for regions. So I will go back to the 2007-2008 year. We'll endeavour to try to go back a little bit further than that, but I think this will provide some context.

I just want to be clear. So this would be the expenditure by the regional health authorities. This wouldn't be the client portion that they would pay on top of. I think that that would be fair to say. So 2007-2008, the total expenditure by regional health authorities was 122.4 million. The next year that increased to 130 million, so that was a 6.3 per cent increase; 2009-2010, that went up to 142.9 million, so a 9.7 per cent increase from the previous year; 2010-11 was 149.5 million, so from the previous year a 4.6 per cent increase; '11-12 was 159.6 million, a 6.75 per cent increase from the previous year; 2012-13 was 168 million, a 5 per cent increase; and in 2013-14, 169.8 million, a 1 per cent increase from the previous year. But in total that represents about a 40 per cent increase from that base year of 2007-2008. So 169.8 million in '13-14 and then for the . . . So that would be the latest information that I have as a total.

Ms. Chartier: — And can I just stop you there for a moment?

So is Home First factored into that amount then?

Hon. Mr. Duncan: — Those numbers do not include the Home First/Quick Response dollars.

Ms. Chartier: — All right. So for the Home First/Quick Response, before we get into regional breakouts, could you give me those? And I know it's only been a three-year or two and . . . It all blends together here now.

Hon. Mr. Duncan: — Yes, so it would have began as a pilot in Regina Qu'Appelle and then . . . I'm trying to think if that would have been two years ago. Maybe before I start answering the question, I'll get the information in front of me.

So the pilot began in Regina Qu'Appelle Health Region in April of 2013. That was a $2 million expenditure. The pilot was expanded in June of 2013 into Saskatoon Health Region. As well that was, I believe it was 2 million at the time. Both of those programs have been . . . So they're annualized now. In this year's budget we added an additional $1 million to each of those programs.

In the '13-14 year we provided Prince Albert Parkland Health Region with $500,000, and that was provided again in 2014-15. And then in October of last year we announced a pilot in Prairie North Health Region and at that time they received about $125,000 for the final quarter of the year. In total they will receive $500,000. P.A. [Prince Albert] Parkland, $1 million and then again as I said, Regina Qu'Appelle and Saskatoon, an additional $1 million on top of what had already been annualized.

Ms. Chartier: — So sorry, 1 million . . . So 3 million for Regina and 3 million for Saskatoon.

Hon. Mr. Duncan: — Yes, that's correct. So the total spend then is 8.25 million across the different sites that are operating Home First/Quick Response.

Ms. Chartier: — Okay. Thank you for that. In terms of the average number of hours provided for supportive home care, can you give me a little snapshot of that in the last several years as well. Just for supportive home care.

Hon. Mr. Duncan: — Ms. Chartier, while we try to track down your last question, I do have the home care dollars for '14-15 by health region.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — So the last number that I would have given you I think was 168 million?

Ms. Chartier: — 169.8.

Hon. Mr. Duncan: — Yes, 169 million, so that would have been for '13-14, the total number. So the total number for '14-15 is 183.5 million. Now I'm just going to . . . So that would also though include the fees that clients would have paid into the program, which I didn't give you on the previous number. So I just want to make sure that . . .

Ms. Chartier: — So the 2014-15 includes client fees, but those other numbers are government.

Hon. Mr. Duncan: — Yes. Just give me a second. Okay. I appreciate your patience. So we just want to make sure that we're providing apples to apples. So the 169.8 number that I would have given you for '13-14, so the comparable number for '14-15 would be 183.5 minus the Home First dollars so . . . Sorry. I'm going to jump around a little bit here. It's approximately 178.5 million for '14-15. That would be comparable to the chart that I would've given you on a previous answer.

Now when I go into the . . . So that's the government funding. The 178.5 million is the government funding. That doesn't include the fees, but the numbers that I have here today for each individual health region includes the fees that were paid in by the residents or by the clients.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — So my comparison for overall what the region spent is comparable, but on the region-by-region breakdown it's not comparable. It's comparable to each other, but it's not comparable to the global numbers that I gave you before because it does include what the clients paid.

Ms. Chartier: — Do you have . . . So when you say Saskatoon Health Region for the recent year do you have, can you give me the percentages of what client fees are in that? Or not the percentages; the actual number. So if it's 50 million, and 40 million is government and 10 million is client fees, like do you have that kind of figure in front of you?

Hon. Mr. Duncan: — I do. So why don't I start just at the top of the list?

Ms. Chartier: — Okay.

[14:00]

Hon. Mr. Duncan: — Okay. So Cypress Health Region, their total spend on home care in '14-15 was 7.7 million and $392,500 was client fees; Five Hills Health Region, 9.3 million and 454,000 of that was client fees; Heartland was 7.9 million and the fees paid were 535,000 — and I'm just rounding numbers here; I could give you exact if you want but that's approximation — Kelsey Trail was 8.6 million and 576,000 of that was fees paid by clients; Prince Albert Parkland was 12.9 million and 360,000 of that was paid by clients; Regina Qu'Appelle Health Region was $42 million and $1.048 million of that was client fees; Saskatoon Health Region was 57 million and 1.8 million of that was client fees; Sun Country, just over 10 million and 436,000 of that was client fees; Prairie North, 11.2 million and 408,000 of that was client fees; and Sunrise, 13.6 million, 719,000 of that was client fees; and Keewatin Yatthé, 1.6 million and 218,000 of that was client fees; Mamawetan, 1.9 million and there were no client fees that were paid in the last year.

Ms. Chartier: — Thank you for that. So does each region then have a different policy around client fees then? It seems to me just . . . I'm assuming so here, but how do most regions

determine client fees?

Hon. Mr. Duncan: — The RHAs are responsible for billing home care clients for services. Individual client fees or charges are based on the client's income and the number of services that are delivered to the client. So clients do have an opportunity to apply for a subsidy.

Clients, regardless of their income, are currently charged 7.76, so $7.76 per unit of service for the first 10 chargeable units of service received in a month, and a unit is defined as one hour of service or one meal. So a chargeable service includes homemaking, meals, and home maintenance, but that doesn't include the assessment, nursing, therapy, or volunteer services. So it really is dependent upon how much of the home service that they are requiring and their income as well.

Ms. Chartier: — So are the fees . . . Sorry. Then I'm not sure if I'm understanding this correctly. Then the fees don't apply to sort of the nursing services then? It's just the home services?

Hon. Mr. Duncan: — That's correct. So chargeable services would include things like meals, home keeping, home maintenance, but it doesn't include nursing, therapy, and other, that type of service.

Ms. Chartier: — But it is mandated by the ministry or each health region. It's the same across the board.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay, thank you. Back to that question around the average number of hours.

Hon. Mr. Duncan: — I'll just maybe add though, that RHAs do have discretion when it comes to if they need to waive fees for individuals that don't have the ability to pay.

Ms. Chartier: — A question on average number of hours for supportive home care?

Hon. Mr. Duncan: — So the services that are provided, I'll maybe start on the . . . So for the supportive services: meals, the unit of service . . . So remember a unit is either a meal or an hour of service. So for meals it was 312,701, and this is '13-14 numbers.

Ms. Chartier: — Sorry, 312,701?

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — So it's for meals.

Hon. Mr. Duncan: — Yes, and homemaking units of service was 885,083.

Ms. Chartier: — So that's hours basically. Is that right?

Hon. Mr. Duncan: — Yes, a unit would be equivalent to one hour. For palliative, meals was 5,265, and homemaking was 27,812 units.

Ms. Chartier: — And this is for '13-14, both of these?

Hon. Mr. Duncan: — Yes, that's correct, '13-14.

Ms. Chartier: — Can we go back? I'd be interested in the numbers back a decade actually.

Hon. Mr. Duncan: — We'll endeavour to provide that information to you. We don't have those with us going back that far.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — But we will try to pull together that information. And then, so the third category on the acute home care clients, so the number of units, units of service, or meals, 18,806 and for units of service for homemaking was 34,658.

Ms. Chartier: — I'm terrible at jotting these numbers down. Okay. I'll have to look at *Hansard*. It's what I rely on sometimes. Does that include . . . Again just double-checking to make sure that doesn't include the Home First hours in there.

Hon. Mr. Duncan: — It would be fair to say that these numbers may reflect the Home First/Quick Response program that would have been piloted in that year in Regina Qu'Appelle Health Region because keep in mind these only go back to '13-14, so that would have been really the only region . . . I think Saskatoon would have received their money later in the year, but it really would be limited in how Home First/Quick Response would affect these numbers.

But certainly the intent where applicable or where appropriate was that Home First/Quick Response would link up people that should be on home care that perhaps were not previously home care clients. So they may be reflected in these numbers, but there's no breakdown to say that this client received these units of service because of Home First/Quick Response.

Ms. Chartier: — Okay. Well if between now and the next time we have an opportunity to meet, that would be great if we could go back, a decade would be great, if you've got those numbers for all three categories. That's possible?

Hon. Mr. Duncan: — We'll see what we can do by the next committee.

Ms. Chartier: — Okay. Thank you for that. Sticking with the home care topic here, there was a RQHR [Regina Qu'Appelle Health Region] . . . or a briefing note about home care being overcapacity as recently as January 2015.

So obviously I know in the budget you put some money in place for individualized funding, and I'm assuming that's to deal with some of these issues. But can you tell me where RQHR is right now in terms of their wait lists and experiencing overcapacity in community nursing and home services?

[14:15]

Mr. Hendricks: — Hi, it's Max Hendricks, deputy minister of Health. So Regina Qu'Appelle does continue to face some challenges in terms of meeting home care capacity needs. Our most recent statistics are from February 10th, 2015, and what that shows is that at the end of January, overall home care

capacity was at 110 per cent.

There were wait times for home service referrals from the community of about 3.89 days and 3.6 days from the hospital. The wait time for nursing referrals was 3.27 days from the community and 1.75 days from the hospital, and the wait time for transition home team referrals was 1.29 days from the community and 1.3 days from the hospital.

Now within that group of clients that are awaiting service for between one and three days, those clients are prioritized based on need in an assessment, and so those that most urgently need the care are getting it more quickly. Now since . . . I think last time you asked about this was at Public Accounts Committee, if I recall. We had reported some numbers, and since July of 2014 there have been some improvements.

At that time, the numbers that we quoted, we've shown the numbers that I just gave you: a minus 1.53-day improvement in the referrals from the community, a point nine three-day improvement in the referrals from the hospital, a minus point three eight referrals from the community, and then a minus 2.81 in terms of home team referrals from the hospital.

So the region is taking action. They've hired a coordinator, as you'll recall, and are trying to line up services. But again, you know, it's a challenge in terms of, we've expanded Home First, and having the individuals, the staff that come in to provide the services or hiring the staff to provide the services has been a little bit slower than we had hoped. But we are improving.

