STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:00.]

The Chair: — Okay. Ladies and gentlemen, we will proceed with this meeting of the Human Services Committee. With us for this meeting we have myself, Dan D'Autremont, Chair of the committee; MLA [Member of the Legislative Assembly] Danielle Chartier; MLA Larry Doke; MLA Todd Goudy; MLA Warren Steinley; the Hon. Nadine Wilson.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Today we will be considering the estimates and supplementary estimates — no. 2 for the Ministry of Health. We now begin our consideration of vote 32, Health, central management and services, subvote (HE01). Minister Reiter and Minister Ottenbreit are here with their officials. Please introduce your officials and make your opening remarks.

Hon. Mr. Reiter: — Thank you, Mr. Chair, and members of the committee. I will start with introductions. Minister Ottenbreit and I have with us: Max Hendricks, the deputy minister; Mark Wyatt, ADM [assistant deputy minister]; Kimberly Kratzig, ADM; and Karen Lautsch, assistant deputy minister. We also have a number of other senior officials that are with us today. If they answer questions, I'd ask them to introduce themselves at that time.

As you indicated, Mr. Chair, I'd like to just spend a few minutes to quickly read some comments into the record and then we'll be happy to take questions.

This has been a monumental year for our government, the ministry, and our entire health system. In 2017 we transitioned the former 12 regional health authorities to the Saskatchewan Health Authority. This move was driven by a commitment to improving front-line patient care for people across the province. One provincial health authority will be able to focus on better coordination of health services across the province, ensuring patients receive high-quality, timely health care regardless of where they live in Saskatchewan. The Ministry of Health, the Saskatchewan Health Authority, and other stakeholders will continue to work together to ensure a truly patient- and family-centred approach to health care in Saskatchewan.

Since 2007 we have achieved significant growth in the number of health care providers in the province. Residents continue to benefit from better access to physicians. Close to 900 more doctors have been added to our physician workforce over the past 10 years. This represents a 51 per cent increase in just over a decade, 62 per cent more specialists, and 43 per cent more general practitioners. In total more than 2,600 physicians are licensed to practise in Saskatchewan. Across the health system, more than 44,000 people work hard to provide a broad range of high-quality health services to Saskatchewan people.

We appreciate the incredible efforts of all our health care professionals and support staff across the system. Recently their professionalism and dedication has been especially apparent through the Humboldt Broncos tragedy. I want to recognize their exceptional efforts once again and say thank you.

I'd also like to note some key highlights from this year's budget. We're on track with our fiscal plan to return the provincial budget to balance in '19-20. Our strategy is to invest in the services, programs, and infrastructure that Saskatchewan people value, today and into the future.

This year we are investing a record $5.7 billion in health care in Saskatchewan. This year's health budget includes a focus on ensuring services are delivered in new, innovative ways to better meet the needs of residents. As Saskatchewan's population continues to grow, we have focused our investment in key areas that will benefit many residents.

One of our key priorities is mental health. We are adding $11.4 million combined province and federal funding to improve mental health services, including services and supports for children, youth, and families.

A few programs and initiatives I'll highlight are funding for new child and adolescent clinicians and specialist positions to reduce wait times and increase capacity for diagnosis and treatment. A pilot project modelled after the mental health capacity building initiative in Alberta will better engage high-risk youth in prevention and intervention programming. This project was recommended by Saskatchewan's Advocate for Children and Youth.

In addition we're implementing a targeted physician training program to improve the capacity to assess and treat child and youth mental health conditions. This will help to reduce wait times for child and youth psychiatry services. And we're also expanding suicide prevention efforts through the Mental Health Commission of Canada's suicide prevention demonstration project.

Another $5.2 million in funding will aim to enhance access to community mental health and addiction supports. This work includes hiring approximately 40 full-time staff for the development of multidisciplinary community recovery teams in eight communities. These teams will provide client-centred support to individuals with complex and persistent mental illness, improving the response to individuals with crisis mental health needs through the expansion of police and crisis teams, or PACT, into the communities of North Battleford, Moose Jaw, Yorkton, and Prince Albert.

Expanding addiction medicine services to address service pressures in P.A. [Prince Albert] and northern Saskatchewan, enhancing specialist consultation services to physicians and other allied professionals, and increasing access to mental health first aid courses across Saskatchewan, and better equipping Human Service staff to recognize and respond to mental health crises.

Currently over 5 per cent of Saskatchewan's '18-19 health budget is spent on mental health services and supports. Our goal is to increase that $284 million investment to 7 per cent in future years. A further $83 million in provincial investments are being made through other government ministries, which can

more appropriately provide certain mental health services and supports. In total our government will spend 367 million in this area in '18-19.

This year we have also fulfilled our commitment to provide individualized funding for children with autism spectrum disorder. We are investing 2.8 million to provide parents with more flexibility to access a range of services that will best suit their child's individual needs. Initial funding will be $4,000 per child under the age of six. Individualized funding will give parents the flexibility and freedom to choose from a range of therapeutic interventions and support that will most benefit their child. In addition to the new autism individualized funding, the Ministry of Health invests 8.5 million annually to support ASD [autism spectrum disorder] services, including autism consultants, support workers, and rehabilitation therapists.

As a further commitment to Saskatchewan families, we are introducing a new program to screen babies born in Saskatchewan hospitals for hearing loss. We are investing $523,000 this year to introduce the universal newborn hearing screening program. This new program will improve hearing services for our youngest residents and help us identify and treat hearing issues as early as possible.

This year we're also investing $600,000 to provide universal drug coverage for HIV [human immunodeficiency virus] medications. This will expand publicly funded HIV medication coverage from 91 per cent last year to 100 per cent for eligible beneficiaries. Our government is also providing $50,000 to AIDS Saskatoon, and another $50,000 to Saskatoon's Westside Clinic for additional HIV supports. Since 2010 we have invested a total of 31.3 million in HIV programs and initiatives, maintaining annual funding of close to 4 million.

Work to reduce emergency department wait times and to improve patient flow continues to be of top priority. The emergency department waits and patient flow and Connected Care strategy will receive more than $28.7 million in targeted funding. Funding for our provincial Connected Care strategy will support team-based community health services and primary health care: 16.6 million to improve delivery of team-based home and primary health care, tailored to meet the needs of communities, and 2.4 million to train and hire more staff to improve access to palliative care in communities across Saskatchewan. Saskatchewan's Connected Care strategy is focused on providing safe, seamless care for patients as they move from one care setting to another.

The continued provincial investment of $9.7 million will sustain the current accountable care units at Regina's Pasqua Hospital and Saskatoon's St. Paul's Hospital. This funding will also support three more units at Pasqua and St. Paul's this year. This team-based model of accountability for hospital in-patient care is focused on improving patient safety and helping them be discharged from hospital sooner. This funding also continues to support ongoing initiatives to reduce emergency department waits and improve patient flow in Regina, Saskatoon, and Prince Albert, including PACT in Regina and Saskatoon.

All Saskatchewan residents will also benefit from provincial funding to the Saskatchewan Health Authority. We are providing 3.5 billion in operating funding for the SHA [Saskatchewan Health Authority] to deliver high-quality, timely health services for the entire province. This is an increase of 71.9 million over last year's total funding for all the former regional health authorities.

In conclusion, I'd like to thank the committee for giving us the opportunity to outline some of the priorities. We know how important the health care system is to the people of this province, and it continues to be a priority for our government. As I mentioned at the beginning of my remarks, our province is on track to return our budget to balance in 2019-20. Our strategy is to invest in the services, programs, and infrastructure that Saskatchewan people value, today and into the future. Health care is an important part of this plan.

Mr. Chair, now we'd be happy to entertain questions.

The Chair: — Thank you very much. Consideration of vote 32, Health, and central management and services, subvote (HE01). Are there any questions? I recognize Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair, and thank you to the ministers and all your officials here today. I certainly appreciate your time and the opportunity to ask lots of questions in Health. You have to excuse my voice. It comes and goes at will, which I'm sure is . . . It's not the best thing as a politician, but that's all right.

I want to start . . . Actually if we could look at your Ministry of Health Plan for 2018-2019, looking at the performance measures. So starting on page 4 of that. So the ministry goal: "Connected care for the people of Saskatchewan: improve team-based care in communities and reduce reliance on acute care services." So the initial performance measure on emergency department waits, which is by March 31st, 2019: achieve a 35 per cent reduction in emergency department waits from the 2013-14 baseline.

I know we had a conversation about that last year, and Mr. Wyatt had responded to some questions about that. So initially back in '13-14 when that was the baseline, the initial target was actually 60 per cent of that '13-14 baseline. It was supposed to be 35 per cent by March 31st of 2017, which I know last year we heard you were holding on to the baseline at that point. So I'm wondering why you've amended that 60 per cent target.

[15:15]

Mr. Hendricks: — Max Hendricks, deputy minister. So this is a repeat of a previous target. I think I will just acknowledge that this particular performance measure has been particularly difficult for the ministry. When we started out with this initiative several years ago to eliminate ED [emergency department] waits, you know, I think there was a feeling that the problem was really kind of in our emergency departments. And as we study the issue more, it's a very, very complex problem dealing with how we provide community services with primary health care in our communities, so those that are coming into our hospitals, but also our ability to move people through our hospitals and to get them out with the proper supports in the community.

So there are several initiatives. Last year we talked about the

accountable care units, and so these are really multidisciplinary teams that are centred in various wards within our hospital or units within our hospital. They are tasked with working to actually transfer a patient with the appropriate supports back to the community. The idea is that over time we want to shift resources from acute-based care to community care so that we can provide care closer to home in a more appropriate setting. And I think patients would support that. But that is going to take time to develop because there are a number of services right now that we have attached to our acute centres but that we don't have in the community, but also a recognition that we have to develop more in our community.

Similarly, I think, on the front end in terms of our primary health care and, you know, our ability to engage multidisciplinary teams in providing chronic disease management, that sort of thing, keeping those complex cases out of our hospitals and our EDs, we're starting to do a lot of work on that. There's a pretty significant investment in this year's budget to address those, and that's partly supported by the federal government's funding for community care and mental health because a number of the people that we're seeing in our emergency departments have complex mental health issues.

