STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Ms. Nicole Rancourt, Deputy Chair
Prince Albert Northcote

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Regina University

Mr. Dan D'Autremont
Cannington

Mr. Muhammad Fiaz
Regina Pasqua

Mr. Roger Parent
Saskatoon Meewasin

Hon. Nadine Wilson
Saskatchewan Rivers

Published under the authority of The Hon. Corey Tochor, Speaker

[The committee met at 13:32.]

Ms. Drake: — Good afternoon. This committee has a Chair and a Deputy Chair, but neither of them are able to be here today, so it's my duty as the Committee Clerk to preside over the election of an Acting Chair for today. I'll first ask for nominations and once there are no more nominations, I'll ask a member to move a motion to have the committee member preside as Acting Chair. I'll now call for nominations for the position of Acting Chair. Ms. Wilson.

Hon. Ms. Wilson: — I nominate Roger Parent.

Ms. Drake: — Roger Parent has been nominated to serve as Acting Chair for this meeting. Are there any further nominations? Seeing none, I would now invite a member to move the motion. Ms. Wilson.

Hon. Ms. Wilson: — I move:

> That Roger Parent be elected to preside as Acting Chair of the Standing Committee on Human Services for the meeting of June 23rd, 2016.

Ms. Drake: — All in favour of the motion?

Some Hon. Members: — Agreed.

Ms. Drake: — I declare the motion carried and invite Mr. Parent to take the Chair.

The Acting Chair (Mr. Parent): — Welcome to the Standing Committee on Human Services. I am Roger Parent and I will be chairing this meeting today.

I'd like to introduce the members and announce any substitutes. Sitting for Greg Lawrence is Ms. Carr. Sitting for Tina Beaudry-Mellor is Mr. Marit. Ms. Wilson is here and Mr. Fiaz is here. And sitting in for Ms. Rancourt is Ms. Chartier.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Acting Chair (Mr. Parent): — We will now resume our consideration of estimates for the Ministry of Health. It is vote 32, Health, central management and services, subvote (HE01). Minister Duncan and Minister Ottenbreit are back once again with their officials. Ministers, please introduce your officials and make your opening comments, and if I could remind officials to please identify themselves the first time they speak.

Hon. Mr. Duncan: — Thank you very much, Mr. Chair. Max Hendricks, the deputy minister, joins me at the table. And we have a number of officials that if we again have them take part in the questions and answers we'll have them identify themselves.

I do have a number of follow-ups from previous estimates meetings that I would like to provide the information to members of the House or members of the committee.

I'll start with Lyme testing. So the number of cases tested at the Saskatchewan Disease Control Laboratory and the number of indeterminate and potentially positive cases, they are referred to the National Microbiology Laboratory in Winnipeg.

And over the last five years the numbers, and I'll give you from starting in the year 2011-2012 fiscal year, so there were 514 cases that were tested at our Saskatchewan lab and 115 cases were sent to the National Microbiology Laboratory for confirmation. In 2012-13 there were 853 tests at the lab and 107 of those went to the National Microbiology Lab. In 2013-14, 804 cases were tested in Saskatchewan and 50 were sent to the national lab. In 2014-15, 1,167 cases were tested in Saskatchewan and 38 were sent to the lab. In 2015-16, 1,351 cases were tested at the lab in Saskatchewan and 37 were sent to the National Microbiology Lab for confirmation. The National Microbiology Laboratory is the only testing facility in Canada which provides confirmation testing for Lyme disease.

With regards to the residential beds in Hope's Home, the question was asked how many are filled by Social Services or how many of them are filled, and these would be ones that are contracted by Social Services. As of June 22nd, the Ministry of Social Services reports that 16 of the 17 reserved beds at Hope's Home are full. This is subject to change however, but all of these children are long-term placements.

A question was asked about the Wascana rehabilitation unit, if there had been any bed closures or conversions. Regina Qu'Appelle Health Region has informed the ministry that there have been no bed closures at Wascana rehab.

There was a question about whether there had been a change to the family respite rooms. The health region has informed the ministry that Wascana rehab has a 42-bed hostel, where often medical students or staff that are working in the region as temporary location may avail themselves of the hostel, as can families of residents book at the hostel. And the region reports that the hostel is typically not full and that the region has never had to turn people away.

I'll table three charts for the members of the committee. These are the run charts from the previous year for both Saskatoon and broken out for Regina Qu'Appelle for the two tertiary centres in Regina.

With respect to palliative care beds, the ask that was made by the committee is to provide an over-capacity run chart similar to what we're providing. Saskatoon Health Region has advised that palliative care over-capacity information is not explicitly tracked, but is embedded in the general over-capacity information reported on their website. The capacity reports on the Saskatoon Health Region website, updated every half-hour, show the capacity in the 12-bed palliative care unit at St. Paul's Hospital. Other palliative care patients would be included within the capacity number, within the capacity reports of medicine units typically, but also could also be assigned to other rooms in the hospital.

Wait times for a bed on the acute palliative care unit are

variable. On average, clients wait a week for a bed. The variability can in part be explained by the RHA's [regional health authority] admission process. First priority is given to admission to clients who are at home and who can no longer manage with the resources of palliative home care. Any medical, surgical, or other bed in hospital can be considered palliative as it is dependent on the patient's clinical condition. The patient will be provided with the necessary services once designated palliative by a physician.

We were asked to provide some clarification on the phrase "inappropriate transfer" that is used in the Saskatoon Health Region Better Every Day report. So the information that Saskatoon Health Region has provided back to us is that they do not believe that this term is accurate and will change the terminology as soon as possible. This was an attempt to differentiate between medically required transfers and other transfers for other non-medically necessitated reasons.

These could include a request by a patient or a family, for example, to be located in a room with someone of the same gender. Or it could be a transfer that is made in order to create a common cohort of patients on a unit. Medically necessary transfers could relate to patients with multiple care needs moving to a different unit, a patient transferring to a higher or lower level of care based on changing condition, or a patient who may require isolation. The region acknowledges that transfers necessitated by non-medical requirements do not make them inappropriate and has committed to changing the wording on their website.

The ask was made by the committee to provide clarification on whether the over-capacity run charts for RUH [Royal University Hospital] included Dubé. And yes, the over-capacity information includes patients who are to be admitted to the Dubé Centre.

We were asked to provide clarification on the practice of triaging and transferring patients within Dubé. The health region indicates that Dubé patients who require shifts in intensity of care, such as observation, may be transferred. And this is a clinical judgment call in these circumstances.

And we were to provide additional information on the physical set-up of rooms on unit 5100 and 5200 at RUH. Are pod patients physically separated from unit patients? The region has advised that the pod is a physically separate space that is staffed according to the needs of the patients in the space. The beds on 5100, 5200 are permanent hospital beds with medical gases, washrooms, and the regular features of a hospital room. The patients are grouped together rather than being interspersed within the postpartum gynecology unit patients.

Ms. Chartier: — Is that everything? Yes. Thank you very much for that. I appreciate that. That whole issue of over-capacity, and it was raised in the House last week, the whole . . . I had heard from a doc about IV [intravenous] poles and bedsheets. And so initially I had heard from one doctor, and I had the occasion on the weekend to speak with actually several medical providers of different sorts. And then actually just even this week as well, and I've continued to hear, not that it happened yesterday, but in the recent past, the use of IV poles and bedsheets. And actually one worker pointed out that they had used lights as the place where to hang the sheet. So I'm wondering . . . Obviously last week in media you said you hadn't heard about that, but I suspect you've asked about that. So I'm wondering what you learned.

Hon. Mr. Duncan: — So the health region has confirmed with the ministry that at times, when the over-capacity situation is to the extent that there is, within the existing resources, the inability to provide for privacy for all patients that require privacy, that they have produced private areas using, trying to curtain off or cordon off areas using, the staff using supplies that they do have on hand.

[13:45]

Ms. Chartier: — Thank you. Can you tell me whereabouts, for example at RUH, that would take place?

Hon. Mr. Duncan: — We're not aware specifically where it would have happened in the hospital. It could have been in the emergency department, or perhaps in a medical area that was facing an over-capacity. We not sure exactly where it would have been.

Ms. Chartier: — Okay. Do you have a sense of how often it happens?

Hon. Mr. Duncan: — I'll confirm with officials. So we don't specifically know when exactly this would have taken place in Saskatoon, but I think it is indicative of just the fact that we are certainly aware and our regional health authorities are aware of the increasing demand that we're seeing on our hospitals, particularly on our seven hospitals across the province.

That's why we have certainly added to the capacity within those seven hospitals, including Royal University, City, and St. Paul's in Saskatoon. Overall on our acute care beds, we're up 152 beds. That's about a 12 per cent increase over the last eight years just in those seven hospitals, and it is why we have launched a province-wide emergency department wait and patient flow that has led to a number of initiatives that are not just trying to improve the care that's provided in the emergency department but also trying to reduce the demand on the emergency department and do a better job of providing services in the community.

But we certainly know, as we have said and I have said time and time again, that we need to continue to do this work because we do know that our largest hospitals continue to be under pressure and that our population continues to grow, and that we are going to be asked to provide health care services for an increasing number of people well into the future.

Ms. Chartier: — Is that a briefing note on this? Do you have a briefing note on this particular issue?

Hon. Mr. Duncan: — No I don't.

Ms. Chartier: — I've been told . . . so I've been told by several now health care providers that this happens and fairly recently. But I've also been told by a manager that it's not supposed to happen because obviously it's a fire hazard. My question around where it happens, I've been told that it happens in

hallways. And so I'm just wondering your thoughts on that.

So obviously we're over capacity, but there's no space. Staff are doing their best job to ensure privacy, which is really important. But obviously again either putting bedsheets on lights or on IV poles, like the fire hazard and then the escape issue as well. So I'm just wondering if you've had that, if that's been a directive not to do that?

Mr. Hendricks: — I'm Max Hendricks, deputy minister. So those situations when hospitals are in extreme over capacity where, as a last resort, patients are placed in hallways, those patients obviously receive the highest priority to find an appropriate setting or appropriate room for them. You know, it could be in a hallway in emerg. It could be on the unit.