Ms. Chartier: — Just a clarification then, to make sure I understand this right. When we talk about the length of days wait, is that for . . . and we talk about the hospital referral and the community referral. So that's literally 3.9 days that you'll be waiting, that you'll be referred and it will be 3.9 days that you're waiting? Because that . . . Is that what that means?

Hon. Mr. Duncan: — So that information, that time would be on average for a client. However if you are considered a more urgent client, your prioritization would be adjusted based on the urgency of your situation. So these numbers are on average.

Ms. Chartier: — Okay. It's interesting, I just had an opportunity to spend the day yesterday with some RNs [registered nurse] who . . . Are you familiar with the term social admit — I had never heard that before — into the hospital? And they've identified for me that there are people who are not getting home care services, who show up at the hospital and have nowhere else to go. Because home care for any reason . . . They haven't been able to access home care, so they're being admitted on a social admit because there's no other place for them to go.

Hon. Mr. Duncan: — I'm not that familiar with the term, but I understand that that may be one reason why somebody would be an admit on that basis. But there may be other reasons for that as well.

Ms. Chartier: — Can you tell me what a social admit then is? Like is there a definition for that?

Hon. Mr. Duncan: — There's no formal definition of what type of scenarios would be defined under a social admit. You know, I think it's fair to say that physicians will admit for a variety of reasons, often not with a definitive or known diagnosis in some cases. And so there's no real kind of defined list of these are all the things that would be covered by a social admit.

Ms. Chartier: — Do you have a sense or is the ministry tracking at all how often that's happening? I was led to believe anecdotally from people on the front lines that it happens a fair amount, at least in our larger urban centres.

Hon. Mr. Duncan: — So we do track the ALCs or alternative level of care. That would be people waiting for long-term care, for example. That would also capture the social admit numbers, so we do track that number.

Ms. Chartier: — Could you give me a sense of what that looks like over . . . again just picking the last several years?

Hon. Mr. Duncan: — Thank you for the question. So the most recent or up-to-date information that we'd have would go back to '13-14. So 7.8 per cent would be related to alternative level of care, patients waiting for an alternative level of care. That would include those waiting for long-term care. It would also include the social admits, and for any other reason that they would be waiting.

This I think really demonstrates why we look so strongly and have invested in a program like Home First/Quick Response, is trying to ensure that we have the appropriate services where possible for the right patient. So 7.8 per cent would be the '13-14 number.

Ms. Chartier: — You said it only goes back to '13-14. Is that just relatively new in tracking that then?

Hon. Mr. Duncan: — This is just the number that we have readily available for now for the committee. But we'll endeavour to return to the committee with more detailed information and try to give some historical context as well if we can.

Ms. Chartier: — Okay, thank you.

Hon. Mr. Duncan: — We do track the ALC number, so it wouldn't be one that we're not familiar with as a ministry or that regions wouldn't be dealing with. It's just the information that we have today is based on '13-14.

Ms. Chartier: — Okay, thank you for that. Just going back to RQHR and the challenges with home care in RQHR. In January you were getting weekly updates, I understand, from RQHR, but your last update was the end of February?

Hon. Mr. Duncan: — So the most recent information that we'd have from Regina Qu'Appelle would be from the first week of April. At that time, their numbers in terms of how they were tracking when it comes to referrals from the community, referrals from the hospital etc., and some of the numbers that you've already heard about, so they would have been tracking along the same lines back in April. Their commitment at that time was that they were going to continue to provide priority

services to those clients that were deemed to be urgent. So the numbers had been relatively stable from the last update in April, consistent with where they would have been in January and February.

Ms. Chartier: — So about 110 per cent capacity?

[14:30]

Hon. Mr. Duncan: — Yes, it would be fair to say that they experience high capacity levels. Hard to say though at that April update whether it would be 110 per cent or not, but they would have been at high capacity levels. But I'd say consistent to where they would have been earlier in the year.

Ms. Chartier: — Would that be considered at level 3 or level 4?

Hon. Mr. Duncan: — Our most recent update would also indicate that they would still have been at a level 4 capacity. It's also important to note though that Regina Qu'Appelle would have received or is receiving in this budget an additional $1 million for the Home First/Quick Response program. As well they'll receive about $750,000 to address their wait-lists for individualized funding.

So it's difficult today to say how that may impact this, but I think it would be reasonable to say that some of their clients would be individuals waiting for that individualized funding. So we'll see, you know, I would suspect we'll see over the next weeks and months how those two initiatives in particular are going to affect their home care numbers.

Ms. Chartier: — Mr. Hendricks, you identified that in your comments a little bit earlier, talked a little bit about staffing, and I know that that was identified: increased flow from acute care; pressures in the system, although I'm not sure which pressures in the system; and staffing vacancies. I'm wondering how many staffing vacancies RQHR is currently dealing with in home care.

Hon. Mr. Duncan: — Mr. Chair, Ms. Chartier, we will reach out to Regina Qu'Appelle Health Region and find out how many vacancies they currently have in home care and report back by the next committee meeting.

Ms. Chartier: — Okay. Thank you for that. With respect to individualized funding and the money that was in the budget, what was the . . . Refresh my memory. What was the total? Was it 2 million for individualized funding? Am I recalling that correctly?

Hon. Mr. Duncan: — Yes, that's correct. It was $2 million.

Ms. Chartier: — And to which health regions was that 2 million . . . Like how was that being divided up?

Hon. Mr. Duncan: — It's $750,000 to both Saskatoon Health Region and Regina Qu'Appelle Health Region, $250,000 to Prairie North, and $250,000 to Five Hills.

Ms. Chartier: — Obviously there was previously some money for IF [individualized funding] in health care previously, but why have you decided to go this direction instead of putting that $2 million into the public system? Like has there been a push from the public for individualized funding? Or maybe I'll just let you tell me why you've chosen to go this direction.

Hon. Mr. Duncan: — So the decision around the individualized funding, so individualized funding is a part of the home care budget that regions do provide. This certainly was in recognition of the demand for individualized funding. So the dollars were provided to those health regions that did have wait-lists. So certainly it's my hope that this will eliminate the wait-lists for the individualized funding in those health regions. The other regions, many of the other regions will provide individualized funding but didn't have wait-lists. These four in particular had wait-lists for their individualized funding.

Ms. Chartier: — Specifically, as I understand, individualized funding had been put on hold. I remember being at a seniors' event here in Regina less than a year ago where I had been told that requests for IF, at least in RQHR, had been put on hold. So this is to address specifically the wait-lists, not for home care but for those who are requesting individualized funding. Is that correct?

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

Ms. Chartier: — I just wanted to make sure I was understanding that. Okay, thank you. In terms of staff vacancies, so you've said you'll endeavour to get those in RQHR. Are you aware of other regions having challenges with home care as well?

Hon. Mr. Duncan: — Just I think as a general comment, I think it would be fair to say that there have been regions, other regions that would from time to time flag with the ministry difficulties in staffing up all of their CCA positions. I think home care wouldn't be alone in that. You know, obviously CCAs work in other areas such as long-term care, and there is turnover when it comes to long-term care as there would be in home care. Oftentimes we'll see CCAs go back and forth between the different types of positions, different types of work environments. CCA positions are ones that regions I think, you know, I think it's fair to say, do from time to time struggle to recruit into and retain employees.

Ms. Chartier: — Thank you. Can you identify which regions have flagged concerns in, particularly, in home care?

Hon. Mr. Duncan: — I think it'd be fair for me to say that particularly the larger regions, certainly Regina Qu'Appelle, have indicated that from time to time they've struggled with trying to fill their continuing care aid positions. It's not something that we track in terms of which regions are reporting to us at a specific time. It just, I would say — this is more anecdotal — affects largely the larger health regions.

But you know, I would think that the smaller regions, you know, they would from time to time have difficulties filling these positions as well, probably not to the same extent that the larger regions. But you know, I wouldn't want to go on record to say that Sunrise or Sun Country never have difficulty filling CCA positions as it relates to home care or any other area of the system.

Ms. Chartier: — On that same vein then, I know you're going to be reaching out to RQHR about home care. Would it be possible to reach out to the other regions around both home care and long-term care staff vacancies?

Hon. Mr. Duncan: — We'll endeavour to get that information to you.

Ms. Chartier: — That would be great. So I'm looking for current staff vacancies in long-term care and in home care in each health region. That would be great. Thank you.

I've already used an hour on home care, and I've got lots of things to cover here. So I think I'll move on here, and perhaps we'll get a chance to come back next time we're together on this. Just out of curiosity, I think I'd like to talk a little bit about lean here. I'm just wondering if either the Ministry of Health or any of the RHAs have any contracts with Lead 2 Lean Solutions.

Hon. Mr. Duncan: — We currently do not have any contracts with any lean consultants as a ministry. We've also sent a directive to the regions that they are not to enter into any lean contracts as well.

Ms. Chartier: — Thank you for that. I'm curious or wondering about the lean leader certification and maintenance. A document that we received — 1, 2, 3, 4, 5, 6, 7, 8, 9 — looking at 10 leaders here. I believe this came in a freedom of information request. I'm wondering if the lean leader certification and maintenance is carrying on, and who would be doing that.

Mr. Hendricks: — As part of our contract with John Black, we had committed to have 800 lean leaders receive their certification. As of February we have 264 lean leaders that are certified and 540 that are still in training. And people are graduating literally every day upon the completion of their requirements of that program.

The ministry and its health system partners will be carrying forward with certifications. We will be doing them ourselves. We have made some modifications to the John Black curriculum to better suit the Saskatchewan context while maintaining some of the rigour and some of the aspects of the John Black approach that we do like most. And so it will be continuing. We still have a backlog of leaders that have to receive their certification and they will be taking the necessary training over the next year to achieve that. But by the same token, we're going to be adding another wave of training hopefully in the fall.

[14:45]

Ms. Chartier: — So it's local people who've already been trained as lean leaders who are doing the certification. Is that correct?

Mr. Hendricks: — Now that we actually have 245 people and actually quite a number who have a high level of training, yes. That was always the plan, is that we would take on responsibility for training future leaders. And that hand-off has occurred and is ongoing.

Ms. Chartier: — Thank you for that. I'm wondering about the kaizen fellowship program and if that's still . . . Can you tell me what that is and how that works and if that's still operating?

Mr. Hendricks: — I can tell you a little bit about that. In addition to certification, we have identified individuals who we thought should take on advanced training in lean, and so some of the more complex tools that we would use in lean like 3P and just the broader general understanding about how it's used in other sectors is something that we wanted to achieve here in Saskatchewan. So we have three people, I believe, that we have identified as kaizen fellows, all situated within the Saskatoon Health Region, but who would be resources to the province. And in addition to the regular requirements of becoming a certified lean leader, which are quite numerous in and of itself, they have to do significant more reading in terms of 27 additional books beyond what a normal lean leader would have to do. They have to participate in events. They have to lead events. As well, they did have the opportunity to tour a few sites in the US [United States] in health care and in industry.