So we're really kind of actually focusing on the ends of this now rather than on the ED in the middle, and it will reduce, we believe, wait times over a period. Now 35 per cent is still an ambitious target. I would like to stretch the system and have them push towards something that would signify significant improvement. Will we achieve it? You know, it's a pretty big undertaking, so I think that we're on the right track. We've scoped the problem, and we have a pretty good plan in terms of what we're doing and where we're going with this.

Ms. Chartier: — Thank you for that, Mr. Hendricks. I agree that the problem isn't in the ED, and we've known that for some time. It's very much about chronic care, mental health, seniors, all those things.

But just getting back to . . . I'd misspoke, actually. The March 31st, 2017 original target was zero waits in the ED. That was the premier who had committed to that from the baseline of '13-14, and then that was amended to 60 per cent by 2019. And then you had an operational or ongoing target which was supposed to be, I think, 35 per cent reduction by last fiscal year, by the end of last fiscal year. So now that's been amended in your ministry goals from 60 per cent by March 31st, 2019 to 35 per cent.

And I know you just said 35 per cent is an ambitious target, and it's a big piece of work for sure, but I'm wondering where in discussions or why you've moved from 60 per cent to 35 per cent.

Mr. Hendricks: — You know, the reality is, is that when we looked at progress across the system, it was very uneven. Regina Qu'Appelle had been doing some really amazing work in terms of primary care in its ACUs, accountable care units. And what we actually saw happen in Regina is we saw the average daily census in our hospitals dropping, and so we were seeing a strategy that was across a continuum that really worked.

And so what we're doing now is we're replicating that in Saskatoon, and we'll move it into P.A. Lloydminster's actually using that strategy as well. And so yes, we realized we weren't going to make the 60 per cent goal. Our interim goal had been 35 per cent. And so, you know, our interim goal, until we hit the 35 per cent, we can't move to the 60 and further on.

To give you an idea, a 35 per cent reduction in emergency wait times would be a pretty significant reduction. And so we're hoping that these strategies that have been working in Regina to some extent — like nowhere near where we want them to be — but we're hoping that as we replicate them across the province and get better at doing it and also use this opportunity to invest in the community and make that shift and invest in mental health, we think we can make some pretty serious inroads into this.

Ms. Chartier: — Thank you for that. So there was just about a $12 million dollar investment last year, I believe, into the accountable care units and into Connected Care, the pilots in Regina and Saskatoon. And I know, this time last year in our conversation, I was told when I asked about where we were at reaching that 35 per cent target, I was told that we were basically holding on to the baseline, if you looked at the whole period of the year. I mean there's ebbs and flows in stays in or in visits to emergency. So at this time last year we were at basically zero progress or very little progress to that 35 per cent. I'm wondering after that $12 million investment and where we are this year, where we are in terms of that 35 per cent.

Mr. Hendricks: — So across the system in Saskatchewan in '16-17 . . . or sorry, from our '16-17 baseline, in terms of those waiting the ED length of stay until they're admitted, across Saskatchewan it has been reduced by minus 17 per cent. The ED length of stay for non-admitted patients is up a little bit, at 1 per cent year over year. The time to finish physician initial assessment hasn't really changed at all. And then the time waiting for an in-patient bed at the 90th percentile is at minus 18 per cent. As I said, those changes are largely being driven out of Regina.

And so we have seen those improvements in that one community. It's now about spreading them across the province. So it kind of shows you there are the possible . . . What we are getting much better at, you know, almost a 20 per cent improvement in the time waiting for an in-patient bed is a significant improvement. Also the time of ED length of stay until admitted being reduced by 17 per cent is pretty good, but it's still a fair ways to go.

Ms. Chartier: — Okay. So I want to make sure that we're speaking the same language that we were speaking last year, that I'm comparing the right things here. So you said the '16-17, which would've been the end of last fiscal year, compared to the '13-14, it's a 17 per cent reduction in the length of stay for those who are admitted into the ED. I just want to make sure because last year . . . [inaudible interjection] . . . So I'll just read into the record what I was told last year and to see if I could get a similar comparison, if that's all right.

Mr. Hendricks: — So '17-18, the numbers I gave you are '17-18 compared to '16-17.

Ms. Chartier: — Okay. You gave me ’16-17 compared to ’17-18. Okay. So how about compared . . . So last year, I just want to read Mr. Wyatt’s comments into the record:

> Basically we’ve made minimal, or in some cases we’re holding on to the baseline. And I think it’s important to point out that since that ’13-14 year, we’ve seen a 20 per cent increase in the number of emergency visits across the province during that same time.

And just to clarify that, Mr. Wyatt came back the next day and said that wasn’t the . . . It was actually less than that but “And so we’ve been, I guess, trying to improve the performance of the system at a time when we’ve seen that pretty significant increase.”

So anyway, I just want to make sure. So he was comparing, last year, comparing last year what you were telling me about ’13-14, you were holding on to the baseline. So I’m looking for like your last fiscal year, where we’re at today comparing to ’13-14 and that 35 per cent reduction when that target was set.

To simplify my question, I guess from the ’13-14 baseline — so maybe this won’t simplify my question — from ’13-14 when the target was set for a 35 per cent reduction by the end of last year and 60 per cent by the end of 2019, so where are we at in terms of that reduction since ’13-14 in ED visits? The wait times, not the visits. The wait times. The reduction . . . [inaudible interjection] . . . Yes.

[15:30]

Mr. Hendricks: — So from ’13-14 the time waiting for an in-patient bed has dropped in Saskatchewan by minus 16.7 per cent. The emergency department length of stay for admitted patients has dropped by minus 7.1 per cent, and the emergency department length of stay for non-admitted patients has increased slightly during that same time period. So but you mentioned that you only wanted to see these and not emergency department visits, but there is context there in the extent that we are seeing a growing population and we are seeing an increased number of visits. And then ’17-18 obviously one of the challenges, you will know, is that we faced one of the more significant influenza years that we have faced, and so those are variables as well.

Ms. Chartier: — So when you talk about your performance measure that’s mentioned in your plan for 2018-19 and that . . . the promise that was made in ’13-14 where you took the baseline, so the emergency department waits by March 31st, 2019, achieve a 35 per cent reduction in emergency department waits from the 2013-14 baseline. So can you tell me . . . You just gave me three different numbers there. Can you tell me what metric is included in that? Is it those three pieces? Or when you say, achieve a 35 per cent reduction in emergency department waits, what does that include?

Mr. Hendricks: — So it’s 35 per cent in each one. It’s a cross-sectional one.

Ms. Chartier: — Of each of . . . So can you just give me those three measures that you just gave me this . . .

Mr. Hendricks: — There are four measures.

Ms. Chartier: — Four measures.

Mr. Hendricks: — So physician initial assessment from ’13-14 is up by 9.1 per cent and time waiting for an in-patient bed down by minus 16.7 per cent. The emergency department length of stay for admitted patients is down minus 7.1 per cent, and the emergency department length of stay for non-admitted patients is up by 5.6 per cent across Saskatchewan.

Ms. Chartier: — Okay. So I just want to clarify then that 35 per cent reduction, you want to see a 35 per cent reduction on all four of those measures.

Mr. Hendricks: — Correct.

Ms. Chartier: — Okay. I may get back to that in next . . . I’d need to ponder that a little bit here and I may get back to that next week when we’re back here.

In terms of some of the performance measures, on page 5 for your strategy: “Enhance access to mental health and addiction services.” For your ministry goal of connected care for people of Saskatchewan, performance measure, benchmark wait times:

> By March 31, 2019, all individuals seeking services will be seen within the benchmark wait times in child and youth as well as adult outpatient mental health and addiction services.

Can you tell me what those benchmarks are for the ministry in those areas, for children and youth? I know that there’s severe and urgent and then there’s different measures, but I’m wondering what your benchmarks are.

Mr. Hendricks: — Okay. So the benchmark wait times for levels of severity of clients who present for these services, in February 2018: 100 per cent of adults with very severe mental health problems were seen within 24 hours; 100 per cent of those with severe problems, within five working days; and 100 per cent of those with moderate problems, within 20 working days; and 99 per cent with mild problems, within 30 working days.

Ms. Chartier: — So, sorry, Mr. Hendricks. So those are the benchmarks that you’ve set. So can you . . .

Mr. Hendricks: — Right.

Ms. Chartier: — Okay.

Mr. Hendricks: — That’s for adult, and then for child . . .

Ms. Chartier: — Would you mind repeating the benchmark numbers then? So for urgent?

Mr. Hendricks: — Yes. Well for very severe . . .

Ms. Chartier: — You call it . . . Okay, very severe.

Mr. Hendricks: — Yes. So those would be your most acute cases, 24 hours.

Ms. Chartier: — Twenty-four hours. Okay.

Mr. Hendricks: — Severe would be five working days. Moderate would be 20 working days, and mild problems would be 30 working days.

Ms. Chartier: — Mild is 30.

Mr. Hendricks: — So that's for adults.

Ms. Chartier: — Adults, okay. Okay. And now are children and youth lumped together in the same . . . Are they broken out as children and youth?

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay, one category. So what are the benchmarks for very severe for children and youth?

Mr. Hendricks: — In 2018, 100 per cent of children and youth with very severe mental health problems were seen within five working days; 100 per cent of children and youth with severe problems were seen within 20 working days; and 98 per cent with moderate problems were seen within 20 working days as well; and 97 per cent with mild problems, within 30 working days.

Ms. Chartier: — Okay. So just . . . You were giving me your results there, but I just want to make sure that I've got the benchmark. So very severe is . . . So you gave me the adult number. So it was 24 hours for very severe.

Mr. Hendricks: — Yes.

Ms. Chartier: — For severe . . .

Mr. Hendricks: — Five working days. This is adult, right?