Obviously, hospital staff are aware of issues around blocking access in corridors or to exits and that sort of thing, and are mindful of that. The whole emphasis though is on having physicians rounding regularly to make sure that those people that are ready for discharge are being discharged on time to make room for patients that are not in the appropriate unit or setting. And so this has become a priority of the region. It doesn't happen that often, but unfortunately it does happen from time to time.

I think that, to the minister's earlier point though, we need to start looking at kind of the root causes of this. And earlier this week the Canadian foundation for health information released a report that talked about preventable hospitalizations from COPD [chronic obstructive pulmonary disease] and actually said 80 per cent of hospitalizations, emergency rooms visits for COPD could be eliminated through proper management in the community. And that's management by primary care providers, but also self-management by people. Obviously this is one of the diseases that we're targeting and working on as part of our chronic disease collaborative. In Saskatchewan alone they estimate that that could be almost 3,700 or 3,800 hospital care days saved a year.

So what we're trying to do is shift where the care is provided to the appropriate setting, which would most appropriately in these cases be the home. But we have people showing up, and the observation of the report was right now our ERs [emergency room] are still being jammed by CTAS [Canadian triage and acuity scale] 4 or 5 patients that could have sought care in another setting.

And so you know, it's patient education, but it's also working to make sure that they're connected and in the community. So these are things that we're working on and, you know, hospitals across our province, as you've seen from the run charts, this is something that's monitored very closely and that a high degree of attention is paid to in terms of trying to find the best option for patients.

You know, we spoke of the pods yesterday, you know, trying to congregate patients that have similar care needs in the same area so they are attached to the appropriate medical staff. Nobody in our health sector, I can tell you, no front-line health professional likes to see a patient in the hallway, so we try to eliminate it as much as possible. But there are times when it's very difficult.

So an element of all your hospital care work is very predictable. You know, it's scheduled. You have your surgery. You have your outpatient, ambulatory care that schedules outpatient surgeries, that sort of thing. And so hospitals do use that as a countermeasure to deal with the unpredictable when we have a large influx into the emergency and subsequent admissions. So it's something that I think we're getting a lot better at working on. Is there work to be done? Yes. We don't like to see patients in these settings.

Ms. Chartier: — I'm just wondering if you've got a policy to direct . . . Is there a policy to direct health care staff not to do that, to not either put patients in hallways or try to provide them some additional privacy? I was told by a manager that, when we talked about this she said, oh they're not supposed to be doing that anymore. So I'm wondering if there's a . . . what kind of directive has gone to staff.

Mr. Hendricks: — It's not a directive, but I think it's a general operating principle that we try to move patients, again as I said, into the most appropriate setting in as timely a way as possible. So when we look at the targets that we're setting in the health care sector, we're looking to reduce the amount of time that it takes to move a patient who is designated from admission to a bedroom. So that time that they would spend in an ED [emergency department] waiting for a bed, we're trying to shorten the length of that time.

And so they understand very clearly that the goal here is to have flow through our facilities so that people aren't in hallways or in a less-than-ideal care setting. As I said, it happens from time to time. We're getting better at it. We're getting better at monitoring, knowing when it's happened, but we also have to have the co-operation of physicians in making sure that the flow is happening so that they're rounding on time, preferably as a multi-disciplinary team, and that they're actually releasing patients that are ready to go home or into a community setting.

You know, recently there was . . . You've heard about an initiative in Regina where they're actually bringing a multi-disciplinary team and working on this. Because by doing that and monitoring the patient more carefully throughout the team using the skills of the different providers, they are able to actually move patients through the hospital more quickly and, I would actually argue, in a more patient-friendly way. And so we want to see the spread of that across the system.

[14:00]

So a lot of good stuff happening. As part of our ED waits initiative, we're seeing a lot of innovations happening in the community, that sort of thing, and also in terms of our chronic disease management collaborative, LiveWell, training people to take care of their chronic diseases. These are all strategies and tactics that are aimed at kind of addressing this issue where it's actually coming from, rather than where it's ending up.

Ms. Chartier: — And when in Public Accounts you'd shared a little bit about how the Regina pilot was going, and that's really great news. But I'm just wondering, again multiple stories as recently as a couple weeks ago, stories of patients in hallways being cordoned off, and then a manager telling me, oh they're not supposed to be doing that. So I'm just wondering how you

communicate, how the RHA is communicating with staff not to build privacy around patients in hallways. Because it's happening, so I'm like did a memo go out?

Mr. Hendricks: — We're not aware of any, obviously, specific ministry directive that's gone out with respect to creating these enclosures around patients who might be in an off-service area.

What we would say . . . What I would say is that generally what health care providers will do is they will respect the wishes of the patient. And a patient that is temporarily in that setting might ask to have a temporary enclosure put around them just if they're sleeping or something like that. And so I think that most health care providers would respect the patients' wishes. And in the event that, you know, I would hope in the unfortunate event that they are in that situation that, you know, issues like access to fire exits and that sort of thing would be considered as part of that.

Ms. Chartier: — Okay. I was just saying, this specific manager. I would, of course . . . We all would want privacy in any space that we were when you're sick. And I know health care workers work very hard to provide the best possible care., but I've been told that it was a fire hazard to do this, so they shouldn't be doing that. It's necessitated sometimes, or patients ask for it, but it is a fire hazard is what I've been told. You've got a patient in a hallway with an enclosure because they ask for it, but in fact it is putting people at risk, so says this manager who told me that they're not supposed to be doing that any more.

Hon. Mr. Duncan: — Mr. Chair, I'll maybe just offer that we can follow up with Saskatoon Health Region to determine: whether or not there was a specific directive that was given to staff; whether or not the health region has concerns that the directive, if it has been put in place, is not being followed; and what plans they have in place to mitigate both a policy that's not being followed; as well as any risks that the policy may, that may be as a result of this practice still being put in place. So we will have that conversation with the region.

Ms. Chartier: — Thank you very much. Just to your point around chronic illness, and there are many reasons why our ERs are stacked — mental health and addictions, not proper housing or places for seniors, chronic illnesses. So I'm wondering with respect to chronic illnesses, the investments in this budget to address things like COPD, diabetes, those kinds of things.

Mr. Hendricks: — Okay. So when the minister, in his opening remarks last week, talked about the investments that we were making or continuing in the health care sector, maintaining one was $4.7 million for ED waits. So embedded in that is that we're continuing with our hot-spotting initiatives which you're aware of. So that's providing opportunities to better manage those patients that show up at emergency from time to time, or they're in hospital and could be discharged earlier by providing alternate community supports for them. So those are continuing, and as I have noted, they're having some success. You know, Connecting to Care is an element of that, but also just generally within the hospital, the number of people that they're actually being able to attach to a different care provider in the community.

The other element is that we're actively looking at our chronic disease management-quality improvement program enrolled providers. And so what these are, are providers that have enrolled and actually have gained special knowledge in terms of the management of six common chronic diseases including diabetes, coronary artery disease, COPD, depression, cognitive heart or congestive heart failure, sorry, and asthma.

Since we started monitoring this in '16-17 — so only a couple of months in now — we've seen the number of providers that have had this, have gone through this and that are completing the templates and the flow sheets for these chronic diseases increase to 682. Our goal is that by March 31st, 2017, there will be an additional 700 . . . there will be 765 GPs [general practitioner] and nurse practitioners who are enrolled in CDM-QIP [chronic disease management-quality improvement program] program and have at least two or more visits that are included in the chronic disease management repository.

I mentioned the LiveWell program. We've continued funding of $150,000 for that program. As well we have a COPD pilot in Regina Qu'Appelle that has two nurse practitioners attached to it. So obviously in the challenging budget that we've had, we haven't had a lot of money for new initiatives specifically in these areas, but we do have base funding that we are attaching to continue to expand those initiatives that are already under way but to look at new ways of reducing pressure on our emergency rooms.

I would also mention that as part of, you know, early discussions with the federal government, you know, provinces have expressed some interest collectively in looking at not only home care, but community supports along the lines that I was talking about in my last statement about ensuring that patients actually do have the support and care in the community that they need to manage there effectively rather than being forced into institutional care.

So a lot of work going on in this area and an increased recognition that this is the space that we need to be working in more than perhaps focusing on just managing strictly within our acute care facilities. And it's something that honestly, I think, that over time as we can take some pressure off our acute facilities, managing in the community, keeping people healthier, and with better outcomes obviously is lower cost.

Ms. Chartier: — Thank you for that, and I couldn't agree more that that is the key, I think. But I'm just wondering, so the $4.7 million ED wait money. So there was 4.7 million last year; there's 4.7 million this year, and then we have the chronic disease management and enrolled providers program. So I think you mentioned that in PAC [Public Accounts Committee] too. I think you were telling us a little bit about that in public accounts. So when did that start? Because you have mentioned in '16-17 your numbers have already gone up, but when did that enrolled providers program start?

[14:15]

Mr. Hendricks: — So the CDM-QIP program is a program that we operate in conjunction with the SMA [Saskatchewan Medical Association]. In our last agreement that we signed with the SMA, we provided $3 million to continue chronic disease

management and quality improvement practice.

So as part of this, you know, the program allows health providers to access electronic and paper CDM [chronic disease management] visit flow sheets, and these prescribe the evidence-based standard of care that the provider is to be following. They generate collective and administrative reports so we can actually have the information and know that patients are being tracked. It also allows them to track, follow up, and make sure that there are disease-specific investigations, and graph review historic cases to see if they have any indicators of increased activity within their patient load, view the chronic disease indicator observations of a patient submitted to an electronic health record.

So this program has a lot of elements to it. It was started on April 1st, 2013 and was continued in the last agreement with the SMA. The early adopter . . . We had an early adopter payment as part of that to try and get people onto the program. We paid out almost $330,000 from April 1st, 2013 to 2015 and a total of $262,000 was paid for active users. And then the biggest part is that as doctors enrol people in the CDM-QIP program, they're paid a maintenance fee of $75 per year to continue to manage the flow of those patients. And so this program has seen some early success.

Another thing that I do want to mention is that the seniors home visit program was outside of the 4.7 million, which is another initiative of approximately $1.6 million that we're providing to address chronic diseases and manage people better in their homes.