Ms. Chartier: — So these three folks are already lean leaders who are doing like a master's for all intents and purposes.

Mr. Hendricks: — Ph.D. [Doctor of Philosophy].

Ms. Chartier: — Okay, okay. And the three people are in the Saskatoon Health Region.

Mr. Hendricks: — Correct.

Ms. Chartier: — And who is doing their . . . I notice one of them was, I think, a director. Patti Simonar. Like who is in their work? How much time is it taking them to do their kaizen fellowship, and who is doing their work in their absence?

Mr. Hendricks: — The three individuals in the Saskatoon Health Region that were selected are all at the director level, and they wouldn't be pulled out of their regular job. Obviously at some point, they would have to have allowances, you know, and time allowances away from work to complete some of the requirements of the program. But these were individuals that were specifically identified (a) for their future prospect and also because they had been shown to be strong lean leaders.

Ms. Chartier: — And how much time will be allotted for them to do this advanced training?

Mr. Hendricks: — They have to complete the training . . . Sorry, your question again? How much time will be allotted for the . . .

Ms. Chartier: — Yes. So you've said that they'll have to be given a time allowance to be able to do some of this.

Mr. Hendricks: — Right. I just actually received information that I misspoke. They have stepped out of their permanent positions to do this training.

Ms. Chartier: — So they're no longer directors.

Mr. Hendricks: — Well they're directors. They'll return to their position. Those are just being filled, backfilled by

somebody else. And they have to do a five-year return service.

Ms. Chartier: — Okay. So are they being paid at their director's salary?

Mr. Hendricks: — Yes, they'd be paid the same salary, yes.

Ms. Chartier: — Okay. And then there's people who've stepped into the director's role.

Mr. Hendricks: — To fill their duties while they're doing this other work, yes.

Ms. Chartier: — To fill their duties. Okay, and then they have to return as lean fellows in whatever capacity, not necessarily as a director. But those three people will be highly trained to support the rest of lean training? Is that the goal?

Mr. Hendricks: — Yes. So in addition to those people that we have in our kaizen promotion offices across the province that are highly trained in lean, these folks would have that higher level as I've described, a Ph.D. And so in some of the, you know, kind of in the furtherance of our understanding of lean and how we deploy it, these people would have understanding because they would have not only reviewed obviously more literature on the subject but would have had personal exposure to other settings and high-performing health care organizations and industries that do use lean. So yes, the expectation is that these individuals will help to further our total capacity and knowledge in this area.

Ms. Chartier: — So just to clarify then, their role right now is . . . They're not in their director role. They're still directors but not . . . They're being paid as directors, not in their director role, and their work right now is just focusing on the kaizen fellowship. Is that correct?

Mr. Hendricks: — Correct. Although the reason that I kind of misspoke before is because they've actually completed most elements of their training. And so right now there's a discussion on what is required for them to complete it now that we've exited our agreement with John Black. So I would need to actually check to see whether they are working in the kaizen promotion office of their region or whether they're back to their original jobs. We can confirm that.

Ms. Chartier: — Okay. And so again you just, I think you've sort of answered my question. There's not a time yet. You don't have a time for how long it'll be before they're finished this fellowship.

Mr. Hendricks: — Yes, they're very close to being completed right now.

Ms. Chartier: — And how long have they been out of their roles as directors and just focused on this?

Mr. Hendricks: — Yes, they've been out approximately one year now, taking their fellowship.

Ms. Chartier: — Okay, and their position has been backfilled since that one-year time then?

Mr. Hendricks: — We don't know how, but our note here does say that they've stepped out of their permanent positions for this period.

Ms. Chartier: — But it's not a . . . sorry, I just want to . . . and I'm sure when I go back over *Hansard* I'll have some clarifications here too but . . . So they're not in their position, but is the goal then to have them go back into their position or to serve in kaizen promotion offices like the Health Quality Council? Or like what . . . Obviously I understand that they'll be supporting lean training and further advancing the deployment of lean, but I am just wondering where and how that might . . . what the expectation is that will look like.

Mr. Hendricks: — I can't speak specifically to whether these individuals will be placed either in a regional KPO [kaizen promotion office] or whether they will return to their regular duties. One thing that I guess is often misunderstood about what we're doing in terms of our lean initiative is that we want leaders to have a high level of training and it's through actually . . . You don't want people necessarily that are only focused on delivering improvement work; you want people that have a high level of training, engaged in day-to-day administration and activities within the health care system. So like, I myself have to become a certified lean leader. These kaizen fellows could actually carry out some of their kaizen activity and be in a normal position within the region, but I would have to check specifically what the plans are for these individuals.

And it's part of, quite frankly, an ongoing dialogue that we're having as we transition from John Black, how best to use the resources and the expertise that we've acquired through this.

Ms. Chartier: — Okay, thank you for that. Just as you've exited the contract here, I'm just looking at some of the deliverables. In terms of the front-line staff that got introductory training, you already gave me the number of lean leaders trained and how that will roll out. How about in terms of front-line staff that got introductory training? Do you have a number for that?

Mr. Hendricks: — So as of, again as of February, we have 23,000 people across the health care system that have taken the introductory element of lean training which is then called kaizen basics.

Ms. Chartier: — Okay. I'm just trying to get a handle on some numbers that have been . . . Actually as recently as March 16th in the House I think, Minister Duncan, your numbers were slightly different than the Premier. On March 16th, 2015, the Premier said the total costs for lean was 40.5 million over four years. And I think you've given it, like, a 36. I can't remember the number off the top of my head, but so I'm wondering what the difference is between those two numbers.

Hon. Mr. Duncan: — So our total forecasted expenditure to the end of the contract with John Black and Associates would be $32.6 million. However there would've been other spending on consultants and other activities that would've pre-dated John Black and Associates. So the 2008 through until . . . at that time it was February 28th, 2015, both including John Black and non-John Black, would've been $39.1 million.

Ms. Chartier: — Okay. That's makes sense. Mr. Hendricks, you had received a letter last May from John Black in talking about reviewing options with the John Black contract and he specified four requirements, and I'm wondering what those were.

Mr. Hendricks: — I can remember three of the four off the top of my head, and maybe you can refresh my memory because we don't . . . [inaudible] . . . One was that Minister Duncan completed the North American tour, and I think Mr. Black's reasons for wanting that was obviously lean leaders . . . One of the reasons that we did North American tour is to have the exposure to Virginia Mason Children's Hospital and to industry as well. And so he thought that would be a good experience for the minister. He also asked that I and Dan Florizone commit to completing our lean training. And there was a fourth one, and we're looking at what it is.

Ms. Chartier: — Okay, so that's only two. Or was that . . .

Mr. Hendricks: — That's three.

Ms. Chartier: — That was you and Mr. Florizone were broken out into two different . . . Okay. And if you could find the fourth, that would be great. So you're finding the fourth. So you are in process of doing your lean leader training?

Mr. Hendricks: — Correct. I had completed to the end of module marathon and so I have to do my rapid process improvement workshop still. And as a CEO-equivalent deputy minister, I have to also do some additional training. Dan Florizone, if I'm correct, has just completed his North American tour in March and he has also done kanban training which is a requirement of CEOs, so he's a little bit ahead of me.

[15:00]

Ms. Chartier: — Okay, thank you for that. So I'll wait to hear what the fourth deliverable or the requirement was. In terms of the cost that you've given me now for lean, the almost $40 million, does that include all travel-related costs both for officials going abroad? And yes, not both, does that include the travel costs for officials going abroad?

Hon. Mr. Duncan: — No, that's just the cost of consultants going back to 2008.

Ms. Chartier: — The 40 million is the cost of consultants going back to 2008. Can you tell me what the . . . So that when you talk about the cost of consultants, does that include John Black's travel?

Hon. Mr. Duncan: — Yes, that includes his travel.

Ms. Chartier: — So the 40 million includes John Black's travel and all his . . . Those with whom he worked is in that 40 million. But officials from various places then, can you give me a cost of how much it's cost for us to send health care officials or officials down to wherever you've sent them?

So when I talk about travel, like not just obviously travel to the States but travel of any officials in Saskatchewan from Saskatoon to Regina . . . Like I don't know if you have it broken out into international travel and local travel, but if you could give me a total cost of how much it's cost to send officials.

Hon. Mr. Duncan: — The travel for North American tour from June of 2012 until the end of February 2015 was approximately $1.6 million. We don't track the travel within the province, say, officials from one health region going to another health region or, you know, for those types of events. That would all be captured within the region's travel budgets.

Ms. Chartier: — So that was all. That's the total amount of travel associated with officials under the John Black contract.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay. Thank you for that. Moving on from . . . Oh, in terms of the 1,000 lean events that were to be carried out, I'm curious how many were held. At the end of the day, how many lean events were held?

Hon. Mr. Duncan: — Lean events since 2012 . . . as of the end of March, sorry. As of March 12, 2015, rapid process improvement workshops, there were 375 of those across the province, and I'll just maybe briefly talk a little bit about them. Through that work, that talks a lot about space and inventory and walking distance, so in terms of space, the square footage, we've seen a 38 per cent reduction as a result of those 375 events; inventory, a 55 per cent reduction; walking distance for patients and staff, a 54 per cent reduction; and total time of processes, a 56 per cent reduction. As well as in terms of quality or looking at the defects that we've been able to reduce, a 78 per cent reduction. Kanban events, there have been 49.

Mistake-proofing events, there have been 107 with 90 of the 107 reporting. I'll talk a little about the impacts. So in terms of inventory, a 73 per cent reduction; walking distance for patients and staff, a 55 per cent reduction; total time of processes, a 94 per cent decrease; and defects reduced or improvements in quality, 99 per cent. So that's 107, and those again, those results are from 90 of the 107.

5S [sort, simplify, sweep, standardize, self-discipline] events, there have been 539 for a total of 1,070 events as of March 12th, 2015.

Ms. Chartier: — And did any go on after March 12th between then and the end of the fiscal?

Hon. Mr. Duncan: — Yes, there have been some since March 12th, and they are ongoing.

Ms. Chartier: — But no more John Black after March 31st?

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay. Well I guess sort of along the same lines, could you describe the status of the 3P designed cancer clinic in Saskatoon? Where is that at? Where is that at, is my question.

Hon. Mr. Duncan: — So in 2013 the Cancer Agency was approved to begin preliminary planning work which did include

lean 3P to determine the scope and the cost of renovation work required at this Saskatoon Cancer Centre. So a 3P event was held in November of 2013. The work that has been achieved as a result of that, it's not an approved project, so that's why it hasn't gone forward at this point. But certainly they've been able to identify kind of what the next step is for them in terms of when this does become an approved project.

As recently as 2009 the Cancer Agency, as they were looking about kind of the future of providing services in Saskatoon, they were in fact looking at adding an extra floor onto the cancer centre in Saskatoon. And at that time, putting a floor onto that, adding an entire floor to that building would have been roughly $100 million. So because of the 3P work, the need for an additional floor at the cancer centre is no longer necessary. They have a plan going forward of what they'll need to do in the future, but certainly it won't require the same extensive building and renovations and frankly construction of an entire new floor of the building. So I think it's been a very successful project for them.