Ms. Chartier: — Yes, okay, but I want . . . You were giving me your achievements or what patients were seen, but I just want to know what the goal is, the benchmark is.

Mr. Hendricks: — Oh.

Ms. Chartier: — Like what you're hoping to . . . Do you know what I mean, what you're . . .

Mr. Hendricks: — Yes, I see what you're saying.

Ms. Chartier: — What you're hoping to achieve.

Mr. Hendricks: — So in terms of our benchmark wait times, that's what I was actually quoting to you.

Ms. Chartier: — So the benchmark wait time is for adults, very severe, for 100 per cent of patients to be seen . . .

Mr. Hendricks: — Within 24 hours.

Ms. Chartier: — Within, a 100 per cent seen within . . . And then severe, 100 per cent within five working days.

Mr. Hendricks: — Right.

Ms. Chartier: — Moderate, your goal is 100 per cent within 20 working days; and mild is 100 per cent within 30.

Mr. Hendricks: — Yes, 99 per cent.

Ms. Chartier: — Sorry, 99 . . .

Mr. Hendricks: — Per cent within 30 working days.

Ms. Chartier: — Is your target for mild.

Mr. Hendricks: — Yes.

Ms. Chartier: — 99 per cent. And it was 100 for . . . That's the result, not the target? I think I . . .

Mr. Hendricks: — It's the target.

Ms. Chartier: — Not what you've achieved. I want the benchmark.

Mr. Hendricks: — This is the benchmark, yes.

Ms. Chartier: — Yes, but your official behind you is saying something different. I just want to clarify . . . Page 5 of the plan, the outpatient benchmark. I just want to know what you're using to measure on page 5 of your plan, like what your goal is.

Mr. Hendricks: — So basically what this, what we're saying is that we're already meeting our benchmark wait times.

Ms. Chartier: — Okay. For outpatient services for all . . .

Mr. Hendricks: — For outpatient services. Yes.

Ms. Chartier: — That's not what I'm hearing in Saskatoon. I hear . . . Okay. We're going to go back here one more time to make sure that I have this correctly. So for a very severe adult outpatient mental health, that 100 per cent of people will see someone within 24 hours.

Mr. Hendricks: — Correct.

Ms. Chartier: — Correct. So for severe, the goal is 100 per cent of those with severe issues receiving adult outpatient mental health and addiction services, that they get seen within five working days.

Mr. Hendricks: — Correct.

Ms. Chartier: — 100 per cent for moderate is 20 days. That's the goal.

Mr. Hendricks: — Right.

Ms. Chartier: — 100 per cent in mild is 30 working days.

Mr. Hendricks: — Yes.

Ms. Chartier: — Yes. Yes, okay. So that's for adults. So very severe for children and youth, the outpatient mental health and addiction services benchmark wait times is everybody seen in . . .

Mr. Hendricks: — Within five working days.

Ms. Chartier: — Five working days. Severe, 20 working days.

Mr. Hendricks: — Correct.

Ms. Chartier: — 100 per cent, moderate is 20 working days?

Mr. Hendricks: — 98 per cent.

Ms. Chartier: — 98 . . .

Mr. Hendricks: — But we're struggling to get to 100 per cent, right?

Ms. Chartier: — Okay. So your goal for moderate children and youth?

Mr. Hendricks: — Yes.

Ms. Chartier: — Is that you . . . So the goal isn't 100 per cent in 20 days.

Mr. Hendricks: — It's 100 per cent, yes, and we're at 98 now.

Ms. Chartier: — Okay. And then mild?

Mr. Hendricks: — 97 per cent is what we're at now. One hundred per cent is our goal, but it becomes more difficult because sometimes people don't return, right?

Ms. Chartier: — Okay. Yes. So that's an average across the province for those benchmarks. So can you give me some sense, breaking down into our two largest areas? Saskatoon, can you give me those measures?

[15:45]

Mr. Hendricks: — So the percentage wait times in Saskatoon for, and I must be clear, adult outpatient was 100 per cent for very severe, 94 per cent for severe, 94 per cent for moderate, and 97 per cent for mild.

Ms. Chartier: — How about child and youth? That's actually where I'm hearing the problem is, puts it clearly on the . . . I think. But what I've understood is that for the very severe it's going well, but on mild to moderate to nip things in the bud . . .

Mr. Hendricks: — For severe, it's 92 per cent.

Ms. Chartier: — Yes.

Mr. Hendricks: — And for moderate, it's 89 per cent; and for mild, it's 90 per cent.

Ms. Chartier: — So moderate, you said 89 per cent? And mild . . .

Mr. Hendricks: — That it's 90 per cent.

Ms. Chartier: — How about very severe?

Mr. Hendricks: — There were no clients to outpatient.

Ms. Chartier: — No clients.

Mr. Hendricks: — They would go to ED too then.

Ms. Chartier: — Okay, okay. So how many, those folks sitting waiting, the 90 per cent percentile, do you know how many children and youth you have waiting in that mild and moderate category for services?

Mr. Hendricks: — What we have, I'm sure you can appreciate we get a lot of data, and what we have is a calculated number. And so we can get you the number that was used in the calculation, the number waiting, but it will be a snapshot in time. And we'll get that for you next week, if that's possible.

Ms. Chartier: — So what's the most recent snapshot in time in terms of . . . So it'll be a snapshot, but from when?

Mr. Hendricks: — From like, right now.

Ms. Chartier: — Okay.

Mr. Hendricks: — For whatever day they kind of brought it out.

Ms. Chartier: — Yes. This week, I'm wondering how many children and youth in the mild and moderate categories there are waiting for services in the Saskatoon area right now. That would be great. So those benchmarks then.

So you've set that performance measure, and so you're actually fairly close to being on target for those benchmarks that you've set.

Mr. Hendricks: — Correct.

Ms. Chartier: — Is there a difference . . . So I'm again hearing that challenges are in Saskatoon, but are you seeing for outpatient services, are you seeing challenges or I guess the average . . . Well I'll wait for that snapshot in time, and then follow up with further questions around that, if that's all right. So we'll carry on with mental health next week.

I was wondering about the mental health and assessment unit that just opened up. I had an opportunity to tour it about a month ago, actually before it was open. But I had heard from several people that the capital money was funded by the Dubé family, and the money is coming out of Saskatoon, but there was no additional money. And so I had heard that. It was interesting because I had heard that from multiple sources, but I found a newspaper article that actually confirmed that. So from October 18th, actually it was not a newspaper article, it was your news release, I think, where it says, "Saskatoon Health Region will absorb the operating costs related to this project."

So is there any reason why you didn't put any new funding into this mental health and assessment unit?

Hon. Mr. Reiter: — As memory serves, at the time . . . I know that was an issue with you in the summer and I understand that. But we were still sort of . . . I think at the time you were concerned, saying that the province wasn't moving ahead with it, our officials hadn't even had a chance to review the plan. As

you know, it was a tight budget last year. They talked to the Health Authority officials, and they felt that they could move resources from other areas without impacting the other areas and still get this done.

Ms. Chartier: — I understand that they're getting this done and it's open, which is great. I still have . . . There's other things around it that I'd like to talk about here in a few minutes. But people who work on the ground in this area are arguing that when you pull resources . . . I mean, it's great that the operation costs that those psychiatric nurses are being funded, but you can't . . . Like it's hard to take money from one place and not have an impact.

Mr. Hendricks: — Saskatoon came to us with a proposal sometime last year, and this was a decision that they were going to make operationally. They felt that in terms of dealing with their mental health patients that they could reallocate resources in such a way that it would not have a negative effect on care, and in fact improve it by creating this unit and treating and assessing patients in a different environment. So it was an operational change that they proposed to us. And we said, okay, if you think you can improve services that way.

Ms. Chartier: — And I mean it fits with your goal, your stated goal of connected care in reducing ED waits. And so, just to be clear here, there was a . . . This has been something they've been asking for. We talked about this in estimates, the third-door option, a few years ago under the former minister, and the need to treat psychiatric patients in emergency a little bit differently.

So this has been something the health foundation, in conjunction with the health region, had been working on. They get a million-dollar donation for capital and I'd . . . Am I hearing you say that there's enough resources in Saskatoon? Okay, let's . . . It's 12 hours of psychiatric nurse care that is being provided in that facility. Is that right? Are those the additional resources that are being provided?

[16:00]

Mr. Hendricks: — Sorry that took so long. We had to find a briefing note electronically. So the operating is estimated to be $1.2 million annually. That was reallocated from other areas, so the total FTE [full-time equivalent] requirement was 11.2 because it's 24-7 coverage with two RNs [registered nurse]. The FTE reallocation, those were pulled from other areas and I'm not sure exactly how to read these but some were pulled from Dubé and the others were pulled from the emergency department. But it was felt like seeing them in this area rather than in the emergency department was an appropriate reallocation.

Ms. Chartier: — Was there a request, either a proposal or a request for additional funds to make this happen?

Mr. Hendricks: — The SHR [Saskatoon Health Region] came to us post-budget last year and said that this was something they would like to do, and unfortunately we did not have money in the budget to do that. And so they said, well we're going to do it anyways. And we said, you know, that's an operational decision. This is the stuff, the decisions that we expect the health regions and the Health Authority, if they feel that they can better meet the needs of a client, they have the opportunity to move stuff around.

Ms. Chartier: — How much money did you bump forward from the federal dollars last year, the federal mental health dollars? It wasn't all spent.

Hon. Mr. Reiter: — I'll get Kimberly to run the number by you, but I understand where you're going with the question, and that's very relevant. In fact the exact same question that you're saying — well a similar question at the time — I remember asking whether we could use federal funding for this now. Officials' assessment of the requirements under the federal program were that we can't. So I'm going to get Kimberly to just explain that, if I could. And she'll also give you the . . . You were asking about the carry-forward numbers from the federal money, correct? Yes. I'll get Kimberly to do that.

Ms. Kratzig: — Sure. Thank you. So the '17-18 funding was guided by an agreed-to common statement of principles with the federal government. And the aim of those principles was to improve access to evidence-supported mental health and addictions, primarily in the community.