Ms. Chartier: — In this budget, there's 1.6 million?

Mr. Hendricks: — There's a continued 1.6 million, yes.

Ms. Chartier: — Continued. Okay. And the LiveWell program, you gave me a number here . . .

Mr. Hendricks: — 150,000.

Ms. Chartier: — And that's been, this year it's 150. How much was it last year, or when did it . . .

Mr. Hendricks: — Sorry, I had the wrong number there. It's $200,000 annualized funding for LiveWell.

Ms. Chartier: — 200?

Mr. Hendricks: — Yes.

Ms. Chartier: — And when did it start?

Mr. Hendricks: — This is the second year of it.

Ms. Chartier: — Second year. And what is the LiveWell program?

Mr. Hendricks: — The LiveWell program allows providers to connect with patients that have chronic diseases. And in turn, what those patients do is . . . It's almost a train-the-trainer model, where those patients then go out and connect with other people with the same chronic diseases, and they in turn educate those people on how to better manage their diseases.

A lot of it's about disease management. But the unique perspective I think that LiveWell brings to us is that I think it's a good experience for patients that are experiencing a chronic disease to learn about management skills from somebody that actually has the disease and can better relate to what they're going through and some of the concerns and anxieties they have with that chronic disease. So initially we found it very successful. And I think one of the areas, the particular interesting application is with our indigenous population, where they can make the cultural connection as well.

Ms. Chartier: — Thank you for that. On that same topic of chronic diseases and keeping people out of the emergency room, so last year some money that the health region used to give to the Paul Schwann Centre for cardiac rehab . . . I'd written you a letter, Minister Duncan, and I have gone through all my correspondence — we obviously both get lots of correspondence — and I don't think you've responded to that. So I'm wondering where you're at with respect to the Paul Schwann Centre and the fact that there was a program that supported individuals to have cardiac rehab and kept it affordable.

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So we will check our office with respect to the response to your letter. I apologize if that hasn't, if we've neglected to send that out to you. So we'll do that as soon as we can.

So with respect to the cardiac programs across the province, and I think it's important to keep in mind there are a number of factors that go into the cardiac programs. So there's the education component, which is separate from the exercise component, which can be separate from a maintenance component to the exercise component. Once somebody is referred into, for cardiac rehab after the cardiac event or the intervention that takes place through the medical system, there is the ability to access in a number of locations a cardiac rehab program. But that's not to say that that may be different from the maintenance of a person's physical well-being after the immediate rehab program portion ends.

And I would say that, with respect to the number of different programs across the province, so you know, what we look to see is, ensure that there is some consistency in terms of the ability to access education and to access the rehabilitation as well as the exercise programs. But that takes a couple of different forms.

In the city of Regina, I think people are very fortunate to have a facility like the Paul Schwann Centre, which is not operated by the regional health authority. Whereas opposed, or I guess an example . . . Another example that I would give is somebody in Melville doesn't come into Regina to the Paul Schwann Centre, but that community has a very good indoor facility that has a number of facilities all under one roof. And I believe that that is where the cardiac, the exercise program takes place for those people in that community. I think they have an indoor walking track and some . . . They have the ability to access other exercise equipment, but in that case the community owns it. And so I think what the community has decided is they already

are paying the bills to keep the lights on in that facility and so they will make it available to their citizens at no charge.

The Regina Qu'Appelle Health Region did provide funding up until the 2010-11 fiscal year. The ministry did provide one-time funds, actually provided funds to the Paul Schwann Centre in the '10-11 fiscal year and the '11-12 fiscal year, and so in fact the program has been running without those funds in Regina for nearly five years now.

Ms. Chartier: — Thank you. And I appreciate it if you could, and again my apologies if the letter has somehow gotten sidetracked, but it would be great if you could look into that. Thank you.

I'm just going directly to the budget here. I'm looking at page 74, the allocation where it's provincial targeted programs and services — the 61.417 million, 2015-16 number compared to the $56.809 million. So I'm wondering if you could break that out for me, what that cut is.

[14:30]

Hon. Mr. Duncan: — Ms. Chartier, can you just clarify? Did you say regional targeted or provincial targeted?

Ms. Chartier: — No, there's both. I'll get to both, but the first is the provincial targeted funds.

Hon. Mr. Duncan: — Okay, on the provincial targeted programs and services, so the reduction is . . . there was a $518,000 reduction due to the end of a five-year federal agreement for international educated health professionals. There was a 500,000 reduction in recruitment and retention initiatives and the bulk of it is a 4 million reduction. As a ministry, in the previous budgets, we had $4 million set aside within the ministry dedicated towards continuous improvement or lean activities, and so that eliminates that funding from the ministry budget. Now it'll net out a little bit different because there are some very small net increases in the targeted programs, but that's the bulk of where the reductions would come from.

Ms. Chartier: — Just to clarify, so I understand here, you said 518,000 was due to a five-year federal agreement on . . . what was it?

Hon. Mr. Duncan: — It was a federal agreement for international educated health professionals.

Ms. Chartier: — And what did it do?

Hon. Mr. Duncan: — The funding for the international educated health professionals was a federal contribution agreement that ended March 2016, and the project facilitated career planning of international educated health professionals in the RHAs by supporting them in accessing applicable assessments, language training, and required bridging programs.

Ms. Chartier: — And that was matching dollars then from the feds every year?

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

Ms. Chartier: — Is there anywhere where that work . . .

Hon. Mr. Duncan: — Sorry, there's a correction. So it wasn't matching dollars from the province, it was just a flow through from the federal government that they paid for.

Ms. Chartier: — So that was federal government money that is not there anymore.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay. And was that annual money or one time?

Hon. Mr. Duncan: — Yes, so it was an annual contribution from the federal government over those five years.

Ms. Chartier: — Okay. The 500,000 for recruitment and retention, that's what I think that was. Can you tell me about that?

Hon. Mr. Duncan: — We did reduce our budget by the $500,000 on recruitment and retention. This basically would have been after looking at our programs and looking at the utilization of some of the programs. So for instance, we just would have come in under budget on some of our relocation bursaries that just were . . . We just were never able to max out on what had been allocated. So we were able to reduce that by 500,000. We don't think it'll have an impact just because we never were able to expend the full amount in previous years anyways.

Ms. Chartier: — And so the recruitment and retention, can you, which grants, tell me what that was?

Mr. Hendricks: — So, Ms. Chartier, we'll come back with a complete listing because actually it was a little bit of money from a lot of different places within the recruitment and retention envelope.

But to give you an example, there was some funding provided to the College of Pharmacy and Nutrition to support clinical placements within Saskatchewan. This was the only college that we actually provided any funding to for clinical placements, and so there was kind of an inequity with other health professions. So for example, we have clinical placements for nursing which we kind of manage through the system, and regions pick that up.

But we'll have to get you a complete list of kind of the adjustments that we made to the programs, and in some cases slight reductions based on just our evaluation and utilization of those programs.

Ms. Chartier: — Can you give me a sense of how many programs are being . . . fell under that?

Mr. Hendricks: — They were grouped into broad categories in the chart that we have, so we'll have to get the detail for you. We can bring that though, back.

Ms. Chartier: — Would it be possible to table that chart with the broad categories?

Mr. Hendricks: — So the briefing note that we're speaking of . . . First of all we would have to go through it and make sure that there wasn't any sensitive information here, but it wasn't the specific detail that you were looking for. It was the year-over-year total budget towards various envelopes within health recruitment and retention. So, you know, it's nursing initiative, workplace supports, workforce supports, central recruitment agency — that's Health Careers in Sask — the midwifery transition council, and other areas that fall within that budget. And so in terms of the reductions actually they might, you know, be spread between a couple of those and we just don't have that detail here to be able to give you anything meaningful that would add up to the 500, but we do have it back somewhere.

[14:45]

Ms. Chartier: — And when could you . . . Obviously we're all done Health but the Human Services Committee is meeting again. When would you be able to get that?

Mr. Hendricks: — We'll see if we can't get it for you before the end of committee today and, if not, we'll have it tomorrow.

Ms. Chartier: — That'll be great. Thank you very much. And the 4 million reduction dedicated to lean and quality improvement. So tell me how that 4 million was spent initially. So that's gone but what was that specifically?

Mr. Hendricks: — Actually so a couple things. This funding was attached to patient-first initiatives and so we would use this money obviously to defer the costs of, related to our lean education program. And last year in '15-16 my staff made me aware that I actually took that money away from them to help balance the ministry's budget. And this year we discontinued that funding.

Our view is that now that we've ended our contract with John Black and we actually have the self-sufficiency in regions, that this funding that was related to education and other supports for lean is no longer provided, so it was given up in this budget year permanently.

Ms. Chartier: — So it was there last year but not used for the said purpose?

Mr. Hendricks: — It was used to offset department pressures, so pressures in other areas as part of our financial management strategy.

Ms. Chartier: — And prior to that . . . So just help me understand because we had a contract with John Black and I'm just wondering what this $4 million was. I'm not quite sure that I understand still when you say lean education and what way was it used.

Mr. Hendricks: — So this was used, this funding was used as part of our total, as part of the total cost of paying for the John Black contract over the period of time that we were in that agreement.

Ms. Chartier: — It was included in the 40 million?

Mr. Hendricks: — It was included in what we used to pay the 34 million.

Ms. Chartier: — Fair enough. So I'm just wondering what part of that . . . Like when you say lean education, and that was used for paying part of that contract. So I just am trying to get a sense on . . . like, booking rooms? Like, what . . .

Mr. Hendricks: — No, just generally in terms of the contract, right? So in terms of the total cost that the ministry had associated with the John Black agreement and the associated cost with that agreement. That funding went to help offset that expenditure.

Ms. Chartier: — Okay, thank you for that. Now looking at the . . . so those were the three things that . . . and then under that obviously the different numbers you broke out, there's a myriad of, like, smaller cuts in organizations. And as you said, I know you'll be providing that to the committee. But looking under the regional health services, targeted programs and services, there's a drop from 83.691 to 40.217 — and that's on page 75 — so I'm wondering what that is.