I also, while we're on the lean topic, I just want to put on the record my personal assurance that the deputy minister will complete his lean training.

Ms. Chartier: — Thank you for that. How much did the 3P process cost for the cancer clinic in Saskatoon?

Hon. Mr. Duncan: — It was just over $650,000 to do the lean work.

Ms. Chartier: — 650,000 for the lean work. Okay. And you talked about it not being an approved project, but doing this work has allowed them to think about the next step. What is the next step for them?

Hon. Mr. Duncan: — The next step for them would be to submit a business case for whatever type of expansion or development that they would need to that would then get on to the radar of the government in terms of approving capital priorities. So at this point, all that information will be used to kind of develop what that would look like into the future, but again it's not to the point where it's gone to government as an approved project or been approved as a project.

Ms. Chartier: — Okay. Thank you for that. Has it been . . . Have they submitted a business case yet?

Hon. Mr. Duncan: — No they haven't.

Ms. Chartier: — Just jumping back here. Sorry to do this. I'm just making a couple of notes of things that I forgot to ask. I had asked you about Lead 2 Lean Solutions, whether or not they had any contracts with the ministry or with RHAs. And you said they don't with the ministries, and you said the RHAs have been directed not to engage any lean consultants. Do you know if any of the RHAs . . . Like are you unequivocal that none of the RHAs have engaged in contracts?

Hon. Mr. Duncan: — To the best of my knowledge, no RHAs are currently engaged in a contract with a lean consultant.

Ms. Chartier: — Thank you for that. I just wanted to go back to a couple of conversations ago almost. So at the beginning of January, the ministry, your ministry sent out a request that there be some restraint measures in place, and some of those restraint measures included vacancy management. I'm looking just at a memo. And I'm wondering if that has come to an end then, those restraints because . . . Sorry, I'm not being very clear here. Let me just gather my thoughts here so I can ask, actually ask you a question.

So in terms of vacancy management, this is in the Sunrise Health Region, all vacancies are on hold until further notice. CEO approval is required. Requests are to be vetted through your VP [vice-president]. So is that restraint measure still in place in this fiscal year?

Hon. Mr. Duncan: — So I would say the message to the regions and to the CEOs has been, if positions are to be filled, that they need to be front-line staff positions, but we're asking them to exercise discretion over hiring and over travel as well. So I guess it's a bit of yes and no. If a position needs to be hired then, you know, we want to ensure that it's a front-line staff position but that they should exercise discretion.

Ms. Chartier: — Okay. Thank you for that. Going back to our conversation just sort of briefly, a few minutes ago, in terms of thinking about the cancer clinic and just thinking about warehouse spaces here: what health regions have rented, leased, or bought additional space to be used for lean training or events, including both office or warehouse space?

[15:15]

Hon. Mr. Duncan: — Regions would have used warehouse space for 3P planning for capital. So that would have taken place in Saskatoon Health Region, Five Hills Health Region, Prince Albert Parkland, Prairie North Health Region, again Saskatoon Health Region, and Cypress Health Region, as well as Kelsey Trail Health Region.

Ms. Chartier: — So all of that was leased space then?

Hon. Mr. Duncan: — All of it was leased space except for Five Hills purchased their warehouse and Prairie North purchased theirs for the Saskatchewan Hospital North Battleford. In those cases, those would be assets that they would have the ability, after the 3P work is finished, to dispose of at their discretion.

Ms. Chartier: — Do you know what Five Hills plan with the warehouse? So they purchased the warehouse space.

Hon. Mr. Duncan: — That's correct. For that specific case they purchased the warehouse, yes.

Ms. Chartier: — And did you know what they plan to use — both Five Hills and Prairie North — what they plan to do with the warehouse space?

Hon. Mr. Duncan: — Our understanding is that at the end of the use for the space, they will dispose of the asset.

Ms. Chartier: — They're still . . . Sorry. Forgive me. But how long is it expected that it would take to go through one of these

processes?

Hon. Mr. Duncan: — So as an example in Moose Jaw, they would still be occupying that space. So that space would continue . . . And I've been to that space and it has schematics on the wall and diagrams of current state, future state. It was used extensively for not just the planning by the region, but also all the different partners that would be involved in the project.

At this time our understanding is that Moose Jaw at Five Hills Health Region, they haven't determined whether or not they're going to dispose of it immediately after the Moose Jaw project completes, depending on whether or not they need the additional space, perhaps for additional planning or just some meeting space. So at this time we're not sure what Five Hills plans to do with their space.

Ms. Chartier: — Is there staff in it regularly? Can you let me know what's involved now? So how often are people actually in the building or utilizing the building?

Hon. Mr. Duncan: — So in the case of the Five Hills warehouse in Moose Jaw, currently it's being used for storage of equipment that's waiting to be installed in the new hospital. So they are using it currently for storage space.

I know that when I toured, not just the construction site, but also I did tour the warehouse — this would've been last year — construction would've been under way. But because all of the schematics that were used, all of the kind of the mapping out of kind of all of the different proponents that are involved, especially because of the way that the facility's being designed and how all the different partners are working together, all of that is — certainly at that time; I believe it's still the case — all of that still would have been displayed. So you know, if there's any issues amongst the different partners that are involved, because that design is fairly unique in that everything is, there's such a sequencing of events of which partner needs to have their part in place before you can move on to the next step.

And in fact, very anecdotally on my part, but you know, it was pretty incredible to see all of the different kind of charting that's on the wall. Frankly, I walked in; I wasn't sure if they were building a hospital or trying to put a man on the moon. It's very detailed in terms of the level of planning that takes place.

So it does provide an opportunity for all the different proponents that are involved in the project to kind of make sure that everybody is on the same page because of how intricate the design is. Everything's so coordinated amongst the different partners that have to play their part.

Ms. Chartier: — Do the different partners have access to the building then?

Hon. Mr. Duncan: — Yes. Yes they do.

Ms. Chartier: — Okay. How much did that particular warehouse cost to purchase?

Hon. Mr. Duncan: — In Moose Jaw it was just over $500,000.

Ms. Chartier: — Do you know what the . . . I'm sorry, when was it purchased?

Hon. Mr. Duncan: — It was purchased in March of 2012.

Ms. Chartier: — Had they rented space prior to that for any lean events or that was the start of their lean journey?

Hon. Mr. Duncan: — Five Hills Health Region was really one of the first regions out of the gate when it comes to lean, so they would have been doing lean work prior to this. However just based on the fact that this is lean 3P capital design work, I would say that this would be the first space that they would have purchased or rented based on doing lean work.

Ms. Chartier: — How about with Prairie North then, so that's for the work on the redevelopment of the North Battleford Hospital. Can you give me again, when was the building purchased and how much did it cost?

Hon. Mr. Duncan: — It was purchased in October of 2012 for just short of $380,000.

Ms. Chartier: — And did you say that their plan is to dispose of it or to sell it when they're done? Or we don't know that yet.

Hon. Mr. Duncan: — It's really going to be based upon whether or not the region has an expectation of needing that space in the future. At this time it would be our assumption that any time that this type of work is complete, that for the most part that they would be looking to dispose of the asset, or in the case of those regions that lease the asset, that they would be ending their lease once the work on that specific project is done. If a region has an expectation that they're going to be doing some additional 3P work on, say, another facility, there may be an opportunity to keep a property or extend a lease. But at this time, you know, our expectation would be once the project ends, that they would dispose of it.

Ms. Chartier: — So this Prairie North could have this facility for the next couple of years or several years actually if you think about it. Is that correct? The timeline for the hospital is like 2018 or 2017, isn't it?

Hon. Mr. Duncan: — Yes. So the Prairie North warehouse would be being used for the redevelopment of the Saskatchewan Hospital in North Battleford. So our expectations, shovels would be in the ground this year. Approximately a two-year construction period, so it would be my expectation that they would keep the property until that time that the project is complete.

As in the case in Moose Jaw, you know, they may have an opportunity to use some of the space for storage until the new facility is complete. They also have the opportunity to do some staff training in the facility, in the warehouse as they prepare to move towards operations in a new facility, especially as it relates to any process changes that may be contemplated, and I'm thinking specifically about the Moose Jaw Hospital. You may know that during a 3P, what does take place is that life-size models of rooms will be built and so, you know, this gives an opportunity for the staff to kind of get a better sense of what the new work environment may look like once the new facility is open.

Ms. Chartier: — Thank you. Along the same lines here, has 3s [Health Shared Services Saskatchewan] rented, leased, or bought any additional space for lean training or events?

Hon. Mr. Duncan: — 3s did have space that they did have either leased or rented. That's on the basis that it would have been around some kanban work, around some training, as well as the laundry work that was done by 3s. They no longer have that space though.

Ms. Chartier: — Okay. Do you know how much that cost?

Hon. Mr. Duncan: — We don't have that with us, but we will able to provide that information.

Ms. Chartier: — Okay. How about eHealth? We'll make our way down the list here.

Hon. Mr. Duncan: — eHealth would have been partners with 3sHealth in the space that they did have, but it's no longer being used by either party.

Ms. Chartier: — Okay. And it was for, you said, for some training?

Hon. Mr. Duncan: — So as it relates to eHealth's use of this space, it would have been for things like meetings, visioning sessions around some of the work that they were planning in the future, some training that would have taken place. And the CEO has indicated that for them it would have allowed them some large meeting space without having to, say, rent a space at, you know, a hotel in the city or something like that.

3s would have been used, and I believe the deputy minister would have seen this first-hand, around some mock-ups around kanban, and especially as it related to the new delivery system for the laundry program that's going to be rolled out across the province. So those would have been some examples of what that space would have been used for. And eHealth's use of the space, as I indicated, 3s would have used it for similar reasons as well.

Ms. Chartier: — So if we could get just cost and when, like period of time that that was leased, that would be very helpful, too.

Hon. Mr. Duncan: — Yes. I'll provide that to the committee.

Ms. Chartier: — Okay, thank you. And going down the list, has the Health Quality Council rented, leased, or bought additional space for lean training or events?

Hon. Mr. Duncan: — Not that we're aware of. We'll check on that, but it sounds like the answer is no.

Ms. Chartier: — And just, obviously we know a little bit about this, but in terms of the Sask Cancer Agency, can you tell me a little bit about what's going on there?

[15:30]

Hon. Mr. Duncan: — So the space was leased in September of 2013, and the lease ends October 2015. And it's my understanding that the cancer agency doesn't intend to renew the lease. So they will be out of that lease by October of 2015.

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

Hon. Mr. Duncan: — They paid $161,000 per year for it. So they operated it for two years, so about 320,000.

Ms. Chartier: — Thank you for that. And if you could just endeavour to get those other questions that I'd asked on that particular topic, that would be very helpful. I think that I will, if you'd just give me one minute, I will ask a couple of questions actually about infrastructure, specifically in terms of each health region. What were the capital requests for each health region?