So there were three key principles for that. One was expanding access to community-based mental health and addiction services for children and youth. The other was spreading evidence-based models of community mental health care and culturally appropriate interventions that are integrated with primary care. And the other was expanding availability of integrated community-based mental health and addiction services.

So again because this is in a hospital, we determined that that would not have been true to the principles that we signed with the federal government.

In terms of dollars for '17-18, so the funding for '17-18 was 3.17 million. We allocated 1.68 million and carried over the 1.49 million into this year's '18-19 allocation.

Ms. Chartier: — I guess my question is, when the then Saskatoon Health Region has a pot of money to provide mental health and addiction services, so they have something that they believe will treat, will better support mental health patients, get them the services they need, and will help your goal around emergency department waits, those are all . . . I find it crazy . . . That's the wrong use. Like it absolutely blows my mind here that you couldn't come up with money to support a mental health assessment unit. That's a really small piece of money and it has to get pulled from other services.

The Dubé . . . So you had said that some of the money was coming from the emergency room and from the Dubé. So let's talk a little bit about where the Dubé is at in terms of capacity, because they are, from my understanding, I mean it's reported every day that they are over capacity. It seems like I'm all over the place right now, but I'm not. This all plays into the same, making sure people have the resources they need. So I would like to get a little bit of information around capacity and over capacity and over census at the Dubé, what that's like right now.

Hon. Mr. Reiter: — I apologize. We just want to make sure we answer your question properly. Can you sort of just reconfirm for me the numbers you're asking for?

Ms. Chartier: — So do you have . . . So every day the Dubé, those numbers get reported. The operating census and over capacity, like, two or three days ago was at 117 per cent. So I'm wondering if you have, like, a monthly average or a . . . this last year, the last three fiscal years. Do you collect those on a monthly basis or a yearly basis?

Mr. Hendricks: — So we're struggling with the fact that we don't have the most recent numbers . . . Like, you're looking for the occupancy rate?

Ms. Chartier: — Yes. So also, I should ask for the measure. I know that the Dubé is always over capacity. There are more people in the Dubé than the building is designed for on a very regular basis, so I'm wondering what language or what term I should be using to get at that number.

Mr. Hendricks: — So today in terms of occupancy at the Dubé it's at 104 per cent for adult and 100 per cent youth.

Ms. Chartier: — So that's today. Do you have those numbers on a monthly basis or at like . . .

Mr. Hendricks: — That's what we have right now, but this is kind of something that we . . .

Ms. Chartier: — So it's tracked every day, though? That is a number that is tracked every day?

[16:15]

Mr. Hendricks: — Yes.

Ms. Chartier: — So do you compile those so you can reflect back and say, hey we were at 117 per cent over capacity in the last fiscal year? Like do you calculate those numbers?

Mr. Hendricks: — Yes. We don't have it with us. And, you know, I think part of the . . . You know, we get these numbers. It's also a question of what's the ministry's . . . you know, what the ministry compiles and what the SHA compiles as well. And so, you know, you'll have to understand some of these more operational details, and these compilations of numbers, we don't have at our . . .

Ms. Chartier: — Fingers.

Mr. Hendricks: — Fingertips. Right.

Ms. Chartier: — I know you've gotten them for me in the past, like a few years ago in estimates. So I'm wondering if I could get the . . . So what is the language that I should be asking then, if I'm asking that question about occupancy at the Dubé? What should I be asking?

Mr. Hendricks: — Yes, that's the question that you should be asking.

Ms. Chartier: — What is the occupancy?

Mr. Hendricks: — What is the occupancy rate? But, you know, I think just to give you . . . You know, you ask questions about the resources that were transferred from Dubé or other areas of the Saskatoon operation to the mental health assessment unit.

Occupancy is not necessarily a function of the staff that you have there. And you know, it might impact it, but you only have so many beds that are being admitted to. What we're trying to do is actually get ahead of it in the community with mental health so that we don't have people showing up in crisis and in acute situations. So we're offering more mental health community supports or mental health supports in the community. So that's what the Connected Care is focusing on in mental health dollars.

Ms. Chartier: — Oh, I completely agree that you shouldn't wait for something to be acute. The best place to treat mental health is when people are mild to moderate. But the bottom line is, today in 2018 there are people who get shuffled around the Dubé at night. In the middle of the night, you've got high incidents of . . . It's been flagged for me from nursing staff there. You've got folks who have major challenges in life, and you've got violence that is taking place. Workers have been assaulted. So resources are an issue.

And I completely agree: back that train up and do the community stuff, but in the short term here, they are struggling with resources. And I mean, this all ties together. The fact that we don't have children with mental health going into the children's hospital, and you've got beds there that could've been converted to help deal with over capacity there. I mean, it all fits together. as I know you know that, that it's a system.

Mr. Hendricks: — Yes, I think, you know, you don't have to explain the issues to me. I understand them very well . . . [inaudible interjection] . . . And so I'm not going to.

But at some point you have to actually say that the current system isn't working. Like am I going to build another Dubé Centre? Another Dubé Centre, if we do things the way that we've been doing them, it will have a very predictable result. So the question is, or the strategy is, yes let's back it up and start taking the pressure off the Dubé.

We have a pretty significant investment in mental health this year, which I think will start to turn some of those pressures hopefully down on those. But you know, I think that we have to realize this isn't, you know, this isn't the ideal place to be caring for these people. And hopefully we can have their needs addressed in the community, and eventually that number will be, you know, at the right place.

Ms. Chartier: — But for people who are acute, you weren't even willing to put additional resources into supporting the mental health assessment unit.

So back to the point about over capacity, I'm wondering if I can get that number for next time. The last three fiscal years please. The average over capacity, if I could get that, that would be very helpful, for 2017-2018, 2016-2017, 2015-2016. So I'm looking to get at the number around capacity and over capacity at the Dubé, if I could. That would be very, very helpful. Thank

you.

In terms of wait times, from seeing a doctor in the emergency department to, if you end up needing a bed at the Dubé, do you track those times once someone needs to be admitted?

Mr. Hendricks: — We don't have those. We'll have to check and see where and if they exist for Dubé separately.

Ms. Chartier: — Okay. I think I did see some slides when I was at the foundation event, where they had the pre-tour, around wait to admission. So I think those are numbers that they do track. So if you could find that out for me.

Mr. Hendricks: — Yes. We'll check it.

Ms. Chartier: — That would be great. Okay. I just want to step back. I know you're getting me some numbers for children and youth, and you were telling me about the benchmarks. So when we talk about the benchmarks, when you talk about meeting those benchmarks, is that actually seeing a regular therapist, or is that for service offered, being like a drop-in, the opportunity to see a drop-in counsellor?

Hon. Mr. Reiter: — I'll just get Kathy to answer that for you.

Ms. Willerth: — It's Kathy Willerth, director of mental health and addictions. So in order to answer your question, I think sometimes it's both. There are some of the areas of the province that have a walk-in clinic. So if you think you can't wait, you're invited to, you know, come into a walk-in clinic and there'll be a clinician available. And in some other areas of the province they are measuring by the first available appointment offered.

Ms. Chartier: — Okay. So I think the number that I'd asked around children and youth and the benchmark, I would like to know in the major centres — so Saskatoon, Regina, P.A., Moose Jaw, North Battleford — how many kids are waiting for service in each of those major centres, not including that option of seeing a counsellor for a quick drop-in service. So I know you'd committed to getting me those numbers a little bit earlier, but I just want to narrow the focus a little bit for when you come back with those numbers next week.

Ms. Willerth: — So I just want to clarify, if that's all right. So you're wanting to know who's waiting for an individual appointment?

Ms. Chartier: — Yes.

Ms. Willerth: — Whether or not they have made use of a . . . We have someone available; if you need someone today, you can walk in and see them. Is that right?

Ms. Chartier: — Yes. Who is waiting yet to see a regular therapist in the major centres.

Ms. Willerth: — Major centres.

Ms. Chartier: — The children and youth in the mild to moderate. I think that that's where the challenge I'm hearing in Saskatoon is. But I wouldn't mind seeing, getting a snapshot of that across the province. That would be very helpful.

Ms. Willerth: — In the mild to moderate areas.

Ms. Chartier: — Yes. Those are the areas that I think the challenges are. But I know you've always got lots of work to do but if, on those other areas, if you could pull that together as well.

Ms. Willerth: — So on the triage category areas.

Ms. Chartier: — Yes.

Ms. Willerth: — Okay.

Ms. Chartier: — That would be great. Thank you. And the other thing, so I know you've said you've committed to checking to see around the triage from the emergency department to actually getting a bed at the Dubé. If you could see if that's a number that's available, that would be very helpful.

Okay. Moving on to North Battleford, I think here. Oh, you know what? Actually I just want to go back. So if you couldn't use those dollars, the dollars that you bumped forward to this fiscal year specifically for the mental health assessment unit, why could you not have used it in . . . I mean you've got additional money coming. I'm sure there was some way to reallocate to come up with the money for the Dubé or for the mental health assessment unit. I just don't understand how there was money that was coming in for community health or for mental health that could have gone to community mental health and then reallocated for the mental health assessment unit.

Hon. Mr. Reiter: — My understanding of it was, when I had asked that question initially, if we could use it for that, my understanding is it needed to be sort of incremental funding. It couldn't be just to backfill some . . . a program that you were already doing. That's my understanding of it.

And I just want to clarify to that, I mean, we absolutely see the need in mental health. And it wasn't that, it wasn't a case of last year, like use it or lose it. The funding that was available, we used much of it. Kimberly ran through those numbers. And the carry forward, it was exactly that; it was carried forward and is being used this fiscal year. So it's not like there was any money left on the table.

Ms. Chartier: — I know it was carried forward, but I know that there's a list the length of my arm of places where people would have liked that money to have been spent.

Hon. Mr. Reiter: — And I understand that, but my point is that that money is being used or going to be used. It's not that we said, no we don't want to use it. We're using it and, like you said, there's a long list that it can be used. And it will be.