Mr. Hendricks: — I think that I've provided a rather complex and convoluted answer to you on this one in the past. So the reason for that is that this is an area where we hold collective bargaining funding that's been allocated within our budget which may not be distributed yet to regions. And so by nature of that, there's some confidential element to the exact amounts within there, so but the primary amounts in this account are transfers to existing funding for RHA programs.

So what they would have been was RHA programs that were approved in the previous year and/or collective bargaining agreements that were settled in the '15-16 year that would then move from regional-targeted program out to RHA base funding. So for example, you know, when last year we settled the Health Sciences Association of Saskatchewan agreement, there was an amount set aside for that agreement in regional targeted. You asked me what that amount was last year; I wouldn't tell you. And so now that money has actually moved into the budget of the RHA for this fiscal year.

We have transfers out for things like home . . . four and a half million for Home First/Quick Response which we've talked about. Other programs, including some of what we talked about in terms of addressing wait times where we may not have identified how we actually want to place that money in regions at this time, so program . . . So we'll announce the money that, you know, we were talking about in terms of utilization the other night. And you know, we would say $5 million, and I don't remember the number exactly. Well we haven't exactly determined whether Saskatoon will be getting 2 million or Regina will be getting 2 million and this region will be getting a million. So it's held there until we make that determination. And then in '17-18, it would be part of the regional-based budget.

There's also a lot of money held there for existing programs, for things like surgical wait times, that sort of thing, until we do determine allocation. So it's kind of a . . . The best way to describe it is a holding area until certain things are known throughout the fiscal year, certain commitments are made

through collective agreements or certain determinations are made in terms of utilization funding, wait-list funding, where that will actually be flowing to.

Ms. Chartier: — I think I have several questions to help me understand that. So the number . . . So the wait time money, or not the wait time money, the surgical money has become part of the global budget but this year there's an additional 20 million. Is that found in that regional targeted programs and services?

Mr. Hendricks: — That is found in that regional . . .

Ms. Chartier: — That is found. So that's already half of that. So there's 20.217 million left over. So I'm wondering what, so . . . And you've said some of this is collective bargaining. And you couldn't tell me or you'd have to kill me?

Mr. Hendricks: — It was transferred out this fiscal year to recognize agreements.

Ms. Chartier: — I got that. I do understand that. But I'm just wondering about program cuts because people have concerns about cuts. So I'm just, I'm hearing you tell me that some of that is collective bargaining money that was there last year and then becomes part of global budgeting. So I get that.

And then you've told me about Home First, and so that was money that was there and then that Home First becomes part of the global.

Mr. Hendricks: — That's correct.

Ms. Chartier: — But there's other things in there. Like that's a pretty . . . That's like a $43 million cut and you've added . . .

Mr. Hendricks: — Can I give you an example?

Ms. Chartier: — Yes.

Mr. Hendricks: — It's a really big reduction that happened there.

Ms. Chartier: — Yes.

Mr. Hendricks: — $10 million decrease in one-time funding for leap year. So last year was a leap year. We provided the region with $10 million for that. There are various things like that where we make year-over-year adjustments. So there are ins and outs of this fund. But the reality is we settled a lot of agreements last year, right? And so a lot of funding went out for SMA, health sciences, SUN [Saskatchewan Union of Nurses], all of these agreements which are now being built into regional budgets. So you're seeing a larger drawdown on that than you've seen in previous years.

Ms. Chartier: — Fair enough. I'm wondering what that, for all the collective agreements that were settled and now become part of the global funding, I'm wondering, out of that amount, what that is.

Mr. Hendricks: — It's 31.8. Or sorry, 21.4 million, roughly.

Ms. Chartier: — That's for the collective agreements, 21.4 million for the collective agreements.

Mr. Hendricks: — Correct.

Ms. Chartier: — So that still leaves us . . . Okay. So I don't have a calculator. Well I've got my phone here. So that still leaves us, if we took out the 20 million for surgeries, that would take us down to 20 million. So 20 million to 83 million, I'm just trying to . . . That's still like 50-some million dollars in money being sort of moved from one thing to another.

So I'm just wondering, very specifically, about if there's any cuts. So you've told me the Home First money has gone into the global budget. But is there anything out of that, any program being cut, that had been targeted?

Were there any cuts in anything as a result of program reviews? You always pique my curiosity when you're pointing and smiling.

Mr. Hendricks: — So I'm just looking through this, and actually all I'm seeing really are a bunch of just adjustments, reductions that aren't program reductions or cuts. You know, I was just looking at this one. There's a reduction in Connecting to Care, but it was actually a transfer to Ministry of Justice that we were making that we don't make anymore. So it's things like that. There are no reductions that I'm aware of in this entire envelope.

Ms. Chartier: — You were transferring money to the Ministry of Justice for the whole hot-spotting or Connecting to Care and so . . .

Mr. Hendricks: — Sorry, the last part of your question?

Ms. Chartier: — Okay, sorry. I know . . . [inaudible] . . . So you just told me about a little bit of money that went to the Ministry of Justice for Connecting to Care or hot-spotting, and you don't do that anymore. So who's picking that up then? And what was that?

Hon. Mr. Duncan: — So maybe, Ms. Chartier, I'll just maybe try to explain this a little bit. So we had funding in our budget for Connecting to Care program that we're piloting in Regina and Saskatoon. So in the last year the Ministry of Justice has been developing a healthy families strategy that is very similar to Connecting to Care, whereas we're more focused on the individual and healthy families is looking at the family unit. And so there was an agreement that a part of what we would have funded in the past, there may be clients that are part of the healthy families that may be more applicable for the Justice program to provide funding for. So that's where a reduction would be on our side of things.

There's a small reduction as it reflects the change to an SGI [Saskatchewan Government Insurance] recovery premium.

There is a $2.6 million reduction but that's basically we provided 3sHealth [Health Shared Services Saskatchewan] with dollars as a part of the linen transition to the new K-Bro site, and so that's not needed any longer because that transition has taken place. So that's another example of what would have been in a previous budget that isn't now part of the base for a region

or an organization. It just is no longer needed, so we reduced that out.

[15:00]

Ms. Chartier: — I understand. I just am trying to . . . Like I don't have what you have in front of you so I'm trying to understand this a little bit better.

So the 2.6 million, the transition money for 3s, for K-Bro taking over the laundry, what was that $2.6 million spent on?

Hon. Mr. Duncan: — So it was largely severance but some other costs just based on the transition from moving linen from outside of the system . . . or from in the system to outside.

Ms. Chartier: — So largely severance. So how much of that was . . . And severance of whom? Which kind of workers?

Hon. Mr. Duncan: — So it would have been severance to employees of the existing laundry facilities within the health system, the regional health authorities, for those employees that chose not to be redeployed into the health system as . . . It did take place in a number of occasions, but not everybody chose that route. Some people did choose to be severed. It would also include some dollars for training of employees.

Ms. Chartier: — You said that was largely severance and mentioned retraining. Of that 2.6 million, how much was that?

Hon. Mr. Duncan: — Mr. Chair, we're sending a message to 3sHealth to get us a breakdown of the 2.6 million. We just don't have that with us right now, but hopefully they'll have it later before the committee ends.

Ms. Chartier: — Thank you. Just with respect so I just . . . Like the money for the Connecting to Care, and you told me that obviously Justice is doing similar work or the whole kind of . . . I'm just wondering, are you telling me that Justice is picking up the cost now this year of whatever that transfer was? What was it? You didn't give me an amount for that actually. But the money that went to Justice, so is Justice picking that up now and it just falls off?

Mr. Hendricks: — So what happened was the ministry was allocated $1.5 million for hot-spotting. Now hot-spotting was to have been considered a multi-ministry initiative but the money was placed in the Ministry of Health.

In terms of the expenditures on our Saskatoon and Regina hot-spotting projects, we had expended approximately $1.1 million. Then there was another $180,000 for provincial supports to do evaluation, that sort of thing. And we transferred the remaining 150,000 to Justice. So it's a journal voucher over to them, like, where it actually moves to their budget and becomes part of theirs for their complementary activities in this area.

Ms. Chartier: — But not . . . it's a reduction this year, so you're not . . .

Mr. Hendricks: — It actually isn't a reduction to the existing programs. It was money that was placed in our budget as a holding for . . . until we decided which ministry it should go to. So it ended up going to Justice.

Ms. Chartier: — Thank you. So is hot-spotting or Connecting to Care then part of the global budget now?

Mr. Hendricks: — Because those two programs are still in the pilot phase, funding is being held in that regional targeted still.

Ms. Chartier: — Okay. So yes, I think my goal here is to understand . . . so estimated 2016-17 is 40.217 million. We know that 20 million of that is surgical, additional surgical initiative money for this year. So I'm trying to figure out what's in and what's out. So the remaining 20.217 million, can you tell me what that supports? And I think you've answered that part of it is the Connecting to Care.

[15:15]

Mr. Hendricks: — Sorry for the delay, and part of the delay is because we want to be able to describe this in the best way possible to help you understand what's happening here. And so not unlike previous years, the Ministry of Health has been given an efficiency target for the health system that relates to various efficiencies as they relate to collective agreements, that sort of thing, with unions. So first of all I would like to say that this is not, in no way are collective agreements not being funded, that sort of thing.

But what we've done in the past is we've gone to unions and to the SMA and to our other providers and said, look, how can we work on areas that can provide regions with efficiencies to reduce their overall costs? So we know that as a health system we have pretty high overtime costs, pretty high sick time costs. Our regular scheduling of staff can be improved. So as a ministry we've been challenged to work with our health care providers to see if we can identify savings potentially that will result in reduced costs for the health system, you know, just given a challenging time, in contrast to something that might result in a reduction of a service or care.

So essentially what we're doing now through the ministry is we've had some initial meetings with unions, and we're challenging them to come up with some ideas that we can work on collaboratively to achieve some efficiencies in this area. We have, I think, some things in mind, you know, the things like I've mentioned and possibly others. But this is something that will, in our sector, that we've taken the approach of working very collaboratively with unions on. And so we'll have to see how this works out through the year.

Hon. Mr. Duncan: — I'll just maybe add to that, Mr. Chair. I think it's fair to say that this is much more than just a '16-17 budget initiative. I think what we're talking about and what we have been talking about as a government is, how do we really correct the course that we're on and transform the health care system so that it can provide the services that people expect and come to rely upon for many years down the road?