Hon. Mr. Duncan: — We don't typically do a call for requests from the regional health authorities, so it would be just based on the dollars that we'd have available both on the capital side as well as the maintenance side, and then after we know that number, then that gives us a good idea of what that allocation will look like, particularly on the maintenance side. But we don't do a formal call from the regions asking for their requests.

Ms. Chartier: — It's about 28 million in repairs or capital that's going to the regions. Can you tell me how that 28 million is broken out into each region?

Hon. Mr. Duncan: — We haven't allocated those dollars yet through the block funding to the regions. We're still in the process of determining those allocations based on things like the VFA [Vanderwiel Facility Assessors] scores for the different facilities. So we're in the process of finalizing that, but at this point regions haven't been notified of the amount they're going to receive yet.

Ms. Chartier: — When do you expect that to be complete?

Hon. Mr. Duncan: — It's my expectation that the regions will be . . . It'll be finalized and the regions will be notified of that within the next two weeks.

Ms. Chartier: — Okay. In terms of the VFA report, one of the comments that came out last year is that it would be continually updated. So it was 2.2 billion, I believe, last July. Where is that today?

Hon. Mr. Duncan: — So the intent of the VFA, it's really a rolling database that regions are asked to keep updated. So it's not . . . I think it's more I would say a database, like a tool, that would be used by the different regions and then that we would have at our avail to make some of these decisions.

We don't have an updated number. Regina and Saskatoon haven't yet updated their portion or their database. So I don't have a number at this point.

Ms. Chartier: — Okay. Thank you. I am going to ask if we could take a short recess and my colleague, John Nilson, will be taking over from here. So thank you to the minister and to your officials for your time this afternoon. We'll see you next time.

Hon. Mr. Duncan: — Thanks, Ms. Chartier. We will endeavour to provide those answers to your questions. I think

we've been keeping a list of the things, but if there's anything that you notice that maybe we've missed when we provide that information, we'll be happy to fulfill our obligations.

Ms. Chartier: — Thank you.

The Chair: — The time being 3:35, 10-minute break. That will suffice? Okay, we'll be back at 3:45.

[The committee recessed for a period of time.]

The Chair: — The time being 3:46, we'll get back at work here. Mr. Nilson, the floor is yours.

Mr. Nilson: — Thank you very much, Mr. Chair. It's my pleasure to be here this afternoon to continue with reviewing the estimates for the Ministry of Health, and I'm going to start off with something I did yesterday in Justice which was . . . Then I had my list of witnesses from seven years before and there were only two people that were still there. This time I have my list from four years ago and there's only three people who have survived over the last four years and that's the deputy minister, Max Hendricks — welcome — and Mark Wyatt and Donna Magnusson. Otherwise everybody else is, you know, they're familiar faces but they're in new roles. And I think that's a good sign, Mr. Minister, that there is a continuing turnover I guess if I can put it that way, but also a recognition that we've got a whole new generation of Health officials that are working on our system.

I'm going to continue I think from where my colleague was working, but I'll cover a few areas in the time that we have available. The first area I'm going to talk about is ambulance billing. It's been cited a number of times I think over the last few weeks or months that the provincial government covers 71 per cent of the ambulance services. Could you tell me what's included in this 71 per cent?

Hon. Mr. Duncan: — Thank you, Mr. Nilson, and welcome to the committee. Thank you for your opening comments and I just say that hopefully you don't see turnover in our positions in the too-near future, but that's for others to decide.

The breakdown of expenditures when it comes to ground EMS [emergency medical services], the majority of funding is provided through government by and paid for by regional health authorities. So that's about sixty-one and a half per cent. So in '13-14 that would've been just under $74 million. So that's seventy-one and a half per cent.

And then about 7 per cent is paid through the seniors' program, the cap on the seniors' plan. So that's 8.4 million. And then about two and a half per cent is through the supplementary and family health benefits. So just under 3 million in '13-14.

The rest of the payors as it relates to ambulance services would be made up of . . . So patients or private insurance, paying their portion, that's about 15 per cent. And then there'd be smaller amounts. That would be SGI [Saskatchewan Government Insurance], workers' compensation. The federal government also plays a part in that. So the biggest chunk of that would be RHA expenditures, which is about seventy one and a half per cent . . . sorry, sixty one and a half per cent.

Mr. Nilson: — Sixty one and a half per cent. So then the 71 per cent that's been included includes then the senior part and the family health benefits because it comes out of the health budget I guess. Or does some of that come out of another budget?

Hon. Mr. Duncan: — Yes. It comes out of the health budget.

Mr. Nilson: — Okay, now I have page 24 from the October 2009 final report on ambulances, you know, the ambulance report. And it has a nice little chart — I can pass you down a copy — and it seems to me it's the kind of chart you probably do each year. So I was just trying to figure out, when you were giving me the numbers now, how it fit together with what was there. And in that one, you know, you'd indicated patient percentage was about 15 per cent of the total cost now, and it was 31. Is that accurate, or is this a different type of a document? Or does it include maybe the 100 per cent of ambulance costs in the province?

Hon. Mr. Duncan: — There's a difference in the two charts. So the chart that I was reading off of, that's by payor, so that would include the RHA expenditure. The final report, the October 2009 final report speaks to the 2007-2008 road ambulance, but it's billings by payor, so it wouldn't have the . . . That chart doesn't include the large subsidy, the sixty one and a half per cent that comes from government.

Mr. Nilson: — Okay. So this is a completely different kind of perspective. The total ambulance bill in the province for everybody, whether it's paid by federal, paid by people, paid whatever, would be something I guess in excess of $100 million. Would that be right?

Hon. Mr. Duncan: — Yes, in the last . . . In '13-14 it was approximately $120 million.

Mr. Nilson: — Okay.

Hon. Mr. Duncan: — And I'll maybe, Mr. Nilson, I'll just maybe clarify. The chart that I was reading off of, because an operator, either a private operator or a regional health authority operation, they're not billing back to that regional health authority, so there's money that goes to the RHA to help support their ambulance service, where the chart you're looking at is just the billings that go out. So they're either going out to the seniors' program. They're going out to family supplementary health benefits. They're going to Health Canada, or they're going to the patient. So that's the difference between the two charts.

Mr. Nilson: — So then this chart that I got out of this report then doesn't include Regina Qu'Appelle Health Region or Yorkton or whichever ones run their own systems.

Hon. Mr. Duncan: — Right. So it wouldn't include the grant funding that would go from the province to the region to provide for their ambulance service.

Mr. Nilson: — Okay. So then the information you gave me now though does include all of that as an overall. So how much, what percentage of the money goes to STARS [Shock Trauma Air Rescue Society]?

Hon. Mr. Duncan: — The chart that I was reading off of, that's just for ground EMS, so it wouldn't include the payment that goes toward STARS. The 120 million is the road ambulance that we would have paid in '13-14. And then this year, on top of what the number will be for the road ambulance . . . I assume it'll be a little bit higher than the 120 just based on grants and inflation, but it wouldn't include the ten and a half million this year, on top of what we spend for road ambulance, that would go towards STARS.

Mr. Nilson: — Okay. And so then in the same idea, how much goes to air ambulance? Is that in addition or is that included in your road ambulance amounts?

Hon. Mr. Duncan: — Air ambulance including support for STARS is approximately 25.5 million. That would be over and above the 120 approximate million that goes towards road ambulance.

Mr. Nilson: — So then that would be 15 million for air ambulance and 10.5 for STARS. Would that be accurate?

Hon. Mr. Duncan: — It's ten and a half million for STARS and then the balance would be the provincial air ambulance service but as well any charters that we would have to pay for outside of our air ambulance service that we operate or that is operated through Central Services.

Mr. Nilson: — So on that air ambulance budget of 15 million, how much, what percentage of that goes for charters as opposed to the government-owned air ambulance planes?

Hon. Mr. Duncan: — In terms of charters, it does vary year from year. The estimate for the '14-15 fiscal year, for an example, it would have been just under $800,000 that would have been the estimate that we would have been purchasing space on charter. And it's based on ensuring that we have, depending on what's happening with our aircraft and our services, just ensuring that we have the capacity that we would need. So it's a very small portion of the 15 that goes towards air ambulance.

Mr. Nilson: — As it relates to the road ambulance amounts, 61.5 per cent of the 120 million, which I think he says 74 million goes to the regions, and they then manage the contracts with those . . . Like Saskatoon has a contract as opposed to Regina which doesn't have a contract. So would the contracted amounts for the Saskatoon ambulance service be included in the 74 million?

[16:00]

Hon. Mr. Duncan: — It would, depending on the region that we're talking about. It would be both to contract with the private operators as well as to operate their own region-based operation — purchase the ambulances, provide for salaries for their staff, etc.

Mr. Nilson: — So in this year, I guess, '15-16 as we're moving forward, would it be about 50 per cent that are region-owned systems and 50 per cent that are contracted systems, or has that percentage changed somewhat over the last few years?

Hon. Mr. Duncan: — Operating in the province today, there's 104 ground ambulance services. Fifty-one of those are owned by the RHAs. Thirty-seven of them are private operations. Fourteen are non-profit, and two are operated by First Nations communities.

Mr. Nilson: — Okay. Thank you. Do you have a number for the total ambulance billings in the province which would include what other agencies pay for — whether it's the federal government or whether it's insurance companies — so that we can get a sense of the total ambulance cost for people in Saskatchewan?

Hon. Mr. Duncan: — Specific to ground ambulance, I can break that number down for you right now. So again — I'll just maybe repeat myself really quickly — $73.5 million is the RHA expenditure, so that's about sixty-one and a half per cent. Private insurance or the patient fees represents about 15 per cent or seventeen and a half million dollars.

The next largest group would actually be Health Canada. About 11 per cent of payments are made by Health Canada. That's approximately $13 million last year. The seniors' cap program is 7 per cent of the total or 8.4 million. Supplementary and family health benefits is just under $3 million or about two and a half per cent. SGI made up $2 million or 1.7 per cent. Workers' comp was about a quarter of a million dollars or about point two two per cent.

And then the other totals are very small. There would be some other federal contributions of less. They're approximately a quarter of a million dollars. Other provinces, less than point one per cent of 1 per cent; and then just another category which would be just over $1 million. I think that's the total there.

Mr. Nilson: — That's all the information that was there in the earlier report, and I just don't have the coloured chart like you have now. Is that somewhere in one of the reports that would be available online?

Hon. Mr. Duncan: — I'm not sure if it's in a report or online, but we'll certainly provide a copy for you.

Mr. Nilson: — Okay. Thank you. It's just interesting to get a snapshot like that to see, you know, how much money we've got into this system.

One of the questions comes of how broad an area is covered by the STARS service, and we know that that expands a little bit each year and maybe contracts a little bit sometimes too. But can you give a bit of an idea of how the STARS system overlaps with the air ambulance coverage?