Ms. Chartier: — And it could have been used last year as well. So I just want to clarify and put on . . . So the Saskatoon Health Region came to the ministry post-budget and said, we have got some capital money for the mental health assessment unit. Do you have any operating money to help us out? I just want to clarify that there was in fact an ask from the Saskatoon Health Region to the ministry for the support for the mental health units.

Hon. Mr. Reiter: — Yes. I understand officials telling me there was. That's not unusual in any area in government though that once a budget's passed . . . I mean, things change. And those sorts of things are operational decisions, as Max had said earlier that, you know, that's why you have officials there. You trust them to make appropriate decisions and to make the best use of the resources.

Ms. Chartier: — How much was the ask for operational dollars?

Hon. Mr. Reiter: — Max tells me it was 1.2.

Ms. Chartier: — Was it 1.2 in this . . . So they wouldn't have . . . Had they built it, their hope was to get it open last October. So last year, I think the ask was a small . . . like, obviously not a full fiscal year.

Hon. Mr. Reiter: — So I understand your question. We'll just check whether that would have been prorated, if it was annualized or not. We'll just check.

[16:30]

Officials are telling me that they think that it was, that would have been a full operating year.

Ms. Chartier: — So they started at 1.2 million for the full operating year and onward. So they . . . Sorry I'm belabouring this, but this I think is important. So do you know what they . . . You said they pulled resources from the ER [emergency room] and from the Dubé. So do you know to what extent, or what was pulled?

Mr. Hendricks: — Well I told you it was roughly 11.12 FTEs, but I would like to actually confirm exactly where those were brought from because the note that we have is old. And so I just, you know, I said it looks like Dubé, ED, you know. But I'd like to actually see where they were eventually taken from, because this discussion went on post-budget. But you know, it wasn't until recently that they actually got it going, so . . .

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

Hon. Mr. Reiter: — Can we just follow up with you?

Ms. Chartier: — Yes. No, that would be very helpful. And I just want to put on the record here too . . . So obviously once the children's hospital opens up you'll have an adult ER, or adult ED. And so you . . . I know that the Dubé family had committed the money, knowing that the ER, the ED was moving to the Pattison. But I know there'll be some space. Obviously there'll be an ED and some vacant space at the RUH [Royal University Hospital].

And I would suggest that might be a really great place for that third-door option, a mental health assessment, and a short-stay unit modelled on the psychiatric emergency care centres in Australia. So just putting that out there, that there could be some good use for that space. You've got a beautiful facility built. You'll have some other vacant space that could be well utilized to better support mental health patients.

Hon. Mr. Reiter: — If I could, the last information I was given, officials are looking at exactly what would be the most appropriate use of that space. I think they're looking at a number of different options, but point taken.

Ms. Chartier: — Okay. So how . . . And I want to know around the transition to the Pattison. So I know that I've been told in the past when I asked about the third-door option, that you don't want anybody to wait at the new ED, that all patients . . . Like, the goal is to make sure all patients are treated well, but mental health patients are different than patients who have physical injuries. So I've been told that the model from the mental health assessment unit will be transposed to the Pattison. So I just want to get a sense of what that's going to look like.

Hon. Mr. Reiter: — I'm just going to ask Karen to run through that for you.

Ms. Lautsch: — Karen Lautsch, assistant deputy minister, Ministry of Health. So in terms of the model of care that is being used in the short-stay unit, we understand from the region that the plan is for the model of care to continue on into the new emergency department for adults, and children and youth in the new James Pattison hospital. So it will be transported going forward into that new environment. In fact the RUH model, I believe, was developed a bit as JPH [Jim Pattison Hospital] was coming on stream with the emergency department. So they had that opportunity there.

And in fact, the kids when they . . . When patients come into the emergency department there'll be two different rooms, secure rooms for youth with mental health needs. There are three for adults. And there'll be a registered psychiatric liaison nurse in the emergency department at all times. And former Saskatoon Health Region is going to see if that's satisfactory in terms of resources that are available for patients that are coming in and make sure that, if it's not, they'll have a second look and see what resources are needed. Okay?

Ms. Chartier: — Thank you for that. I just want to move on here to the North Battleford hospital here and just some current numbers. So how many individuals are admitted to the rehab beds currently at the Saskatchewan Hospital North Battleford each year in the last three years? Not including those sent by the court for forensic assessment. Last three years, please. Yes.

Mr. Hendricks: — We don't have the exact numbers with us but the recollection is that about 30 are admitted per year.

Ms. Chartier: — Okay. Could you get those numbers for me for the last three years for our next . . .

Mr. Hendricks: — Yes, we can verify them. I just . . . You're asking for rehab, not forensics.

Ms. Chartier: — Not forensics.

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. And how many individuals . . . So I've got a few questions in this then. How many individuals are admitted more than once each year to the rehab beds?

Mr. Hendricks: — We've sent the question back to home base and we'll try and get an answer for you.

Ms. Chartier: — Okay. So how many individuals are admitted from the last three years to the rehab beds; how many individuals are admitted more than once each year to the rehab beds. This is just in terms of general hospital mental health beds: can you tell me how many general hospital mental health beds you have here in the province?

Mr. Hendricks: — So in answer to your question, the bed numbers for Cypress are 10 beds; Five Hills . . .

Ms. Chartier: — Cypress . . .

Mr. Hendricks: — The old Cypress doesn't exist anymore, but bed numbers, 10; Five Hills, 12; Prairie North, 22; P.A. has 29 adult and 10 adolescent.

Ms. Chartier: — 29 adult and sorry, how many adolescents?

Mr. Hendricks: — Ten. Regina Qu'Appelle has 50 adult and 10 adolescent. Saskatoon, 54 adult and 10 adolescent, and obviously this wouldn't include any changes in Saskatoon. It doesn't reflect the mental health assessment unit, that sort of thing. These are in-patient beds.

Ms. Chartier: — In-patient beds, yes.

Mr. Hendricks: — Sun Country would be 10 and Sunrise would be 15.

Ms. Chartier: — Ten and then Sunrise 15. Okay, for a grand total of?

Mr. Hendricks: — 232.

Ms. Chartier: — 232 general hospital in-patient beds. Are those Saskatoon numbers, that's the Dubé? 54 adult and 10 adolescent.

Mr. Hendricks: — Correct.

Ms. Chartier: — That's right. Okay. So how many individuals spend more than 60 days in the beds, in the 232 beds each year?

[16:45]

Mr. Hendricks: — For the month of February in 2017, we had — because the 60 days is kind of a standard, right, that we honour — so zero in Swift Current, zero in Moose Jaw, zero in North Battleford, one in Prince Albert, two in Regina, six in Saskatoon, zero in Weyburn, and one in Yorkton.

Ms. Chartier: — So that's for February 2017. Do you have those numbers for each year, like the last three, the last . . .

Mr. Hendricks: — Yes. So like I can give them to you by community. Do you want them by community?

Ms. Chartier: — It doesn't have to be by community. Total for let's say the last . . . so '17-18, '16-17, and then '15-16, the number of individuals who've spent more than 60 days.

Mr. Hendricks: — So for January 2017 . . . So just for clarity, the total number in '17-18, February 2017, that I gave you was 10, the total.

Ms. Chartier: — Okay, so you gave me the number for February 2017.

Mr. Hendricks: — That would be zero, one, two, six, zero, one. And that equals 10, right? Just for comparison purposes.

Ms. Chartier: — Okay, so just a second. Was that a snapshot in time or was that . . . So I'm looking for the . . .

Mr. Hendricks: — That's a snap. February, for the month of February 2017.

Ms. Chartier: — Do you calculate that, not just a snapshot in time, but do you calculate, like looking back, reflecting . . . Like when you're planning the North Battleford hospital, you look at the numbers of folks. So for the last three years, do you have that number of individuals who spent more than 60 days? Like not for the snapshot February 2017, but for each of those fiscal years, how many people spent more than 60 days in those designated mental health beds?

Mr. Hendricks: — We don't check the total number over a year. We take a snapshot, kind of to see how we're doing, you know. And so, yes, it's kind of done in a specific month every year to try and be comparable.

Ms. Chartier: — So it's always February. You don't have other periods of time, like you don't have a total for a year?

Mr. Hendricks: — I'm sure, like we could go back and do, they could do a data run or something and we could find out the total number. But in terms of figuring out where we're at in the system, looking kind of at one month, you know, we've got 10 people waiting in acute care more than 60 days. That gives us an indicator.

Ms. Chartier: — So you've chosen . . . I wouldn't mind if you could go back for the last three years. But for our purposes here today, so your snapshot of February 2017, there were 10 people waiting longer than 60 days in general beds.

Mr. Hendricks: — And the previous year in January — the months move around a little bit — but it's 13. March of 2016, it's 17. Sorry, that should . . . let me check something here. The first number I gave you is February 2018, sorry. Because that's more recent.

Ms. Chartier: — The first number was February of 2018, which is 10. So then '17 was . . .

Mr. Hendricks: — 13.

Ms. Chartier: — Okay. I'm very confused now. '16, January . . .

Mr. Hendricks: — We did it March of 2016 when we asked the question. It was 17.

Ms. Chartier: — 17. And then the previous year?

Mr. Hendricks: — In March of 2015 it was 18.

Ms. Chartier: — March 2015 it was 18. Okay. That was March 2015, okay.

If it is possible to do a data run . . . So that was the snapshot in time, how many people at that point in time have been waiting longer than 60 days. I just want to make sure I'm understanding that. Okay, so I would like the year, the total number for each year for the last three years. Well I just need the last three years . . . [inaudible interjection] . . . Okay. For the next time we meet, what I'm looking for is the last three years, the number of people who spend more than 60 days in designated mental health beds in general hospitals.

So how many individuals are admitted to the mental health beds in general hospitals three or more times each year in the last three years?

Mr. Hendricks: — Again that would be a very specific data run that we'd have to . . . And I can't even commit to get through that next week because we're not sure what that entails.