So I would say that I'm very encouraged by what we have been hearing initially from a number of our provider unions that we have engaged with. And I would say that we have a number of mechanisms to pursue that, namely the partnership agreements

that we do have with SUN and with our provider unions, as well I think as a good working relationship with the SMA, just to name a couple. We'll be continuing this work with them and look forward to having their input on this.

Ms. Chartier: — Okay. Sorry, I'm very confused now because my question was, with respect to regional targeted programs and services in the 40.217 million, what was in and then basically what was out? So it's an interesting answer you've given me, and I think I want to delve into that a little bit more, but I'm wondering . . . tell me why you just gave me that response.

Hon. Mr. Duncan: — The problem with providing an answer of what's in and what's out is because some things are in, are new. Some things that are in were still in regional targeted funding last year, so they're not new to regional targeted. Some things that were in last year are now part of the base budget for the regional health authority. So in discussing this with our officials, the difficulty is in trying to make your numbers balance that you're writing on your sheet. We don't have a way to do that, because some things are now in that weren't in; some things are out that were in. Some things that were in last year in regional targeted that didn't move over to the regions are still in, and some may have even a higher amount than they did last year. So that's the challenge that we're having right now.

Ms. Chartier: — I understand that it's not just one thing's out and one thing's in, but I'm wondering, in that 40.217 million, what is in? So 20 million of that is covering the surgical initiative. And then the other 20.217 million, what does that cover?

Mr. Hendricks: — Okay. So, Minister Chartier . . .

Ms. Chartier: — I like the sound of that.

Mr. Hendricks: — Ms. Chartier, sorry. So in terms of transfers to health regions to existing funding for the appropriate subprograms, there was $31.824 million. 21.4 million of that, the biggest chunk, was for collective bargaining; four and a half million was for Home First/Quick Response, that was moving that program into the regional care budget; 1.8 million was for the transfer of surgical money . . . or sorry, wait times money from the previous year for chronic kidney disease, diagnostic imaging, and surgical; 1.2 million was a transfer for the cochlear implant program; 1.09 million for the transfer of primary health services; and then 1.76 for a variety of other small programs.

[15:30]

In addition, we had $3.1 million . . . 3.2, closer to 3.2, that is a net of a whole bunch of different numbers. So there was the 10 million I had mentioned for one-time funding for leap year funding; 704,000 due to a decrease for a budget shortfall related to health sciences, a budget allocation. These are very small numbers all related to kind of what our agreements cost versus what we had costed them at.

But in total, there's a group of numbers that nets out to 3.1 million, the most significant of which is — or 3.2 million, sorry — is the $10 million decrease for one-time funding for the leap year which is offset by some other things, the biggest one, the biggest offset being a $7.179 million increase for the SUN agreement cost that is now settled, to recognize those costs.

Ms. Chartier: — Okay, so that 7.9 million SUN allocation was in last year's budget? Sorry, no because they . . .

Mr. Hendricks: — No. So it's an increase for SUN that relates to the agreement that expires on March 31st, 2018. So we settled an agreement; there were adjustments made to what that agreement and the actual costing would be, so those were added to the compensation amount. There was $26 million as well as a global number for existing program changes. And then $25 million, $25 million of that was an increase for wait times; 20 million specifically for the surgical initiative; 4.3 for diagnostic imaging; 977,000 for chronic kidney disease; and $158,000 for cardiac care.

Ms. Chartier: — That was the 26 million total that you just . . . those latter things.

Mr. Hendricks: — Yes. So I'm giving you . . . But then there are offsets to these too for various things as well: 800,000 increase for the annualization of the seniors' house call program, $696,000 increase for community-based endoscopy in Saskatoon, and the list goes on.

Now some of these things are things that are planned but have not been discussed with regions, and so we don't have the exact details of them. As the minister mentioned, included within that was the $2.642 million decrease now that we provided for linen services transition, which we're trying to get you the details on; a 150,000 decrease for SGI overpayments; $150,000 decrease for the Connecting to Care transfer to Justice that we talked about.

As well, we have new program funding for increased costs related to Swift Current long-term care, and those are operating costs, some additional money for EMS [emergency medical services] operating costs. So there are a variety of ins and outs, again some of which agreements are still pending and that sort of thing. So I cannot give you exact numbers in some cases, but there are a lot of ins and outs on this. But those are kind of the big totals.

Ms. Chartier: — Okay. And as confused as I was when we . . . Anyway, that's okay. So with respect to the 21.4 million for collective bargaining, so you said some of this is the money for SUN. Did I understand that correctly? So who actually . . . Instead of asking that, the 21.4 for collective bargaining, tell me who that covers.

Mr. Hendricks: — Collective agreement for health sciences, out-of-scope, SCA [Saskatchewan Cancer Agency], and SGEU [Saskatchewan Government and General Employees' Union], SUN, and joint job evaluation costs.

Ms. Chartier: — Your comments that you prefaced the answer to this question I find curious, around you commenting that you fully fund the collective agreements. But you've mentioned efficiency target, so I'm wondering how that efficiency target or . . . And you said you were working with your provider unions to find efficiencies, but I'm not quite sure. I still am confused as

to, if you're funding the collective bargaining, why you prefaced your comments with that.

Mr. Hendricks: — So there are areas within, there are areas that aren't necessarily related specifically to the mandate increases that were provided for collective bargaining. So when we cost them, for example — so in this year, one and a half per cent, right? — we build that into our budget. But there may be other discussions that we want to have with SUN that lowers system costs, right? And so we want to talk to them about overtime usage, churn, turnover in the regions, so the orientation costs. We want to talk to them about premium . . . sick time use, sorry, premium time use at the churn.

And I think there are a variety of common issues that we want to talk to them about. I think we want to talk with them about, you know, in terms of some of their collective agreement provisions. So for example, and this isn't reopening the collective agreement, but looking at their benefit plans, making sure they're in line with actual cost expectations.

So I think there's a lot of discussion to be had with health unions and the SMA in terms of what their membership can do to assist us in running the system in a more cost-effective way.

Hon. Mr. Duncan: — I'll maybe just add to that, Mr. Chair, to say that, as the deputy's indicated, one of the areas with respect to for example our RN [registered nurse] workforce that has been identified not only by one health region but also by the provider union, SUN, and that's the issue of churn, and what churn is costing us in the system. And so the union, I think greatly to their credit, SUN has worked very proactively with Regina Qu'Appelle Health Region to identify in a very small area, using kind of a pilot that they've been doing, so some significant work in terms of some savings and just a better management of the workforce.

We would like to pursue that but at this point, you know, I can't sit here and say how much we want to save because of that, because we'll have to see, you know, there's other issues. How quickly can we deploy this in other areas? What are some of the costs to doing that? So it's hard to say we're going to find X amount due to this because it's going to take a lot of work to expand this just beyond one or two units that this has been tried.

Those are some of the gains that we want to attempt to make with our provider unions but I can't sit here today and say, because of churn we're going to target X number. I hope to have a better idea as we go out through the year and kind of get a sense of how quickly regions and our unions and the ministry can work at this. But it's again, it's looking at kind of proof of concept and seeing some positive results, and again to their credit, seeing a provider union like SUN be very proactive to say the region, the management have identified this as a problem; we think we can be part of the solution, and this is how we feed into that.

Ms. Chartier: — Thank you. I've had that conversation with SUN too. So I just want to clarify then just because your comment sort of . . . I won't say it's a red flag but made me sort of pause there. So collective bargaining agreements are fully covered, but you're asking unions to, and I think it's a fair thing to ask everybody to think about how we do things better, but there is no set expectation that X party comes up with savings. So for example, two years ago or there were two years in a row where there was an efficiency target where, or a lean efficiency target where fewer dollars flowed. There was an expectation that health regions saved X amount of money. Is that anywhere built into this? And not specific to lean. Just is there an expectation of saving, cutting whatever it needs to happen to save a set amount of money?

Mr. Hendricks: — So yes, there is and I think that . . . So going back to one of your comments, there wasn't necessarily a lean savings target per se that was given to regions. It was a combination of shared services. It was a combination of looking at initiatives like the ones that I'm speaking about here.

So the Ministry of Health has been given a $40 million target to work with health regions, to work with our unions, to work with the SMA on looking at ways that we can find efficiencies throughout the fiscal year. And we will do so in a way I think based on collaboration in the past that has minimal impact on the patients that we serve and the services that we provide. But again we've taken a very collaborative approach with our unions, and we're optimistic when we're talking premium time, sick time in the order of, you know, $120 million a year across the health care system, you know, as I mentioned, when we're talking pretty darned significant surpluses in some benefit plans, that sort of thing that aren't being utilized.

You know, we've had some great successes in other areas. We've had great successes in WCB [Workers' Compensation Board]. Last year the system received some big refunds. So we're going to be looking in all areas to manage this amount. Now at the end of the day, we'll have to look at how well we do in achieving that. And so we've been given a target and, you know, a target is a target, and we'll work towards it.

Ms. Chartier: — Okay, so by treasury board? When you say the ministry has been given a target . . .

Mr. Hendricks: — Oh, by treasury board, by cabinet, yes.

Ms. Chartier: — Yes, by cabinet you've been given . . . So cabinet has said, Ministry of Health, you've been approved for the five point . . . whatever the total budget is, but we're expecting you to find $40 million.

Mr. Hendricks: — Yes, some of it.

Ms. Chartier: — Okay. So you know how we had the conversation the other day about how much is allocated for growth, how much is allocated for aging population — all those kinds of things. So work with me here. I need your help understanding this. So I know when those lean targets were in place the previous couple of years for health regions, or the lean efficiency targets, that units started out in a deficit place, saying, you used to get this; you have to find this much money. And they were ultimately in a deficit position.

So we had the conversation. I'm wondering, that 40 million . . . I need you to explain how that works. So your 40 million target needs to come off for next year or you should have gotten $40 million to cover what you already cover. So you're asked . . . Treasury board would have been $40 million higher and you

didn't get it. You're told you've got to save 40 million.

Help me understand this. I've never made a budget in government, so I really need to understand this. I guess the question is, from estimates to actual, is there the expectation that between now — so we have this estimate before us that the committee will be voting on — to actual at the end of this year, that you're supposed to save $40 million?