Hon. Mr. Duncan: — So I'll maybe begin, Mr. Nilson, by just describing a little bit. So when a call does come in and it's a critical patient, ground ambulance, air ambulance, and STARS dispatch are all a part of that call to make the determination of which service would be the most appropriate service to send out for that individual. Of course that's going to depend on things like weather; you know, the helicopter would have certain limitations during certain weather conditions. The same would be true for ground EMS, just depending on the situation.

In terms of the radius, certainly the STARS helicopter in Saskatoon has a greater distance that it can fly. It's a bigger aircraft, a bigger helicopter. It's approximately 700 kilometres round trip that it can go unrefuelled so about 350 one way. Then the other decision that is made is in terms of fixed wing can get to a location more quickly. It also depends on exactly how far we're talking about.

But I can tell you that as of March 2015 — I'm just looking at a chart here — it does look like STARS has been active in every single health region in the province.

Mr. Nilson: — I'm assuming that that expanded but I wasn't sure how far. They do take flights into the far North then as well, and then they have a base in Prince Albert then? Or how does that work?

Hon. Mr. Duncan: — I'll just maybe, Mr. Nilson, just correct myself. It looks like 11 of the 12 health regions STARS has operated in. They took two calls in Mamawetan Churchill River as of March 2015. It doesn't appear that they have travelled into Keewatin Yatthé Health Region at this point.

I would assume that the Mamawetan Churchill would be La Ronge or fairly on the south end of that health region. Certainly anything further north than that typically would be air ambulance, if we're using an air asset. But the AW139 began operations out of Saskatoon last fall, and it's a larger range than the BK117. So 11 out of 12 health regions it looks like it's operated out of.

Mr. Nilson: — Okay. Well thank you for that. Do you have like a map or something that shows where they've gone? Is it possible to provide sort of a visual representation of that?

Hon. Mr. Duncan: — We'll try to provide for you a map of the range of the different helicopters that are in operation. I believe I've seen that before in a different presentation, so we'll try to track that down. As well I believe on STARS website, they'll have a map of all the different locations that they would've flown into since their time operating in Saskatchewan.

Mr. Nilson: — Thank you very much. Now I was interested to hear you say that there's a common, I guess, number that people can contact for all three of the services. Is that province wide or is it located in each region? How does that system work, and how does it tie in to the 911 system?

Hon. Mr. Duncan: — So typically what would happen, and this would be referring to a scene call, so something that would be generated by 911 — a hospital transfer would be a different type of call that would take place — but a scene call that would come through 911. There'd be I guess an assessment by 911. They would then essentially link a call in through the ground-wide area, the dispatch for ground ambulance as well as our air ambulance as well as STARS, their call centre as well. So then all three would be on the phone. There'd be an assessment made amongst the individuals that would be on the phone, and then a decision would be made on which service to dispatch to the scene.

Mr. Nilson: — Okay. Thank you for that. Now once that decision has been made, can you explain how much it would cost if the decision is to use an air ambulance versus a road ambulance or air ambulance? I guess we've got three choices. Can you explain how the costing works?

Hon. Mr. Duncan: — Depending on which service is provided, the ministry would bill for, if it's air ambulance or STARS, that's billed directly by the ministry. That's $350 per flight that's billed to the patient. If ground ambulance is used at some point during that scene call, then there would be a bill that would be also generated either by the regional health authority if it's a region operation, or a private operator.

Depending on how much service is required, whether or not it's STARS arriving at a scene call and taking somebody directly, say to the General Hospital and avoiding a ground ambulance, in some cases it may involve a ground ambulance as well as either air ambulance or STARS.

[16:15]

Mr. Nilson: — Does the patient or the person in distress have a choice to say, well I'd like to have the air ambulance take me or the STARS take me because I don't want a bill for the road ambulance?

Hon. Mr. Duncan: — So typically what would happen is — and I should also mention that there would be a transport physician from STARS that would be a part of making this decision as well — it would be made in consultation with the three organizations and with the transport physician. If air ambulance, or particularly if STARS is an option, usually the patient is in distress to the point where they're not able to make those types of decisions.

Mr. Nilson: — But if they were able to make a decision, do they have any say in this? It's basically saying, you know, I don't want a road, I don't want a road ambulance bill. I would prefer to go with one of the other two services.

Hon. Mr. Duncan: — It would be, the decision would be made around what is the best use of resource, what is the best resource to help that individual out.

Mr. Nilson: — So the answer is no, he wouldn't have any say. Is that the answer?

Hon. Mr. Duncan: — Well I would just say that based on how, when a call comes in to 911, and all these groups are linked together, usually when 911 is called there wouldn't be the ability when these organizations' — air ambulance, STARS, and ground ambulance — dispatch are making the decision, I'm not sure there would be a period of time where the patient would be consulted in that decision. They would make that decision based on the information from the scene and what would be best for the patient from a medical perspective, not necessarily from a financial perspective.

Mr. Nilson: — Well I guess we'd all hope that's how it is but, you know, there is this other added aspect now of a variation in the cost depending on which of these services are assigned to you. One of the areas that you've indicated when you gave me the information around who covers the costs . . . Well I guess there's two areas. One is the seniors' area. So we know that

they have the same kind of cap, would that be on the road ambulance as the air flights? Is it $350 as well?

Hon. Mr. Duncan: — So the seniors' cap is for ground ambulance only, and it's 275.

Mr. Nilson: — So 275, okay. And then if somebody is under the supplementary health benefits and family health benefits, do they get 100 per cent coverage of whatever happens there?

Hon. Mr. Duncan: — So with the supplementary health program, this would be benefits that would be paid and nominated by Social Services, that would cover the entire cost of both road and air ambulance for those individuals that are eligible and are receiving benefits under the supplementary health program.

For the family health benefits program, this covers the cost of road ambulances for children of low-income families that receive benefits under the family health benefits program.

Mr. Nilson: — Okay. Let me see if I can understand what you've said. So for supplementary health benefits, which is covered through Social Services, is that in the Social Services budget or is it in the Health budget?

Hon. Mr. Duncan: — It's in the Ministry of Health budget, but the individuals are nominated by Social Services. Most likely they're receiving the Saskatchewan assistance, they're on the Saskatchewan assistance plan.

Mr. Nilson: — So basically if I'm somebody who qualifies for the supplementary health benefits, I have been assessed and basically judged to be in receipt of those kind of benefits by the Ministry of Social Service employees. And then they basically get the full coverage; they don't have to worry about any kind of costs. Okay? Well thanks for that explanation. And the minister nodded to agree with my assessment there.

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

Mr. Nilson: — Perfect. Then with the family health benefits, perhaps you can explain how those benefits work and who does the assessment of whether people would get those.

Hon. Mr. Duncan: — So the family health benefits program, this would also be, so families would be nominated by Social Services and those families that are eligible to receive the family health benefits under that program, the ambulance costs for the children of those families would be covered under the program.

Mr. Nilson: — Okay. These are families that are different than the ones that are getting the supplementary health benefits?

Hon. Mr. Duncan: — Yes. So it would be based on a higher income that the families would be eligible for, versus families that are eligible under the Saskatchewan assistance plan for the supplementary health program. So it's a higher income cut-off. As well, I think it factors in the number of children that the family have and their income as well.

Mr. Nilson: — Is that something that's online somewhere that you can look at to actually see how the descriptions work? Or perhaps you can provide that for me.

Hon. Mr. Duncan: — We would have information on our website that would describe the benefits that would be involved. There would also be information on the Social Services website describing the program and having eligibility criteria, and I assume an application form as well for those families. But that would be information that is either on the website or if you'd like we could probably provide that information as well to you.

Mr. Nilson: — Okay, and do you have sort of rough income levels where these ones apply? So I mean, I'm assuming for the supplementary health benefits that would be the lowest income people and lowest income families. And so where's the cut-off point there?

Hon. Mr. Duncan: — Just looking at the newly redesigned government website, so there is information that has compiled all of the information together for the different programs. That is, I think, easily accessible for individuals that are looking for this.

In terms of the family health benefits, so it would be based on your family net income. So with . . . It would have different income levels based on the number of children that an individual family would have.

Mr. Nilson: — Okay. Thank you. So then the people who are in the . . . with the family health benefits, is that the group of people that have had their ability to have coverage for their children reduced in this budget? Because I think there's the provision here that if there are families that have children age 13 to 18, they won't get family health benefits anymore. Is that accurate?

Hon. Mr. Duncan: — I guess the best way for me to try to answer this is that . . . So the eligibility or the nomination process, that's done by Social Services, so if they did make . . . they made changes to their part of the program, certainly we provide the family health benefits, but it's separate decisions that had been made. So we will continue to operate the family health benefits, but it's not a change that we've made that is necessarily going to have an impact on our budget necessarily. It was more the change to the eligibility criteria that Social Services made. So I guess it's probably a better question for Social Services, because it's not our program. We provide the benefits under the program, but it's their eligibility. They determine the eligibility and the nomination process for it.

Mr. Nilson: — Okay. But my question is going to be, did you reduce your budget for the family health benefits as it related to a whole number of areas, but I guess specifically as it relates to ambulance as you put together the budget for 2015 and '16? Or was that not part of the process?

[16:30]

Hon. Mr. Duncan: — So our budgeted amount this year for the family health benefit remains relatively unchanged from last year, based largely just on increases that are required for contract payments. What we've seen over the last number of years is the number of beneficiaries under the family health

benefits has reduced significantly over, I would say, the last decade. So we're not factoring in necessarily changes to social services eligibility. We've been factoring in budget decreases, or in this year in any event remaining relatively stable because historically the number of families that are eligible has been reduced based on income rising in the province.

Mr. Nilson: — Okay. Thank you for that. So now let me see if I understood everything that I've heard for the last half-hour and give an example. I'm 63 years old and I'm in a car accident just north of Cupar. Can't get through the roads because they're so flooded, and so the air ambulance has to go up there and pick me up, takes me into Regina to the Regina General so no road ambulance is necessary. How much would it cost for my ambulance service for that event?

Hon. Mr. Duncan: — $350.

Mr. Nilson: — Okay, thanks. This is just like a game show here. Okay. So if I'm 65 or 66 years old and I'm in the same accident and I'm taken by the helicopter, how much does that cost?

Hon. Mr. Duncan: — If you're taken by the helicopter, $350.

Mr. Nilson: — So there's no deal on the 275 for over age 65 as it relates to the helicopter?

Hon. Mr. Duncan: — That's right.

Mr. Nilson: — But if I went in an airplane, which would be hard . . .

Hon. Mr. Duncan: — It would be 350 if it was by airplane if you were over 65. The 65 is only on ground ambulance.

Mr. Nilson: — So thanks for that. So if I was then a low income, so that I qualified for the supplementary health benefits and was in that same accident, it would cost me zero for whatever form of transportation there was to get me to the Regina General. Is that correct?