Ms. Chartier: — Yes, I guess I'm looking around the . . . My concern here is the North Battleford hospital and access to that facility. So if you do have an opportunity or can figure out how to do it, people who are in general hospitals three or more times each year in the last three years. If you can sort out how to do that, the data around that would be great.

Mr. Hendricks: — But I should point out that not all of these people are waiting to get into SHNB [Saskatchewan Hospital North Battleford], right? Sometimes there's other services as well.

Ms. Chartier: — Other services like day homes, yes. No, for sure, but some of them are. So in terms of the North Battleford hospital, you're moving the beds from 156 — I think that's 28 additional beds — to 188. Is that right: 156 to 188?

Mr. Hendricks: — That's 188 beds.

Ms. Chartier: — So it's 32 additional beds over the number . . . [inaudible interjection] . . . 32, I think.

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. Can you sort of break out for me how . . . So it's great that you'll have the correctional centre there and the opportunity for patients or inmates who have mental health issues. But what I'm wondering is, in terms of concrete measures and programs when the hospital opens, what do you have in place to increase the number of people admitted for rehab beds and not just the forensic beds? Have you put in place any measures or programs to make sure that those folks waiting in general hospitals have access?

Hon. Mr. Reiter: — I apologize. Could you just clarify for us? You asked if we have any measures to . . .

Ms. Chartier: — What is the plan to make sure? So about 30 people are admitted each year to the hospital right now but obviously there's the rehab beds and the forensic beds. So in terms of measures or programs to make sure that some of those folks who are waiting in hospital longer than 60 days, who should be going to North Battleford, actually get the opportunity to get there, so is there . . . Have you taken into consideration that?

[17:00]

Mr. Hendricks: — So as you mentioned, 32 more beds at SHNB, 32 more than we have now. We have turnover of about 30. So our other, you know, the other strategy is what we're calling our community recovery teams that will provide supports in the community to people that will be returning from SHNB to the community. And so it's funding for the establishment and operation of multidisciplinary teams in eight different communities — so Saskatoon, Regina, Prince Albert, North Battleford, Moose Jaw, Swift Current, Yorkton, Weyburn — to provide client-centred support to individuals with very complex needs, serious or persistent mental illness, so those ones that we might see exiting SHNB.

So the goal . . . Obviously not everybody from SHNB can be returned to the community. Some are there for longer just by the nature of their mental illness. But the goal is obviously to provide supports to allow them to reintegrate in the community at some point.

Ms. Chartier: — So is the community recovery teams, is that basically assertive community treatment? Is that the same kind of idea?

Mr. Hendricks: — It's community treatment. The funding will support, you know, the addition of 40 full-time equivalents in a range of disciplines. So it'll be occupational therapy, peer support, addictions, social work, vocational supports, and other staffing. And it will enhance our current rehabilitation team. So it's kind of a multidisciplinary team that will . . .

Ms. Chartier: — So it is a sort of community treatment then?

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. One of the things that I raised a few years ago in committee was there'd been a paper that had been written — that actually has disappeared from the website — when the regions were no longer around everything that had to happen. It was about rebuilding the North Battleford Hospital. But it also was about step-down beds and supportive housing.

So I'm glad to see this piece around community recovery teams. But what has ever happened to that? It was a joint paper from the health region and the ministry. And it used to be whenever you Google "step-down beds in Saskatchewan" that's what would come up, and it's no longer available. But I'm wondering what has happened to the plan for step-down housing, because there was . . . step-down and supportive housing which was a key component of the rebuild of the hospital, that community support.

Mr. Hendricks: — So maybe I'll start by saying that . . . And I know what you're referring to. There was discussion at the time that SHNB was built to have 120 community residential supported beds. You know, I think the feeling is now that in

light of, you know, certain things in terms of community supports and social services done in community housing and supports that we have in the community, a refresh of that number and our requirements is actually needed, in terms of, you know, like, what are . . . There have been significant increases in support of housing and then, you know, I mentioned the community recovery teams and how can, you know, that play a role in transitioning people out of SHNB.

But you know, it's not something that has been forgotten about. We are, you know, we're . . . As part of our mental health funding envelope over the next while, we're going to be making some . . . We anticipate there will be some announcements in this regard.

Ms. Chartier: — So I'm not sure, when you say significant increases in support of housing around mental health, can you tell me a little bit about that? Like, what have I missed?

Mr. Hendricks: — So I don't know that you missed anything. Some of the supportive housing, just to give you an example: the Housing First initiative announced by the federal government, as well as the Saskatchewan Health Authority for groups like Phoenix House and that sort of thing, where they provide funding for supportive housing beds for people with complex mental health and addictions issues. So there have been improvements in that area. But what I would, you know, steer you back to a little bit is the fact that in the very, very near future we hope to announce something regarding our residential supports for people with mental health . . .

Ms. Chartier: — Okay. But in recent history, so Phoenix House does great work here, but really at a time, in terms of sort of designated mental health housing in Saskatchewan today, what do we have? Supportive housing.

Mr. Hendricks: — In terms of the total number of residential spaces, in June 2017 there were 1,206, which was an increase from 1,168 in the previous year. And so these include group homes, apartments, approved homes, that sort of thing. So the total number of community beds had, over that one-year period, increased by 38.

Ms. Chartier: — And how about let's . . . Just out of curiosity, do you have it back to 2007? I don't need all the years, but just . . .

Mr. Hendricks: — I don't have that, I'll guarantee you.

Ms. Chartier: — How far back does your list go?

[17:15]

Mr. Hendricks: — I have that back to what I just gave you, one year. Just hang on. I might have late-breaking news.

Ms. Chartier: — Okay.

Mr. Hendricks: — They were just showing me the same thing that I had read to you.

Ms. Chartier: — Okay. How difficult would it be to get those numbers?

Mr. Hendricks: — We can try.

Ms. Chartier: — Okay. Maybe like even going back to 2010. We'll just pick 2010: eight years.

Mr. Hendricks: — See what we get.

Ms. Chartier: — Okay. Sounds good. I just want to go back just to confirm with respect to the question that I'd asked about the Dubé around capacity. So there are 54 adult beds and 10 children's beds. So I want to know the . . . So that's the census, and I want to know the average over that number. So I just want to make sure that what I'm getting next week is I want to know the average over capacity or the average over census . . . [inaudible interjection] . . . Okay. I just want to make sure. I'm going back over my questions and notes here, making sure that I know what I'm getting back.

With respect to the recruitment of psychiatrists and waits, so we have, with the question that we talked a little bit about yesterday, Mr. Minister, around wait times, I just want to . . . And wait times for specialists, pardon me.

So the wait time for psychiatry has grown. Here in Saskatchewan the average wait in '15-16 was 138 days and in '16-17 it's 162 days, which is a 17.4 per cent increase. And yesterday you told me that you'd had Mr. Hendricks write a letter to the Saskatoon Health Region. So that's the average across the province, but you'd said that the numbers are particularly sticky or difficult in Saskatoon. So when did Mr. Hendricks write the letter, and what has been the result of that letter?

Hon. Mr. Reiter: — The letter, if memory serves, we think it was about a month ago and it asked the CEO [chief executive officer] of the SHA, Scott Livingstone, to look at the processes that are in place in Regina and Prince Albert because they were more effective. The wait times are much longer in Saskatoon, as you had said. So certainly we're going to be following up with him but, you know, as you can understand, it's going to take a little bit of time. But we'll be following up with him periodically and monitoring the progress.

Ms. Chartier: — You haven't heard back from him then, yet?

Hon. Mr. Reiter: — [Inaudible] . . . either of us have talked to him about it since then but we certainly will. Like we'll follow up because I appreciate, you know, we want action as quick as we can but it was a relatively short period ago that the direction was given.

Ms. Chartier: — Just around child psychiatry in Saskatoon, so I just want to clarify numbers here. So I think we're down to nine child and youth psychiatrists and some of them, many of them have children so they don't work full time. We've lost two in the last little bit and one will be retiring this summer. So we know that the waits . . . Can you quantify the wait to see a psychiatrist in Saskatoon? I know Mr. O'Soup had said two years, and those are numbers that I've heard from psychiatrists too. But can you quantify the wait and then tell me a little bit about your thoughts around our losing these child and youth psychiatrists?

Hon. Mr. Reiter: — So to your point, you know, as I said before, we're extremely concerned across the province, but the problem is more, is larger in Saskatoon. So the retirements, obviously we're very concerned about that. It's going to exacerbate the problem. So clearly recruitment is part of the issue.

One of the things that we've done in this budget, there's just under $3 million that's going to be targeted to increase child and youth mental health and addictions clinicians and specialists. So waiting to hear back from the SHA on sort of the best strategy on how to approach that. But again, obviously recruitment's a huge part of that. I'm just going to get Max to give you just a little bit more detail on that now though.

Mr. Hendricks: — You had asked about the wait times for child and youth psychiatry in Saskatoon. So they're 18 to 24 months. But part of the reason for my letter was, when you compare and contrast that to Regina and Prince Albert, it's two and three months respectively. And you know, in terms of the number of child psychiatrists that Regina has — and we still, I think we have nine in Saskatoon according to our numbers — there's just a little over five in Regina.

But with, you know, Saskatoon has a slightly larger population, but what we see is that the actual referrals to psychiatrists in Regina are much lower than in Saskatoon. And it's because they're using a different approach where they're referring to different mental health workers that might be more appropriate to a case, so not a wholly physician-based model. And so I've actually . . . One of the things that we've asked Saskatoon is to look at a different model where not everybody has to see a psychiatrist.

Sometimes you can have a different intervention that's entirely appropriate before that and then . . . But that's not to say that as a ministry and government, we're not trying to do more. We're absolutely, the 2.9 million specifically targeted, as the minister mentioned, at increasing the number of mental health personnel across Saskatchewan. So you know, it's a pretty significant improvement this year.

Ms. Chartier: — The challenge in Saskatoon too, is it true that lots of those, that the people needing to see psychiatrists are . . . you've got a feeder pool from the North? Would that be the case as well?