Mr. Hendricks: — Yes, that would be correct. So just in terms of the budget process and how that works, and you know, the other night you said, you can do it, Max. And okay, so here I go. What happens is the ministry does . . . We go to treasury board and, you know, we identify the pressures in the system, right? We identify the costs of maintaining existing programs and that sort of thing.

But you know, what we also do as a ministry, which we've been quite aggressive on, is that as a country, and I'm going to take it more broadly here, as health care systems we spend more than most OECD [Organisation for Economic Co-operation and Development] countries on health care, and yet we have some of the poorer outcomes amongst OECD countries. And so there's this constant tension in terms of what we're spending versus what is coming out the other end of the health care system.

So you know, in my job and in my minister's job, he's not purely an advocate or I'm not purely an advocate for just always saying, give us more money. Because when I look across the system and look upstream towards education, social services, you know, all these programs — housing — impact health care in pretty significant ways. Those are the predeterminants of health.

Health care budgets are growing to 40, 45, 50 per cent. There are a few provinces that are over 50 per cent of their budget, British Columbia being one of them, on health care spending. So that at some point in the future, you end up with a situation, unless we do something differently, there's a Ministry of Health and a Ministry of Finance because that's all there's room for.

And so when we go into treasury board, we come up with ideas and say, you know, these are things that we would like to try. And one of them is, you know, I . . . SUN will tell you, we sat down with SUN, and the minister mentioned that there were some very, very positive discussions with that union. And they said very clearly, we do not support premium time that is excessive, right? You know, there are times when it's necessary. Somebody calls in sick. But as a general rule, they do not want to see nurses working beyond the allotted time in a given week because of safety issues, that sort of thing. And so straight-time pay is the desirable situation. So as a system, when we look at what we're spending on things like that, we have to actually ask the question and work with our providers. How can we bring those costs down?

[15:45]

When we look at things like our benefit plans, many of which are in considerable surplus, the question becomes why are benefit plans funded to that level if they're not being used to that extent by memberships, or there are other things that we could be working with the unions to look at those. So there are a lot of systemic things that we could be doing.

And you know, it goes broader than that, you know, in the context of the transformational delivery that the minister and the Premier have been talking about. I think that there are several areas that Health can actually be working that improves the quality of care, the safety for our patients, but that it can be done at a lower cost.

And I'll tell you right now: the first thing, lower cost doesn't speak to patients. It doesn't speak to health care providers. They don't like that discussion because generally they equate lower cost with a lower standard of care. That's not true at all, as I alluded to in my opening statements. There are things that we can be doing better in this system, that produce better patient experiences, better outcomes. And so that's what the $40 million challenge is. And so, as Ministry of Health, go work with your unions. Work with your providers and start delivering a system that, as taxpayers, we can sustain going forward in the future.

And quite honestly, I would be having this conversation with my minister whether or not the province was having a fiscal challenge right now because I'm having them with my FPT [federal-provincial-territorial] deputies at those tables. And in every single province in this confederation, they're talking about the fact that health care spending will become unsustainable. And so we have choices to make, and I think right now we're at that critical juncture where we do have to start making the choices that will protect the future of medicare in this province.

So yes, a complex answer to the $40 million but, you know, that's the conversation that I would be having with the Johnson-Shoyama student that you asked about the other night, is to say how can we actually balance the budget of Health? How can we actually protect those programs so that we're not paying for it on the bleeding edge in the most expensive place, which is in the health care system.

Hon. Mr. Duncan: — And I'll just, if I could just add really quickly, Ms. Chartier, the challenge with identifying a number, or a $40 million target: one, obviously it's got to be achievable, and so we set an expectation that it is achievable. But I think more important than that, in working with our provider unions and working with the SMA and other stakeholders, this is more than just finding 40 million in '16-17. And it's more than just getting us into a position where, as a government, we're in a better position to balance '17-18.

This really broadly speaks to, as the deputy minister has been talking about, the long-term sustainability of the system. And so while we will work very hard — and I hope our providers, I think they have been engaged in early conversations about how do we find those efficiencies this year to help us with this year's budget and to set us up in a better place for next year's budget — my hope is that people aren't just gunning for a $40 million target this year to kind of satisfy the requirements of the budget, but that they're thinking longer term to try to put in place sustainable changes so that we don't each year . . .

So you asked a question about when we go to treasury board,

did we ask for X amount, whatever the budget is, plus $40 million? Well no. We actually started out a lot higher than that. And you kind of, you have to scale back your expectations and your demands and your requests of treasury board.

So my hope is that . . . Because the challenge in that is that the easy decisions and the things that you either don't fund or that you stop funding, we're kind of running out of those things — the low-hanging fruit, in terms of the sustainability of the health care system. We've done — and I'm not just saying Saskatchewan, I think across this country — we're moving into the territory where each year the discrete decisions that we make are going to get harder and they're going to get harder and they're going to get harder. And so that's why we need to be talking with our stakeholders about, yes a $40 million target for this year. But it's not really about this year; it's about the long term.

Ms. Chartier: — Fair enough. And I don't disagree that the big picture is health care spending. This is a big philosophical debate we could be having, which we shouldn't be having here because I have budget questions to ask. This is about spending money on things like housing and on anti-poverty reduction, all those kinds of things, but that's about choices and priorities.

But I guess my question . . . and I don't disagree that we do have to do things way better than we do. But I'm wondering how this $40 million . . . So you're working with your provider union. So you have in your budget, so when you go out and do all your media and you say the Health budget is $5,167,124,000, in fact that is not really the budget. So when you say there's X amount of increase, really the goal is $40 million less. So I want to know how that $40 million . . . So we've talked about working with provider unions and overtime, those kinds of things, but specifically around the health region. So you're working with your providers. Does that include health regions? And what are your expectations of health regions?

Hon. Mr. Duncan: — So maybe just as a bit of a clarification, I think maybe a better way to think about this is, the budget this year in Saskatchewan for the Ministry of Health for 2016-17 is $5.167 million . . . Sorry, billion dollars. Million dollars . . . I think the culmination of all of these committee meetings, I think we blew through that $5 million. $5.167 billion. But it is our expectation in a general sense that we will actually do $5.207 billion worth of services within that $5.67 billion.

The challenge in even saying that though, is that I know throughout the year things that we have not contemplated, have not planned for, there will be a request that we pay for them or that we somehow fund the service. And so there will be times where, you know, I'll go to the deputy and somehow, deputy, find the money to do this within your budget.

So there's always those pressures. So I just want to be clear though, 5.167 billion is the budget.

Ms. Chartier: — I'm wondering what the goal or what the conversation is with the health regions, what their expectations . . . So I guess, two questions. First of all, did every ministry get asked to save $40 million? So what percentage . . . Can you tell me, give me a sense of how treasury board came up with $40 million for Health, or how you with treasury board came up with $40 million for Health?

Hon. Mr. Duncan: — So I'll maybe try this again. I can't speak specifically to the direction of treasury board as it relates to other ministries. I would say that even though it was a very difficult year and a difficult budget year for all of us, including the Ministry of Health, I think that I'm pleased to be able to walk out of this process for the '16-17 budget year with an increase, even though it might be a lot smaller than we're used to in the health care system. And even under this government, under the former government, and even . . . You know, I look back on the four years now that I've been the minister, and I don't know if this is a coincidence or not, but the Health budget keeps going down each year.

Anyways, I guess the best way to explain this is, all the things that we believe that we can deliver and the programs that we can deliver, and ensuring that we can deliver on our agreements and on the priorities that we identify through the treasury board process, these are the things that we said that we can deliver. And treasury board has said, basically, okay, now do so in a $5.167 billion budget. That's going to mean some decisions that we're going to have to make and some conversations that we're going to have to make with our stakeholders, including our provider unions.

And yes, now that the regional health authorities have a better idea of what their allocation will be and knowing that some money gets held back by the ministry as we kind of make final determinations about where money will flow, the regions are doing essentially what we've had to do over the last number of months as a treasury board and build their budgets based on the number that they've been allocated, and then make the commitments that they do to us, and to government, of these are the services that we can deliver within the envelope of funding that you've provided to us.

Ms. Chartier: — So just back to my question how that $40 million . . . Was there a formula that X ministry spends X amount of dollars? So I'm wondering how the $40 million need to save, how that target was arrived at.

Hon. Mr. Duncan: — No, I don't want to leave the impression that there was a formula that treasury board used and that every ministry has some sort of target that they're required to hit. I can say that these are the things that we said that we could deliver upon as a ministry and as a health care system. This is the envelope of funding that treasury board has allocated to us. And as a part of that, we're going to have to work with our stakeholders to do the things that we said that we can deliver, with basically finding some ability as a system to find $40 million that are not in the budget, to be able to cover all of the things that we said we can deliver.

Ms. Chartier: — Sorry. Forgive my ignorance here then. So you have this amount of money, $5,167,124. I understand from this conversation that there is a target that you have to shave off $40 million. And then you've just talked about money flowing and the decisions about where money will be held back. So is that 40 million . . . I'm not exactly understanding. I understand that you've said there is a $40 million efficiency target. And so I want to know what that looks like in the real world to health

regions. You've talked about your union providers and working with them, but I'm wondering . . . So health regions can look at their allotment. So let's say Saskatoon Health Region, 1.080528. Is there an expectation that they are shaving off some of that allotment, and all of the health regions?

Mr. Hendricks: — In terms of the budgeting process, what happens over at the Ministry of Finance is they look at the available spending room that they will have in the coming fiscal year, based on the forecast. So they look at commodity, expected commodity revenue, income tax revenue, corporate revenue, all that sort of thing. Based on that, they issue ministries' targets and ministries are asked to work within that target.

So typically what happens is, you know, we kind of do a scenario that says, were we to leave everything unchanged, this is what it would look like, right. So we satisfy all of our collective bargaining obligations; programs are growing as they normally do, that sort of thing. And the very term, status quo means you're not changing anything, right, you're letting everything go as it was.

And so when they issue that target to us, we do a couple of things. Obviously when we first receive it, we are upset. And then after we've gotten over that, we start talking about the ways that we might actually achieve that target. And so that discussion happens with our health regions.