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

Mr. Nilson: — Okay. So then if I was somebody who had a little more income and I had a child from zero to 12 and that child needed the ambulance, they would be covered for all of them and there would be no cost. Is that correct?

Hon. Mr. Duncan: — We're just going to clarify that. We're just going to clarify whether or not the family health benefit for a child would include air ambulance or STARS. Our notes say ground ambulance, but we just want to clarify that it includes everything.

Mr. Nilson: — Well while they're working on that one, let's go for another question. Okay so basically we're into June now and all the water's dried up with Cupar, so you can actually use the road but you have to go slowly. And so you're the same 63-year-old guy and the road ambulance obviously is the one that's going to pick you up. Am I correct in assuming that the fee would be the $350 for the road ambulance plus so much a kilometre to get me to the General Hospital? Is that correct?

Hon. Mr. Duncan: — So first of all it would . . . we want to ensure that the service that we're providing is appropriate for that patient. So in the example, you're 63 years old. You're north of Cupar when the call comes in. It would be $245 for the call and then $2.30 a kilometre, round trip from the location, Regina and back. And if your initials, if your initials are Glen Hart, and you're coming from Cupar, we might charge you a little bit more.

Mr. Nilson: — Or they may leave him out there too. But no, that would not be good.

But no, I'm serious. So now if I'm in a situation where I'm in an accident and I'm assessed on the ground obviously by the EMTs [emergency medical technician] and others and taken by helicopter to the Regina General and then the assessment there is that this patient has to go to Saskatoon because that's where the appropriate surgical service is, say for a renal issue or something like that, what happens then with the ambulance costs for the 63-year-old guy?

Hon. Mr. Duncan: — So in a scenario like that, first of all it would depend upon whether or not it was a motor vehicle accident because then SGI comes into the picture. If it was a workplace injury, Workers' Comp would come into the picture. If it wasn't those cases, it would then depend as well upon whether or not the transfer was being made from Regina to Saskatoon, on that portion of it whether it is done by air ambulance or whether it's done by ground EMS. The charge would be dictated by which route was taken.

Mr. Nilson: — Okay. So they've decided that it's to be by road ambulance from Regina to Saskatoon. So you've got the road ambulance fee, 245, plus the kilometre charge to get to the General, do the assessment, then put in an ambulance to be delivered to University Hospital in Saskatoon. Would that be another $245 plus the kilometre fee for that transfer?

Hon. Mr. Duncan: — It would really depend in a situation like that whether or not it was continuous care from that ambulance operator. So that would factor into whether or not there would be an additional charge. If it was a couple of days later and it was ambulance operations out of Regina taking somebody to Saskatoon, if it's advanced care, paramedics that are used, then there's a higher charge than the 245. It would then be 325 plus then the 230-kilometre charge round trip.

Mr. Nilson: — Okay. And then if this same scenario involved somebody who had supplementary health benefits, their bill would be zero because it's all covered and that then would be dealt with in your budget line for the supplementary health benefits under the Ministry of Health?

Hon. Mr. Duncan: — That's correct.

Mr. Nilson: — The same scenario and it's a child whose parents qualify for the family health benefits, that's where it's a little less clear exactly what happens. But perhaps you have an answer to that question now.

Hon. Mr. Duncan: — Yes. We believe so, that it covers emergency transportation so that it would include air.

Mr. Nilson: — So it would include air, helicopter, or the road ambulance. Well anyway I appreciate, you know, the answers to the questions. And as you know, all of us who have been working around on this problem are some of the most knowledgeable in the province about how the system works. And it strikes me that this conversation, if I can call it that, points out the fact that maybe we need to do some work around the ambulance fees and how we structure this.

And I know it's got other factors involved, but I think for citizens of the province it may be that we have to look at the total amount we've got allocated for this and see what we can do to set up a more transparent, a more straightforward system. I mean obviously the rules all work if you kind of know what they are, but I would defy people to figure it out in the 10 minutes that they've got after some kind of a bad incident.

Ms. Jordan: — Good afternoon. I'm Deb Jordan. I'm the executive director of acute and emergency services with the Ministry of Health. Beginning in June of 2014 and in follow-up to just some of the themes that we were discussing here, the Patient First Review that was conducted in 2009 identified a number of priorities that were top of mind for Saskatchewan patients. Certainly improvements in access to surgery was the top consideration. Improvements to access to diagnostic services were as well. Transportation or EMS and access and the different, sometimes overlapping, sometimes gaps in coverage were identified by patients as a concern.

So the surgical initiative was the lead-out, out of the Patient First Review. There's currently work on ED [emergency department] waits in patient flow, mental health and addictions services. But in June of 2014 we began a process with regional health authorities and representation from time to time of the executive of the Saskatchewan Emergency Medical Services Association, aimed at moving, looking at a deep dive into our current state for ground EMS in the province and moving toward, with patients at the focal point, not necessarily funding formulas as the outcome, but what is it that our patients value, what is it that they need, and focusing our improvement work in EMS, ground EMS, on better serving patients.

Mr. Nilson: — Okay. Thank you for that. And I think when Minister Duncan was working on the health plan back in 2001, this was right there on the list too if you look at the health plan. So I think actually the three that you listed are probably the priorities that were there, so that's good that we're consistent on that. So I encourage you with that work. If you need some advice more directly in the papers or other places well let us know and we can help out with that.

But clearly the public's frustrated with this whole area. Do you have a breakdown so that you can tell me what the average cost would be using the STARS helicopter service versus the air ambulance airplane service versus the road ambulance service?

Hon. Mr. Duncan: — The cost to the patients?

Mr. Nilson: — Like an average for how many patients were there covered in last year's budget year in each of those categories and how much was the total cost for the system. That's one, if you want, you can get it for me later because I don't think you can pull it up right away unless you had the charts right there. But if you could, I'd appreciate that, just so I get a bit of a sense of how that works. I know that clearly when the call goes in and the medical staff and team are working to decide which service to use, that's not necessarily their first goal, but it has to be a factor as well. So that whole area of the ambulance cost and then the interrelationship with some of the other stuff is important.

Now one of the other questions that I had as it relates to this is the $10.5 million for STARS comes as the amount that's in the Health ministry budget, is that correct?

[16:45]

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

Mr. Nilson: — So how much comes from some of the Crown corporations or from other areas of government so that I can get a total picture of what is coming out of this budget?

Hon. Mr. Duncan: — I'll maybe just back up, Mr. Nilson. So we will provide you with the information. We don't have it right now. And just in terms of the different levels that patients would have paid for STARS air ambulance, we've provided the ground ambulance, but we'll provide that for you when we can pull that together. It's not going to be this afternoon.

So you're looking for what other government agencies would have paid towards the fundraising aspect that STARS does in conjunction with the government. We'll just check to see if we have that number.

We'll provide that information for you, Mr. Nilson. We just don't have it here with us. The information would in the past have been provided as a percentage of their revenue or their fundraising, but it wouldn't be dollar amount by Crown corporations. So we'll have to find that from each Crown corporation.

Mr. Nilson: — Okay. I would appreciate that because I know there are some amounts, but I just don't quite know the exact amounts that are there.

I've got a question again going back on the supplementary health benefits area, and you indicated that they're primarily people that are on social assistance. But are there people that get this supplementary health benefit who aren't on social assistance?

Hon. Mr. Duncan: — The nominations for the program are done by Social Services, so we wouldn't have the information as to if there are other people that would receive that benefit that aren't on the Saskatchewan assistance plan. That would be done by Social Services.

Mr. Nilson: — So you don't have any idea of the number that might be in that category at all, or would you even know in Health?

Hon. Mr. Duncan: — The supplementary health program does provide assistance with non-insured health services to, as we've talked about, social assistance recipients as well as those that are on the transitional employment allowance, so the TEA

program. It also provides assistance to wards of the state, inmates of provincial correctional institutions, any residents of long-term care facilities whose income falls below or is at the seniors' income plan level, as well as recipients of the provincial training allowance program.

Mr. Nilson: — Okay, so that's substantial. It brings in a whole group of people there. Do you as the Minister of Health or does the Ministry of Health have any discretion to enrol people into this program and sort of designate them from the Health side?

Hon. Mr. Duncan: — So the nominations are done by Social Services. We don't do the nominations for the program. There are, though, certain exceptions that we can make when it comes to if somebody has exceptionally high drug costs. We can add them on the drug side that would do things like help to lower their co-pay, but those are very exceptional circumstances and it wouldn't be that they would be on the entire supplementary health program. It would be specific to something like a drug cost.

Mr. Nilson: — And that would be done solely within the Ministry of Health to sort out a cost problem for pharmaceuticals?

Hon. Mr. Duncan: — Yes, that would be done by the Ministry of Health, and it would be typically on a temporary basis.

Mr. Nilson: — Okay. Well thank you. Now I see the time's getting a little short here, so I've got a couple more areas to go into. How many people are on the Regina Qu'Appelle Health Region wait-list for individualized funding? Would you have that kind of information?

Hon. Mr. Duncan: — So as of March — I believe this is when the date is — there were 18 people across the province that were waiting for individualized funding. Two of those individuals would have been in Regina Qu'Appelle Health Region.

Mr. Nilson: — Okay. And when they're on the wait-list they have access to the home care service. Is that correct?

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

Mr. Nilson: — Thank you. Then I have one of my favourite questions. I don't get to ask it very often, but how many people are suing the Minister of Health?

Hon. Mr. Duncan: — There is currently one lawsuit as it pertains to the Minister of Health. It's not this Minister of Health. It pertains to a previous case under a former minister.

Mr. Nilson: — Is that still before the courts then?

Hon. Mr. Duncan: — Yes, the then minister has been named, so it's going through the process.

Mr. Nilson: — And I assume that's the minister just prior to you. Would that be accurate? I'm just curious. I don't think there's any lawsuits against me still, but there sure were a few.

Hon. Mr. Duncan: — It's my predecessor, yes. That's correct.

Mr. Nilson: — Okay, good. And that's on the public record then as far as you know. So it's a regular lawsuit. Okay.

Now one of the issues that's I guess outstanding as it relates especially to the Ministry of Health is the response by the ministry to written questions in the legislature. And it appears that, not just Health but many areas, the written questions have been basically not responded to and are going to be dealt with in that process. Do you have any explanation about why there have been so many that have not been dealt with in a timely fashion?

Hon. Mr. Duncan: — I'd certainly be willing, Mr. Nilson, to confer with House business in terms of written questions, but I do know that there have been a large number of written questions that have been entered into the legislature. I know that we've received a fair amount of those written questions, and I think it's just the sheer volume that we're trying to work through in the fairly short timelines that typically written questions get answered. It's our intention to work through that process and to answer the questions in a timely way, but I think Health would be no different as with other ministries in just trying to get back in the sheer volume of written questions that we do have.

Mr. Nilson: — I also have a question about the freedom of information requests. It appears that your ministry does stand out in that area in how long it takes for answers to come forward. Can you explain what the problem is there?