Mr. Hendricks: — Yes. Well but interestingly P.A. is more similar to Regina in terms of the wait times. So the North would draw into P.A. but it would also draw into Saskatoon. I think what we've heard is that just, you know, not being critical or anything but the model of care in Saskatoon is more traditional than Regina, where they've looked at using other health care workers and not just direct referral to a psychiatrist.

Ms. Chartier: — Well I know what psychiatrists are telling me, and they're telling me that they would like to see far more clinicians, psychologists, registered social workers. I mean, the managing medication, like it's an awfully expensive use of a . . . There are people who can do cognitive therapy or whatever therapy that is required who aren't psychiatrists. And managing meds is . . . If you did wholly and fully invest in additional clinicians in Saskatoon, psychiatrists would much rather get through their wait-lists. And that's what they're telling me, is that they want additional clinicians. There's a psychiatrist who heads north who's hired her own social worker to support her work.

Mr. Hendricks: — So that's what we've asked the SHA to do, is take a look at the model in Saskatoon.

Ms. Chartier: — But I guess my question is, in terms of timing what are you anticipating?

Mr. Hendricks: — We asked for them to come back to us by the end of May.

Ms. Chartier: — Again on the whole recruitment and retention piece, obviously we have a lower . . . Psychiatrists aren't the only way to deliver mental health care, but they're an important part of the medication management for sure. But we still do have lower per capita than other places in Canada. The number of psychiatrists — I'm sure you're not unhappy about my voice — we have a lower per capita, the number of psychiatrists. And again, what they're telling me is that recruitment and retention isn't simply about more money. It's about making sure you have a robust team around you to support the work, and even around the child psychiatry piece. And they pointed out the children's hospital would have been a great opportunity.

Even though they're not the only way to treat and support mental illness, we have an issue obviously. It wasn't just a retirement. I think the two people who left recently or in recent times weren't retirements, from my understanding. So that goes to retention, like what the challenges . . . So I'm curious if you're hearing anything around that piece.

[17:30]

Hon. Mr. Reiter: — I'll start, and then if Max wants to jump in . . . You know, what you're saying, absolutely I understand that. And I think that's kind of what Max's point was on the Regina, P.A. thing, not that we can't do better there as well, right? But obviously what we've had in place there, I would say including for recruitment and retention, obviously is working. But also to your point about other clinicians, that sort of thing, that model in those two cities clearly seems to be working better than what we're doing in Saskatoon. So that's sort of your point, I think, is part of what we're trying to implement in Saskatoon.

Ms. Chartier: — That recognizing, too . . . So we look at two or three months, you said, so 18 to 24 months is absolutely unacceptable. But two and three months when you have a mental health issue is too long, too. So I'm glad to hear that you're thinking about recruitment and retention in Saskatoon. But this again, we are below the national average.

Hon. Mr. Reiter: — Just a couple points there. You know, I'd just said a minute ago that, not that we can't do better in Regina and P.A. as well — we can and we need to. But also the numbers you're giving there are the averages, so more acute ones are going to be seen more quickly.

Ms. Chartier: — And I know acute, generally in Saskatoon you don't wait for acute support. It's nipping it in the bud, like those early on. Like that's the whole point, is you don't want

that acute . . . that end of it to grow. You want to be able to make sure people don't end up in that position. So you're working with the former Saskatoon Health Region, those folks, to try to . . . and the current region I guess, the one region, on improving that. Okay.

I am going to change gears here a little bit. I just want to make sure that I've . . . That's been two and a half hours of mental health and I think I probably have further questions. In terms of long stays, and I know we were kind of . . . This will be my last mental health question for the day. In terms of long stays, I'd asked you about general hospitals and those staying longer than 60 days. But a few years ago we had the discussion. There were people who'd been in some of our acute psychiatric facilities for years. So I'm wondering if you have any quantification. What's the longest stay that someone in one of our acute facilities has been, like the Dubé, for example?

Mr. Hendricks: — We don't have that number, but as part of our growing data run that we're going to do, we could add that to the list.

Ms. Chartier: — Thank you. I'm always very appreciative of that. I do very much appreciate that. And I know that you were able to pull those numbers a few years ago because it was a real issue around long stays, in a large part because of lack of community resources.

I'm wondering about children as well. I'd asked a written question around community living folks, and I was told in my written questions that you couldn't answer that because of privacy issues. But I know that a few years ago you did answer, because some of the folks who were in the Dubé had co-morbidities, like psychological issues and cognitive disabilities. So they were community living clients as well. So I'm also, just in terms . . . Okay, looking for adult and youth numbers in terms of long stays. What's the longest stay for both adults and youth in our, probably in the Dubé, but in any of our general hospital beds? . . . [inaudible interjection] . . . Yes, that would be great.

I'm going to shake things up here and ask you a totally different question here around critical incidents. So last week our leader had asked about the power outage in Moose Jaw. It's always a little disconcerting with the shuffling here.

An Hon. Member: — Sorry. We're just trying to target the most appropriate . . .

Ms. Chartier: — That's okay. Yes. No, no, no. For sure.

So we had asked about the power outage in Moose Jaw and you had, in a scrum or at some point, acknowledged that someone had, in fact, had been injured and as a result of that power outage . . . And a couple of days later this individual passed away. So I'm like . . . But it wasn't noted as a critical incident. So just in terms of some thoughts around critical incidents and helping me understand how critical incidents get classified, and how much time do folks have to report it, and if someone doesn't report it, is there any recourse?

Hon. Mr. Reiter: — Sure. I'm going to get Mark to speak to the critical incidents in a minute though, but first I just want to address your comments. In the House and then immediately after when I scrummed, I wasn't aware of that. And then I was made aware after, so I went out to try to clarify that.

So obviously we're extremely concerned when something like that happens. I have contacted the family. I've offered to meet with them and will be meeting with them in the next while. They've asked that this be a private matter, so I'm going to respect that of course, but I thought you should know that.

Ms. Chartier: — Yes. No, no . . . the issue itself. I'm asking about how the critical incident . . .

Hon. Mr. Reiter: — Just in general, yes.

Ms. Chartier: — I know that there was some concern around the fact that a critical incident, that that wasn't noted as a critical incident. So I'm wondering about the process around that.

Hon. Mr. Reiter: — Absolutely. I was extremely concerned, so I've asked officials to look at that. We're still following up on that specific one. But to the critical incident, the general question, if I can just get Mark to address that.

Mr. Wyatt: — Hi. Mark Wyatt, assistant deputy minister. So critical incidents would be considered to be the most serious of events that involve . . . of an adverse event that might or might not result in direct harm to a patient. Saskatchewan was the first province to introduce legislation requiring the reporting of critical incidents. That goes back more than a decade. And I mean, the general premise for reporting critical incidents is not so much to cast blame, or it's not about casting blame. It is about learning and documenting incidents as they occur in the health delivery system and then being able to learn from them.

So the process will involve an initial report that is required by, in the past, regional health authorities, now the Saskatchewan Health Authority. Those are followed by a root cause investigation that's completed by again now the Saskatchewan Health Authority, and a follow-up report that is provided to the ministry around the outcome from that report. Our provincial quality of care coordinators work directly with the site that is reporting the incident and, in some cases, we may go on to issue a safety alert province wide if it's identified that there is an incident that has occurred that could have potential and for which there is usually evidence to indicate what the remedial action or corrective action that should be taken, based on the completion of one or more critical incidents.

Just with respect to this particular incident, it's our understanding that it wasn't reported as a critical incident and there are ongoing conversations with the Health Authority, as the minister indicated, about that in particular.

Ms. Chartier: — I guess the question then when . . . So I mean if someone dies because of something that has happened in a health facility, although it wasn't instantaneous — it was two days later — how is that not a critical incident? Like in terms of timing and the regulations, how much time do folks have to report that critical incident? Can it be backdated? Those kinds of things. So what happens, what opportunity is there to . . . So it wasn't reported as a critical incident but the question is,

should it have been reported as a critical incident?

Hon. Mr. Reiter: — Sorry. I thought I addressed that but I maybe didn't. First of all, I should mention too though, you said, and then passed away a couple of days later. I'm not sure about that; I don't know the timeline. But when I was under the understanding that it wasn't addressed as a critical incident, I was extremely concerned. Mark subsequently has sent a letter to the Health Authority asking for an investigation review to be done of that, and he might want to add to that as well.

Mr. Wyatt: — Yes, I've written to Beth Vachon who is the vice-president of quality, safety, and strategy for the Health Authority, generally just indicating that this is an issue that's been raised both through the media and the legislature, that it was not reported as a critical incident. Based on the ministry's assessment, we feel that there is the potential for this to have been reported as a critical incident and asking . . . The specific request is that they reassess whether it should be reported as a critical incident.

The fact that significant time has passed, from our perspective, you know, I think there is an important message when it comes to the reporting by the Health Authority that even if — and I don't want to speak specifically about this situation — but even if there is a conclusion that harm was not directly related to something like a power outage, if there is the potential for harm where, whether it's electronic monitoring or other kinds of safety protection that is dependent on obviously having power in place, or I mean there's any number of potential risks that could take place if you have both a power outage and your backup generator is not functioning. So from our perspective that, you know, that has the potential for being a critical incident. Because critical incidents do not have to actually result in patient harm. They can be a situation where there is a close call, a near miss, where there's a problem that does need to be addressed and that root-cause analysis needs to be undertaken to prevent that future harm from occurring.

Ms. Chartier: — I think that there's . . . I'm glad to hear you've written a letter. But I think that there's been some advocacy for months now on this issue, both with quality of care . . . Like it didn't just come up in the legislature and it hasn't been via me, but there's been some advocacy both with the quality of care coordinator, with an MLA from that respective area. There has been some work.

So I think I'm just trying to understand, and forgive my ignorance here of the regulations, what's required of a critical incident and is this . . . So what I'm hearing you say, that there is the possibility to go back and have something classified as a critical incident?