I think in terms of a ministry that has a large third party provider, very early on, as early as, you know, last fall we were talking to our health regions. We were saying, what are some ways that we can do this as a system that don't compromise patient care, that don't compromise kind of the most important services that we provide as a health system. And so they're very involved in that discussion as we go through it.

When we get to treasury board, when ministries actually make their formal presentations to treasury board, within that — in addition to making recommendations about how we would manage within the 1.1 per cent — we have to identify areas that we would have to actually effect change on, to manage within that while maintaining our obligations in terms of collective bargaining and other commitments that the ministry has made, and priorities of the ministry and of government.

[16:00]

And so when asked to look at those areas that we could save on, you know, one possibility might be to say that, you know, we're going to delete from, or we're going to exit from this large program, you know. And that wasn't the choice that the ministry took. We said we would like the opportunity or we feel there's the potential to work with our unions, to work with the SMA, to try and achieve savings literally from money that in some cases is doing no good for the patient. Because a patient doesn't care whether it's a nurse that's on overtime or one that's on straight time pay. In fact, they might prefer the nurse that's on straight time pay because he or she has worked fewer hours that week.

We're working with the SMA to say, you know, we've created programs. We have fees that might need a look at, or programs that are underutilized, or are there things that we can do there. And so we're having these discussions with them. So essentially what the ministry did was say rather than, you know . . . For example, we would rather have more money for surgical care because it's a priority for the health care system, and we feel that we can offset that by doing something differently that is, you know, takes away from bottom line and that is non-value added in terms of the patient perspective. So yes, we put ideas forward to manage within the budget that we were given and the targets that we were given.

So yes, the ministry will manage a $40 million kind of target. We have ideas in areas and we've alluded to those today but, you know, a little bit of flexibility as to how we manage that number as well.

Ms. Chartier: — Okay, thank you. I just again . . . and don't disagree with much of what you're saying, but how did you come up with the $40 million? Was it you or executive government that asked? Like who decided it was going to be a $40 million efficiency target?

Mr. Hendricks: — We put forward the number to balance to the target that we were given.

Ms. Chartier: — Okay.

Mr. Hendricks: — So in a general sense they set the target.

Ms. Chartier: —Okay, so you picked 40 million, and what target did they set?

Mr. Hendricks: — Well at the end of the day . . . And I can't divulge that. That's cabinet information. But at the end of the day there's always a little back and forthing that says, you know, we say we can do this; they accept that idea. We say we can try and do this but that's pretty low probability, and they would say okay, no that doesn't count. We could propose a change that they say we don't like. Or they could say, this is a new program that's really important to us; by the way, you have to accommodate that new program and do this. So there are bunch of trade-offs. Your target is never the same as what your final number is. I've never seen it the same in my, all of my years.

Ms. Chartier: — So obviously you thought 40 million was doable and you've talked a lot about your unions and the . . . So like you said you'd rather have a nurse who is working straight time than overtime. And you've talked about SMA fees. So in that 40 million that you believe is doable, you must have some sense of what that's going to look like. Who's saving what in what areas? So that's your target. That's your goal. What is your expectation how you'll find that money? Like what . . .

You've talked a lot about unions and the SMA so I'm wondering what the expectation or hope on overtime versus straight time. Okay, I'm talking a lot here. I just want to know what that $40 million is going to entail, what you think it's going to entail. Who's going to carry that?

Hon. Mr. Duncan: — I'll maybe jump in. I think it's far too early in the discussion that we're having and going to have with the provider unions and other stakeholders, and obviously the

RHAs have to be a part of that because even if a provider union has an idea, it's not us that implements it typically. It would be the RHA that employs members of provider unions. I would say that . . . So in terms of the 40, and what our expectation in terms of how that would break down, we don't have any targets on what that would look like.

And the reason would be, is that I don't know the value of setting a target say, you know, a $5 million target on this provider union or this particular stakeholder, when they may generate ideas that would produce 7 or 10. And so I don't know why we would sell ourselves short in that process. So overall we need to find about 40 million through this process, but there's no kind of internal breakdown of where we're going to try to derive all of that from.

Ms. Chartier: — Okay, but a couple of years ago you put targets on health regions two years in a row. So obviously you can do that, because you have. So I'm wondering why you think $40 million is doable. Where is it that you're going to . . . Obviously you've thought about this, and you've come up with a number. You said you've suggested the 40 million, so I'm wondering where you think that that's going to break out.

And yes, I'm not going to, six months from now say, Minister Duncan, you said that this is what you were going to . . . Because we're talking in generalities here. I don't need specifics but I'm . . . 40 million, you think you can do it? I want to know how you guys came up with that target. You must have some idea.

Hon. Mr. Duncan: — Ms. Chartier, I think . . . So in the past, when we've looked at trying to find efficiencies . . . That number has always bounced around. It's, you know, been in the 30s and the 20s and the 40-million range. I think that . . . No doubt that, you know, it's going to take a lot of work to get to this, and RHAs are going to have some work ahead of them to do.

We're also in a situation though as a government that we don't want to be in, and that's in a deficit. And the expectation is that we would not, going forward, be in a deficit. And so, you know, I think it would have been unrealistic for me as minister to go to treasury board and to say, well we'll find $20 million.

We're a $5 billion budget. We're 43 per cent of the provincial budget, or 44, whatever the number may be. So our number had to be realistic but it also had to be something that . . . You know, I could have said, well, we'll save $200 million and nobody would have believed it at treasury board. So you know, we looked at a number of factors, in part what our previous targets had been and in part what the challenges ahead of us as a system, and we believe that we can do 40.

Ms. Chartier: — Okay. Thank you for that. I know, unfortunately Health estimates goes very fast and I have lots of questions here left on other topics.

Just with respect to ambulances and EMS dropping off patients — I'm thinking specifically about Saskatoon — but in the Saskatoon and Regina health region, RQHR [Regina Qu'Appelle Health Region] and Saskatoon Health Region, do you have your average off-load times over . . . I don't know how long or what period you keep those stats, but . . .

Hon. Mr. Duncan: — So in the normal course of the business of the ministry, we don't receive that information from the regional health authorities although we would have access to it in the event that there is a particular conversation that we're having with the regions about their EMS services or about any other type of related services. But we don't, as a normal course, just receive and collect and collate that information.

Ms. Chartier: — I suspect though that . . . Would the region flag it for you? I hear stories very frequently in the last week or so, 13 ambulances waiting at RUH, many from Saskatoon, which means there's no ambulances on the road in Saskatoon. And at any given time, ambulances from across the province . . . One day for example, 13 at Royal University Hospital, 8 or 9 at St. Paul's, all in the back hallway with patients that they can't discharge because there is nobody, there's no beds. And so that means there's fewer EMS providers, and in some cases in Saskatoon, there's none. On occasion where you've got firefighters sitting at medical calls who can't transport . . .

So I suspect that there's been conversations, because that's not anything new. That's a real problem that happens on a regular occasion. So I'm wondering what conversations you've had recently, particularly with Saskatoon Health Region, on that topic.

Hon. Mr. Duncan: — So the ministry would have been engaged in conversation with, in this case, Saskatoon Health Region and MD Ambulance. This would have been back 14, 18 months ago when Saskatoon was experiencing an issue with their off-load times and not having an ambulance available during periods of time because of capacity issues and so forth.

Regina Qu'Appelle, the same would be true in times past. But I know that the ministry has indicated that Regina Qu'Appelle Health Region, using some rapid process improvement workshops, have really done a good job of reducing their off-load time here in Regina.

[16:15]

With respect to the last couple of weeks, there hasn't been a conversation between Saskatoon and the region. We're there to provide support. The ministry is there to provide support. But, you know, I would say that on a day-to-day basis . . . You know, this is Saskatoon working through this problem and this issue that they're having. And unless they contact the ministry, it's hard for me to say in the last couple of weeks what conversation they would have had with the ministry, because there hasn't been a conversation about it.

Ms. Chartier: — Could you endeavour for this committee then to have that conversation with the Saskatoon Health Region, and ask them for the last six months of their off-load averages and table that with the committee at your earliest convenience?

Hon. Mr. Duncan: — We will have the conversation with Saskatoon and have them work with MD to provide that information for the committee.

Ms. Chartier: — That would be great. The one thing I forgot to

ask on the last question here around the regional transfers is the 20 million for surgical initiative, the additional 20 million. Where and how will that be allotted and when will that be allocated?

Mr. Hendricks: — So we're still in discussions about regions. Obviously it'll be those regions where we've had the greatest, you know, we've seen the greatest uptake in our waiting lists. So the discussions are largely involving our largest three, possibly four regions. And so we'll finalize that soon and have those numbers available.

Ms. Chartier: — And will that money flow in the next couple months? When will that money flow?

Mr. Hendricks: — It'll start flowing in the next couple months when they can start. Yes, definitely.

Ms. Chartier: — Okay, thank you. I'm just going to pass it off to my colleague for one moment.

Ms. Beck: — Thank you. Good afternoon. I'm just wondering if you could provide a breakdown about how much each health region paid out last year for individualized home care funding, and how many people received funding within each of those regions.

Hon. Mr. Duncan: — So in the last provincial budget, we did provide funding. We did have a wait-list at that time for people waiting for individualized funding in four health regions. So I'll just maybe start by saying that in last year's budget, Prairie North Health Region received 250,000; Regina Qu'Appelle received 750,000; Five Hills Health Region received 250,000; and Saskatoon Health Region received $750,000. That money does continue in this year's budget as well.

I have some historic numbers if you want as a comparison in terms of individualized funding.

Ms. Chartier: — Sure. That was a boost last year to individualized funding . . .

Hon. Mr. Duncan: — Yes. That's right.

Ms. Chartier: — So just to clarify, it's the same amount this year in those four regions?

Hon. Mr. Duncan: — Yes. So that . . . Yes, that's right.

Ms. Chartier: — You know what, actually though, just the year. So 2014 . . . or 2013-14, I guess . . . no, that would be . . . Do you have '14-15?

Hon. Mr. Duncan: — Yes. So in '14-15, there were 91 clients receiving individualized funding. And in '15-16, it was 111. And I can also . . .