Mr. Hendricks: — I'll explain that. I've now had a meeting with the Privacy Commissioner, and you are correct that the amount of time that it has taken the Ministry of Health to respond to some FOI [freedom of information] requests has been quite long. A number of reasons for that: one is the scope of the responses. Oftentimes literally the number of documents that are required numbers in the hundreds and even thousands in order to prepare a response to the FOI.

What we have done in the ministry is actually we've made some changes based on the discussion that I had with the Privacy Commissioner. First of all, we are working with requests, people who are requesting FOIs, to try and narrow the scope of those FOIs where possible. But within the ministry, we're also streamlining our processes because where we had it going to one individual in sequence, then the next individual to review, and so on and so on, we're now using parallel processes to get through it faster. Our goal and my commitment to the Privacy Commissioner is to try and bring Health in under the requirements of the legislation.

So just for your awareness, it's something that I'm concerned about as well. And we are . . . I'm actually planning on meeting with the Privacy Commissioner in the very near future and reporting our progress on it. We are making some already.

[17:00]

Mr. Nilson: — What was the procedure versus what's now the procedure? I mean like does it go through like 10 people or three people? I mean, I think there used to be an officer that kind of was in charge of that and managed and got the information in an appropriate place and then had it dealt with,

and I think it's somebody that I kind of knew.

Mr. Hendricks: — So you're correct. It does come in, and we do have a privacy officer or director of privacy and a privacy unit within the ministry. And they accept the initial submission from the person requesting it or the agency requesting it.

One of the things that we found is that . . . well we found several things. We did a value stream map of the whole process to try and figure out where there were unnecessary delays. And one of the delays that we found was within the initial receipt of the FOI request.

But typically after the privacy unit, they will go out and they will fan out in two areas where they might think the records exist and have people within those branches search for responsive records. So that takes a period of time. And then once the information is assembled, there's a duty to go through and review the information, make sure that (a) it's complete, but (b) also that does include information that is not responsive or that divulges personal information. So that normally will go through a few people, including the deputy minister's office, to make sure that it complies with the intent of the legislation. And so there are a few steps.

Where actually we're taking more time though is that rather than going to a branch, the first branch for example, to review and make sure that it was responsive — before it went to the second, the first branch had to be done with it — and literally some of these are this thick, so it would take some time to review. Now we put them in parallel so that branches are looking at them in a simultaneous fashion. We've cut down the time that the privacy unit is actually taking to get them to the branches, and also upfront we're narrowing the scope, the end. We actually have added a charge because this has become so laborious in terms of assembling this information, we want to make sure that when people are requesting this information, that they're actually refining the scope of their search to what they really do want.

Mr. Nilson: — So, as you know, some of my colleagues were very pleased with the responses from, on freedom of information requests that were made, you know, about a year ago. And then all of a sudden that changed. Was there a change in the process after the receipt of information, I think it was last May or June?

Mr. Hendricks: — Well, as I said, the process has changed more recently and favourably in response to the Privacy Commissioner's concerns, but also our own in the ministry in wanting to be accountable and transparent. But there was no change as a result at any time in May that would have caused us to slow down FOI responses. Literally it was, it's more likely because of the sheer volume that we are receiving and, as I said, the scope of those requests as well.

Mr. Nilson: — So do the FOI requests go to the minister's office, or to Executive Council before they are released to the public, especially when they come from some of my colleagues in opposition?

Mr. Hendricks: — The reality is that we are not allowed, I'm not allowed to know who is requesting the information. So there is no decision made based on who the request is being made from. In terms of that, if I asked Duane, who is the head of the unit, he's not allowed to tell me who the requesting party is.

Mr. Nilson: — Well that's the right answer. Good. Thank you, I appreciate that. But I know that what we perceived was that after the freedom of information request where we got a lot of very interesting information from the Health Quality Council last year, all of a sudden things just tightened right up. So that was where my question comes from. So what happened between that process, which was quite open, and what's going on now?

Mr. Hendricks: — First of all, it was a different agency. The volume that the Health Quality Council, the number of FOI requests that they receive compared to what we do receive, is significantly different. But you know, minister Nilson, I would invite you or any of your colleagues, actually if you come on to the third floor in the T.C. Douglas building, where you've been several times, we now have on our visibility wall a measurement and a performance metric for responding to FOI requests. It's that serious that we've actually . . . It's something that our senior leadership team is reviewing and watching how, seeing how, and measuring how quickly we do respond to them.

Mr. Nilson: — Well I appreciate that, but it's been pretty, you know, frustrating. The other question comes is, I assume many of the documents now that are requested are electronic as opposed to paper documents, and so some of the methods of calculating fees seem a little bit outdated when some of the fee requests come. And so perhaps you can explain how some of these decisions are made.

Mr. Hendricks: — Obviously a manual search of paper records is much more difficult than an electronic search. And there have been cases, a couple of cases, where I think it's fair to say that, you know, even I have looked at the estimate and I said, that's a little bit out there. You know let's have another look at it, right? But in some cases it's not necessarily as easy as it appears.

For example, there have been requests around expenses for our lean consultants and that sort of thing. And literally we have to go through our online MIDAS [multi-informational database application system] system and search for expenses, and it actually does require a significant amount of analyst time. And so some might not be as easy as they first appear.

You know, just on the FOIs, I will say this though, that the other challenge is ministries don't have a huge amount of resources for privacy work. And in fact, you know, to some extent — and we always want to be transparent and accountable — but the nature and the frequency and the scope of some of these really detracts from a lot of the other work that we could be doing. But we realize it's important, and we're committed to making sure that we do improve our turnaround time. We're committed to it very much.

Mr. Nilson: — Thank you. And on that particular point, I think I would say to the ministers that it sounds like they need a little more money in that budget, so maybe you can move some over there. But thank you very much for the responses to all of my questions this afternoon. And as you probably can tell, I wouldn't mind doing this for 40 hours if you'd let me, but I'll

get a few small chances to be part of this. But thank you very much for your response.

The Chair: — Ministers, do you have any closing comments?

Hon. Mr. Duncan: — I don't. I believe Minister Ottenbreit wants to make a closing comment though.

Hon. Mr. Ottenbreit: — Yes. Thank you, Mr. Chair, and Mr. Nilson. Thank you for your questions and the committee work today. I'd like to take this opportunity to do a bit of a clarification on — I hesitate to say an allegation or an insinuation, but an inference in the House today — as to this government and how we expect people to pay their ambulance bills.

It came into the House today, a phone conversation that I was unknowingly recorded in, which is fair enough. I have nothing to be ashamed of in the conversation I had with Sara Bucsis-Gunn about her daughter, Leandra, unfortunately who passed away, and still had or may still have quite a high ambulance bill.

Ninety per cent of the context, I believe, and this is all in my recollection — and I know you have the recording, so I would encourage you to listen to the recording and again, correct me if I'm wrong — my recollection of the conversation that went probably for an hour and a quarter for the most part was around one grieving parent talking to another grieving parent that had lost a child.

But recognizing in my position right now, you know, you bear the words you speak. And I do represent the government, so I want to be as respectful as I possibly can to all involved. Again, 80 to 90 per cent of that conversation revolved around me supporting that family in what they had gone through. The parts of the conversation, I saw myself — and again I'm the minister; so the whole conversation I'm the minister — but the parts of the conversation I remember representing the ministry, the government, revolved around current supports in place and options that they had had and had admittedly exercised. And I made sure in the conversation that they were aware of everything that was available to them, and in fact they had been.

I thanked them for bringing the case forward. I thanked them for the information because, as Minister Duncan has spoken of many times, we are constantly looking at the ambulance services and how we can better improve. And I'm not going to go into the details of the 71 per cent and of the things that we cover in lieu of, maybe higher coverage for ambulance.

But in the course of that conversation again, laying out those options, making sure they exercised all options, and maybe looking at other options there might be — including the Kinsmen club, and again with the options available to any citizen of this province when it comes to income levels — every example that I exercised, they either had too high of an income, assets, whatever the situation might be. They didn't qualify for those because of their level of income.

The part brought up in the House, the inference today that I said, I insinuated that they should be doing steak night fundraisers, charity work of any kind on their own to pay their ambulance bill, quite honestly disgusted me. I was really bothered by that. But then in consideration of my conversation with the family, I was quite comfortable with the conversation. And again, I encourage you to listen to the tape.

The part that the Leader of the Opposition brought up in the House, inferring that that was basically the course of that conversation, to me misrepresents the conversation and quite honestly disappoints me severely in his conduct, in the conduct of the opposition in backing that. I'm assuming most members would have known what was going on.

The only part of that conversation — and I would say it was, my recollection again, maybe at most 10 per cent, 5 per cent, 1 per cent of that hour and a quarter — revolved around opportunities that were maybe presented to my family in our time.

I present to many families that I know of around the province that have difficulties paying certain bills that weren't covered, non-insured services that haven't been covered, and communities wanting to step up and help their fellow people. My experience has been very good in those situations, where people there, they want to help someone that's going through a difficult time. They don't know what to say. They don't know what to do. They want to help. They'll donate. They'll put on a steak night fundraiser, some sort of a charity event. That's been my experience with the people of this province. And again, the inference that that was the scope of the conversation, that's what they should do to pay their ambulance bill, again disgusts me.

Now again, the course of that conversation basically was thinking about opportunities that people had afforded, and at no time suggested that that should be their course of action. Admittedly Sara was upset when I brought that up, and I could tell that, so I backed away from it. I didn't push it any farther, but I wanted to make sure they were aware of that option, that people would be willing to help in a situation like that.

So just for clarification, in that conversation, again of an hour and a quarter I spent on the phone with her about her daughter and her family and their situation, I was making sure that they knew that option. And again, at no time did I infer that that was what they should be doing, to fundraise, and at no time did I infer that they should do it. My reference was that many people like to help. And possibly if somebody exercised the opportunity, took the opportunity to help them, to maybe put on a fundraiser like that, they might want to look at that. And again, she didn't really seem to want to go down that road and I left it alone.

[17:15]

But to infer again that that was the course of my conversation and my suggestion to them, I think doesn't do this place, it doesn't do the opposition any respect of the office that they serve. And I would encourage them, we see this time and time again in the House where there's half-truths and innuendos and assumptions and insinuations that aren't true, that facts aren't checked, I would encourage you to encourage your colleagues — and admittedly, Mr. Nilson, I know that you had nothing to do with this part of it I know, and I haven't seen you do a lot of

insinuations so, to your credit, I respect that — but I would encourage you to encourage your colleagues to maybe do a bit more background work and hold themselves to a higher standard than they have. Thank you.

Mr. Nilson: — Mr. Lawrence, could I respond?

The Chair: — Actually it is now 5:15, so I would ask a member to move a motion of adjournment.

Mr. Tochor: — I so move.

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

Some Hon. Members: — Agreed.

The Chair: — Carried.

[The committee adjourned at 17:16.]