Hon. Mr. Reiter: — Mark's going to touch on the process. But before he does, you know, to all the points you just made, that's fair. All those steps I think needs to be part of what's looked at. If there were errors made or if the ball got dropped somewhere, we need to know, because we need to rectify to make sure it doesn't happen again.

So to the point about going back though, I'll get Mark to touch on that.

Mr. Wyatt: — The legislation actually requires that critical incidents are identified within three days of their occurrence or within three days of becoming aware of a potential or of what they're reporting is a critical incident. There are many situations where you don't learn about a critical incident until some time has passed and other events bring that to the attention of the Health Authority. And so, I mean, I think our expectation is that these are reported.

There's a lot of this, you know . . . There are a lot of factors that go into whether something is reported as a critical incident. I think different, clearly different interpretations are made by different individuals around whether something should be classified as a critical incident. There's a lot of exchange that takes place between our provincial quality of care coordinators and the delivery system about what should and shouldn't be classified as a critical incident.

And that's an ongoing exercise of interpreting what is considered to be falling under the purview of the legislation. But from our perspective — and that was the reason for following through with the letter — there is value in having something classified as a critical incident. And especially in a situation where there is an ongoing, you know, obviously ongoing concern being raised by the family about the decision that was made at the time not to have it formally reported in that way.

[17:45]

Ms. Chartier: — Is there a stat? So the family's had a struggle trying to get it reclassified as a critical incident. Is there . . . I know this isn't, like, something that happens all the time, thankfully. But is there a process that one would follow if you had a loved one, and when something happened and you felt like it was a critical incident and it wasn't classified as one? Is there a process that one would follow?

Mr. Wyatt: — I mean the standard process is to have it reported and to contact the quality of care coordinator in the location where the care was provided. In a, I guess, in a situation where something has not been reported through the site contact, you know, that we do receive calls about patient safety concerns in the ministry. Our provincial quality of care coordinators will deal directly with patients. And so that's another avenue for people if they're, I guess, not satisfied with the response that they've received from a local quality of care coordinator.

Ms. Chartier: — I think the problem is that it literally has been months of this individual doing, and this family doing, everything that I would have as an MLA said you should do this, this, this — like in our advocacy that we embark upon as MLAs representing folks — and to no avail. I think that that's been . . . So that's why I was wondering about process, like what the heck needs to happen for this to happen?

Hon. Mr. Reiter: — I, you know, I'm looking forward to the meeting with them. You know, I want to hear what they have to say about that. But I think, you know, your point on that is valid and I think that's what I'm hoping the, you know, Mark having SHA review it. I'm hopeful that, as I said, if that's the case these kind of things shouldn't happen and, as you put it,

thankfully they don't happen very often. But we need to strive to make sure they never happen.

Ms. Chartier: — And just, and when was the letter written to SHA?

Mr. Wyatt: — It was actually sent today and we've asked for a response by June 8th.

Ms. Chartier: — Sorry, by . . .

Mr. Wyatt: — An initial response by June 8th.

Ms. Chartier: — By June 8th. Okay. Thank you for that. I'm just going to move on here. I appreciate that.

Just a totally different topic here again. In terms of payouts — and I think we'll have to get into this a little bit more next week — but in terms of payouts from the amalgamation, have all the severance been . . . In conversations with a few people, what I'm hearing is the payouts for severance haven't all happened but in fact SHEPP [Saskatchewan healthcare employees' pension plan] is allowing, or there's income continuance that's taking place instead of one month's severance. So I just wanted to confirm that's the case.

Hon. Mr. Reiter: — Sorry, continuance instead of . . .

Ms. Chartier: — Continuance for some folks who would have been severed in the amalgamation, that they are getting . . . they've been allowed income continuance rather than getting one lump sum.

Mr. Hendricks: — So in a couple of cases, or at least one I know about, we've kind of bridged people. We've allowed them to continue on so that they bridge then to retirement so that they qualified for SHEPP. But I'm not sure . . . You said salary continuance?

Ms. Chartier: — Income continuance, yes. This admittedly is not my area of expertise, the pensions and how this would work. But what I've been told is that — and maybe you can clarify this for me, and there may be really valid reasons for doing it — but that people who've been severed haven't necessarily received their lump sum severance. But it appears that they're being allowed income continuance instead of getting the lump sum. And again there may be valid reasons, but I'm just trying to clarify if that's happening.

Mr. Hendricks: — So maybe two comments. One is that you're referring to the settlements as lump sum. They're not always lump sum. In some cases they're structured. So you'll received a lump amount, and then you'll receive payments over a year or so. And, you know, there are a couple of variations on that that we've done to accommodate specific circumstances. In terms of one that would fit the bill for what you're describing, there's only one case so I cannot talk about it because that would be a violation of employee information or whatever.

Ms. Chartier: — Yes. Yes. But it is happening. Has everybody been offered . . . Again forgive my ignorance; this is not my area of expertise by any stretch of the imagination. So who and, like, how do you decide what someone's going to be paid and how they're going to be paid with respect to their severance?

Mr. Hendricks: — So there's a formula that we use and it's based on the Public Service Commission's formula.

Ms. Chartier: — For the amount?

Mr. Hendricks: — Yes. So it's a combination of their years of service, age, that sort of thing. And so we apply that formula — or the SHA has, not us — but across the system.

Ms. Chartier: — So that's on the amount. But on determining how it's paid out, how does that happen?

Mr. Hendricks: — So generally we've tried to structure settlements so that a smaller lump sum is paid out; then we pay it out over a period of time. The reason being is that, you know, generally in executive positions there's obligation to mitigate. And so if the person, you know, ends one day and then they go out and they become the CEO in Manitoba the next day we would say, whoa, whoa. You know, that would reduce our requirement to pay that severance down. And so we have those requirements in the contract and so less is going out the door.

Now in a couple cases — and I can't remember exactly how many — again it was, you know, a slight alteration was made based on a pension consideration usually, to try and not create hardship for these people that were asked to leave.

Ms. Chartier: — And is everybody offered that opportunity, instead of taking one lump, or is everybody treated the same? Or you're looking at circumstances?

Mr. Hendricks: — Yes, it would be very . . . Like the case you mentioned about the income continuance, clearly there was something that we felt was of value in continuing that relationship for a period of time, right. In the other ones, it would be a very specific, you know, circumstance or issue, like you know, a person has two months until they're eligible for retirement or something, and that sort of thing. So we've taken that into account.

Ms. Chartier: — Okay. When you say there's value in continuing the relationship, it's . . .

Mr. Hendricks: — For a period of time.

Ms. Chartier: — For a period of time. Can you explain what that means, like for the individual?

Mr. Hendricks: — Well I can't talk about the specific case and the individual, but you know, there's just a situation where at certain times people would be involved in a particular project that is sunsetting. And you know, they are willing; we're willing. And so at the end of the day, yes, they are exiting the system, but we've allowed . . . We've not said it has to be on this date, right.

Ms. Chartier: — Okay. No, that makes sense. I know, I'm conscious of the time here. I know when I've asked for things in the past, I just want to clarify, that often we spend the first 10 or 15 minutes of the next committee meeting going through them. I'm wondering if it's possible for those things that I've asked

for, if — I know there was one that you couldn't deliver possibly next time — but for those things that you've committed to, if it would be possible to get them in a form that could be tabled, just to save us some time, and then have the opportunity to . . . Because it's very difficult when you're reading them and reflecting on them, but if they could be tabled with the committee, that would be very helpful.

The Chair: — If you're going to table anything, we ask for eight copies, and other ministers have offered that they would table within 30 days.

Ms. Chartier: — And just with all due respect, I think there was a commitment to deliver these things by Wednesday.

Hon. Mr. Reiter: — We'll try and do it as quick as we can. We'll table. Sure. Yes.

Ms. Chartier: — Yes, so we're able to continue on the conversation over the next couple of weeks. That would be very helpful.

Hon. Mr. Reiter: — We'll try and do as much as we can. If they can't have it all, we'll draw it to your attention, but we'll . . .

Ms. Chartier: — You bet. Sure. No, for sure. You've always been good.

Mr. Hendricks: — Just for clarity, though, the one thing that I said might take a little bit longer. That group of mental health things, where we'll actually have to go to the . . . do data runs, that will probably all fall in that group, that we will have those next week probably. We'll start the work, but . . .

Ms. Chartier: — Okay. Whatever you have, that would be very helpful.

Hon. Mr. Reiter: — Whatever we have, we'll table next week. Yes.

Ms. Chartier: — That would be great. And in that category of questions . . . And I know we're out of time here, but I'm interested in total severance payments in 2017-18 in all of the former RHAs [regional health authority] and the Saskatchewan Health Authority, and the number of employees severed, and the number of former employees that have been terminated but severance has yet to be paid.

So again, total severance payments in '17-18 in the RHAs and the new Health Authority, the number of employees severed for each RHA, and the number of former employees that have been terminated but severance has yet to be paid, and also total severance payments in 2017-18 for eHealth, the number of employees severed, and the number of former employees that have been terminated but severance has yet to be paid.

So I wouldn't mind starting the conversation on Wednesday on severance payments if possible. And if that . . . that would be great. I don't want to short myself time here, but it looks like that's what I've just done. I think, yes, with a minute to go, we probably shouldn't start a new conversation.

The Chair: — Okay. Thank you very much, Ms. Chartier. Do you have any closing remarks that you want to keep short?

Ms. Chartier: — No, thank you. I look forward to further answers and I appreciate your time today. Thank you.

The Chair: — Mr. Minister, do you have any remarks?

Hon. Mr. Reiter: — Sure. I thank Ms. Chartier for the questions, the committee members and the staff for their time, and our officials for their time. And we look forward to the discussion continuing next week.

The Chair: — Okay, we have reached the end of our agreed-to time for today. I would ask a member to move a motion to adjourn. Mr. Steinley has made a motion to adjourn. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned to 3 o'clock tomorrow afternoon . . . no, sorry, to the call of the Chair. Okay.

[The committee adjourned at 17:59.]