Ms. Chartier: — Sorry. Total across all regions?

Mr. Duncan: — Yes, that's correct.

Ms. Chartier: — Okay.

Mr. Duncan: — And just for context's sake, over the last decade the average individualized funding, monthly funding that a client received averaged, in 2006-2007 it averaged $1,983 a month and in the current year it averages $3,721.

Ms. Chartier: — Okay, thank you very much.

Just changing gears here. So we have the committee in the fall regarding organ and tissue donation, and one issue that always comes up, well around blood donations . . . so this is a very specific question. Have you completed any study or analysis on organ and tissue donation from men who have sex with men? Has there been any research or analysis done on that?

Hon. Mr. Duncan: — So as a ministry we haven't done . . . undertaken any research in this respect.

Ms. Chartier: — Because we set up a committee that will be looking into organ and tissue donation, is there any plan on doing this kind of research?

Hon. Mr. Duncan: — Nothing specific to that issue, but I will say that what the ministry is interested in — and certainly I think the committee will be interested as well — is looking at best practices and other practices from other jurisdictions. So we don't have anything slated with respect to this specific question that we're going to be conducting research. This may be an area that the committee wants to look into, and we will assist in that. I think that's been one of the roles that the ministry has been tasked, is to provide any assistance that we can to the committee. But we don't have any specifics on this issue.

Ms. Chartier: — Okay. And just to confirm, what are the current rules from donation with respect to men who have sex with men? Are they able to donate organs and tissues in Saskatchewan?

Hon. Mr. Duncan: — So that would be . . . So that's not a regulation or a policy or under the Act of the province of Saskatchewan. That would be mandated by Health Canada. We just don't, off the top of our heads, have that information, but we certainly could find that out for you.

Ms. Chartier: — That would be great. Thank you.

Just with respect to organ donation and increasing the number of donors here in Saskatchewan, I know you've heard me say this in the House, but I understand that many of the stakeholders, when this new bill was enacted last year, in some of the consultations they had suggested one way to improve donors would be having donor physicians, following the model that Ontario has. And I understand their ask of you was to have four donor physicians — two in RQHR and two in Saskatoon Health Region. I'm wondering why you've chosen not to go in that direction.

Hon. Mr. Duncan: — So the issue of physician donors, we haven't ruled that out. There was nothing in the way of the Act that was passed last year that either excluded or would have precluded us from moving in that direction. So we did make the changes with the Act last year, but it didn't . . . A change to the Act wouldn't have been required specifically on this issue. So

we haven't ruled out the idea of incorporating physician donors, donor . . . [inaudible].

[16:30]

Ms. Chartier: — Did you have an ask for physician donors?

Hon. Mr. Duncan: — I wouldn't say that it was necessarily part of the consultations on the bill that passed through the House a year ago because it wouldn't have taken a change in the legislation to add this to the system. But it is something that is considered a leading practice in a number of jurisdictions, and it is something that we have been asked to consider as a part of our budget in the past. And so it's something that we are not closing the door on. It's something that we are considering.

Ms. Chartier: — Thank you. And I understand we're just about out of time here and I thought we had another 20 minutes, so my apologies. But with respect to the Ombudsman's report and the ministry's commitments around the recommendations of the Ombudsman's report, I know Santa Maria has implemented them all but you were in various . . . in progress. So I'm wondering where you're at with respect to those recommendations.

Hon. Mr. Duncan: — Thank you for the question. So the ministry has been working hard with our partners with respect to implementing the recommendations as it relates to the Santa Maria issue. So we have been working together to address the Ombudsman's recommendations and to ensure that the standards that are set out in the program guidelines are implemented.

We've undertaken a thorough review of policies to ensure that high standards are maintained in the special care homes. The ministry has recently developed an educational DVD [digital video disc] to support orientation and training for all regional staff on the program guidelines for special care homes.

A quality oversight committee was established at Santa Maria. This included leadership from the ministry, the health region, Emmanuel Care, Santa Maria, and a resident family member. The committee's guided the successful implementation of all 14 of the Ombudsman's recommendations that were directed towards Santa Maria. Santa Maria has also taken steps to improve care, including hiring a care consultant to lead the review of specific care concerns, and recommending improvements to care procedures. And they have implemented a number of improvements such as moving towards a resident-centred community of care model, increasing staff training, and new communication procedures.

The Ministry of Health is working with the RHAs on a number of other long-term care quality improvement initiatives. This includes spreading the practice of purposeful rounding to 67 per cent of long-term care facilities in the province by the end of the 2016-17 fiscal year. This will help to ensure that residents' needs are met in a timely way, prior to the need to ring the call bell.

We've also launched a new geriatric program in Regina Qu'Appelle Health Region that will increase capacity for multidisciplinary assessments, short-term rehabilitation, and specialized outpatient clinics. As well, we've had the recent opening of a specialized dementia or behavioural unit in Regina Qu'Appelle Health Region to assist with assessment, stabilization, and care planning as needed by seniors throughout southern Saskatchewan.

Ms. Chartier: — That's the action to implement all of the 11, 12, 13, 17, and 19. I just want to make sure that that's . . . Like is there any other action that's being taken on those recommendations?

Hon. Mr. Duncan: — So that was I think a pretty quick way to go through that. I can go into more detail though in terms of how the ministry is following up with the recommendations that speak specifically to the Ministry of Health.

Recommendation no. 12 directed that the Ministry of Health ensure all health regions to:

> Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines* . . .
>
> Identify, track and report on specific and measureable outcomes that ensure the standards of care . . . are met . . . [And]
>
> Include these specific and measureable outcomes as performance requirements . . .

So the regional health authorities will have program guidelines related to care and nutrition operationalized by mid-June of 2016. The remainder of the guidelines will be operationalized at a rate of about two sections per month over the following six months through to December 31st, 2016. The educational DVD that I did speak about was mailed to every long-term care facility on April 8th of 2016 and it is expected that all care staff will watch the video by March of 2017. And the Ministry of Health is currently working with the Health Quality Council and several RHAs to develop an LTC [long-term care] resident experience survey to be implemented in this budget year.

Recommendation no. 13:

> That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes*.

The current content in the first phase of reporting includes facility information and about 10 to 12 metrics that correspond to policies from the care and nutrition sections of the *Program Guidelines for Special-care Homes*.

There are a couple of other recommendations that speak specifically to the Ministry of Health.

Ms. Chartier: — 17 and 19.

Mr. Hendricks: — So 17, sure:

> That the Ministry of Health amend the *Program Guidelines for Special-care Homes* to provide more details of the steps

needed in concern-handling and appeal process . . .

So in consultation with our partners the ministry has drafted policy 17.3, concern handling. The Ombudsman recently has received the policy and will provide feedback and that will be incorporated into the final draft.

And recommendation 19 speaks to identifying:

> . . . care needs of current and future long-term care residents.
>
> Identify the factors affecting the quality of long-term care delivery. [And]
>
> Develop and implement a strategy to meet the needs of long-term care residents . . .

So this work will continue, based upon the learnings that we did find during the seniors engagement session that was held a couple of years ago that did have an emphasis on long-term care. Certainly I won't speak to all of the policies that have been put in place in terms of purposeful rounding or other initiatives that were paid for through the Urgent Issues Action Fund, but as a government we as well have reduced to finding efficiencies within the regional health authorities through redirecting administrative costs into providing for additional front-line care into long-term care in this budget year.

Ms. Chartier: — I think you just missed 11. I think you started with 12. So 11 was on the previous page and then that, that's it. I know everybody's . . . It's been a long day for everyone.

Hon. Mr. Duncan: — I believe recommendation 11 is specific to Regina Qu'Appelle Health Region and not the Ministry of Health.

Ms. Chartier: — Fair enough. Yes. Fair enough. Okay. Yes. Thank you.

The Chair: — We will adjourn considerations of the estimates for the Ministry of Health. Thank you, Mr. Ministers, and officials. Any final comments?

Hon. Mr. Duncan: — If I could, Mr. Chair, I just want to thank members of the committee and Ms. Chartier for your questions over the preceding four sessions of the deliberations on the estimates for the Ministry of Health for the 2016-17 budget year.

[16:45]

I also do want to take the time to thank all the people that you see in the room here, most of who didn't get an opportunity to speak to members of the committee or appear on camera, but certainly I think members of the committee can see that it takes a great deal of people to not only get us ready for our appearance at committee, but also most importantly all the work that goes behind the scenes in creating a budget and creating this particular budget.

What you don't see is the literally hundreds of people behind the scenes that work in the Ministry of Health and our partner agencies, including the regional health authorities, eHealth, 3sHealth, the Saskatchewan Cancer Agency, just to name a few, that not only do great work each and every day, but also compile all the information that we look for.

And so to all the people behind me, I thank them, but I also hope that they will pass on my thanks and the thanks of the members of the committee for the work that they do, not only each and every day but also specifically on the work that they did in preparing the '16-17 budget.

I think it's going to be a challenging year for us, but it's one that I'm excited about and I'm excited about the challenges before us and what I believe are some important changes on the cusp in terms of ensuring that we have a sustainable health care system not only this year, but well into the future. So thank you.

The Chair: — Thank you, Mr. Minister. Ms. Chartier.

Ms. Chartier: — Thank you, Minister Duncan and Ottenbreit, and Mr. Hendricks and all the other staff here who are here today. I wish sometimes you could just speak at the mike instead, and you didn't need the translator. But I appreciate all the information that you provide to the ministers and the deputy minister and to committee members for your time. I know it's a long slog here for everybody. But thank you for helping me do my job as the opposition critic and getting answers for people in Saskatchewan to help us all understand this a little bit better. So thank you for all that you do. And yes, that's all for now.

The Acting Chair (Mr. Parent): — Thank you, Ms. Chartier. I would ask a member to move a motion of adjournment. Ms. Wilson.

Hon. Ms. Wilson: — I so move.

The Acting Chair (Mr. Parent): — Has moved. All agreed?

Some Hon. Members: — Agreed.

The Acting Chair (Mr. Parent): — This committee stands adjourned until Monday, June 27th, 2016, at 7 p.m.

[The committee adjourned at 16:47.]