STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

Mr. Dan D'Autremont, Chair
Cannington

Ms. Danielle Chartier, Deputy Chair
Saskatoon Riversdale

Mr. Larry Doke
Cut Knife-Turtleford

Mr. Muhammad Fiaz
Regina Pasqua

Mr. Todd Goudy
Melfort

Mr. Warren Steinley
Regina Walsh Acres

Hon. Nadine Wilson
Saskatchewan Rivers

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[The committee met at 15:00.]

The Chair: — Okay, welcome to the Human Services Committee. I'm Dan D'Autremont, the Chair and the MLA [Member of the Legislative Assembly] for Cannington. With us this afternoon, we also have MLA Muhammad Fiaz, MLA Todd Goudy, MLA Warren Steinley, and the Hon. Nadine Wilson, as well as MLA Danielle Chartier for the opposition.

Before we start today, we received information from the Ministry of Health in regards to questions asked on May 9th, 2018 committee meeting, which I will table: HUS 44-28 Ministry of Health: Responses to the questions raised at the May 9th, 2018 meeting.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will now begin considerations of the estimates and supplementary estimates — no. 2 for the Ministry of Health. We will now continue our considerations of vote 32, Health, central management and services, subvote (HE01). Joining us as well is MLA Larry Doke.

Minister Reiter and Minister Ottenbreit are here with their officials. Please introduce your officials and make your opening comments.

Hon. Mr. Reiter: — Thanks, Mr. Chair. I have at the front table with me the Hon. Greg Ottenbreit, as you indicated, and Deputy Minister Max Hendricks. We have a number of other officials here that I'll ask to introduce themselves as they take place at the front.

And as far as opening comments, Mr. Chair, I read a number of them into the record last week, so I have no further comments.

The Chair: — Very well. We will continue our consideration of vote 32, Health, central management and services, subvote (HE01). Are there any questions? I recognize Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. And I have to say I have to start by thanking everybody here for last week when I was not well for your willingness to do this this week instead. I really appreciate that, so thank you. I have a little bit more of a voice than I did a couple weeks ago. So thank you for that.

Getting to where we ended last time around severance payments in the regional health authorities, I'm wondering if you've got those numbers.

Hon. Mr. Reiter: — We've tabled . . . I apologize, I'm not sure. We tabled all the information we had available.

Ms. Chartier: — Okay, I don't yet have those.

Hon. Mr. Reiter: — I think they were just tabled, like just a minute ago.

Ms. Chartier: — Oh yes. And those are included in what was tabled? In a moment, when you're conferring around other questions, I'll take a look at that. Okay, I will wait a moment here.

I usually don't like to bring casework here, but I did have a difficult case — and I actually have a consent form — that I think plays into the larger concerns around dermatology waits. So if you'd like, I will pass the consent form on to you here.

But I have someone with whom I'm working who has a condition that he has spent many days . . . I'm looking for your advice on how best to deal with this particular case. He has a condition where he has had to have lesions removed multiple times in hospital, and this young man now . . . You know what? Maybe I'll just read the letter from his sister into the record, if that's all right, and then we can go from there:

> Hello Danielle. Thank you for listening to our concerns. My brother, Ryan Mooney, went to the ER at RUH in Saskatoon on March 3rd. He had surgery to address lesions caused by hidradenitis suppurativa. He was kept in hospital for three nights and then released. He was prescribed antibiotics and pain medication.
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> He had to return to the ER at RUH on March 20th, as his incision had become infected. Surgery was performed a second time and he was kept overnight. He was released again with another prescription for antibiotics and pain medication.
>
> He has since attended City Hospital every day to have the packing removed and replaced. He returned to RUH for an appointment with a surgeon on April 11th. The surgeon at that time made an urgent referral to a dermatologist, as his condition can lead to cancer if left untreated. Upon not hearing regarding the referral to the dermatologist, he called the dermatologist's office on May 7th to confirm that they had received the referral and inquire as to the appointment date and time. The dermatologist's office told him the wait-list was six to 12 months unless it was urgent. He explained the referral indicated it was urgent. He was told unless he has skin cancer, it's not urgent. He explained his condition leads to cancer if left untreated. He was told to call back when he has cancer, otherwise the wait time is 6 to 12 months.
>
> My brother continues to go to City Hospital daily to have the packing removed and replaced. In addition, he continues to form new lesions and the existing ones become infected on a regular basis. He has not been able to work since March 3rd. He is unable to sit down, walk long distances, or lift any kind of weight. He is a utility tree trimmer. His job requires him to be able to walk long distances and lift and operate a chain saw. Also because he has had open lesions since March 3rd, he is unable to work because it would be impossible to keep the area clean and open. In addition, he continues to be in daily pain.
>
> The dermatologist he is waiting to see also provides cosmetic procedures. There are often new reviews on the dermatologist's website as to the Botox and lip injections

> he is providing to non-medical clients while my brother sits on a wait-list. He asked to be placed on the cancellation list, and they said that's not available to him.
>
> The wait time to see a dermatologist has made it unable for him to work. He's applied to EI sick benefits but has not yet received a payment. He's accessing the health care system daily but those measures are not curing the problem, and the nurses at City Hospital have told him there's nothing they can do to stop this condition, prevent new lesions, or prevent cancer. It is the dermatologist who can do that. Please let me know . . .

And then she provided a consent form.

So I know a few weeks ago we talked about the dermatology wait-lists, or wait-lists in general, and from '15-16 to '16-17, the waits have gone up from 104 to 131 days as the average wait, so a 24.8 per cent increase.

So this particular individual, before coming here, I suggested she call the quality of care coordinator, which she did. And she said to me:

> Called the Health Authority quality of care coordinator. They said private dermatology clinics are not part of their jurisdiction. So I called the College of Physicians and Surgeons quality of care office. They said they can't tell specialists how to triage their patients. There's nothing they can do.

So I don't know what else to do for this poor fellow, and recognizing . . . I'm looking at the website, the Saskdocs website. When we look at hiring of dermatologists, even to this particular clinic to which he was referred, it says, employer: Saskatchewan Health Authority, Saskatoon.

So I've a few questions there. I don't understand how the quality of care coordinator couldn't help this individual, but I'm hoping . . . I mean, this person is at their wit's end, and I'm wondering what direction you would have for him.

Hon. Mr. Reiter: — We just discussed this quickly. Our officials, I don't think, are aware of the specific case. Thank you for the consent form. I would suggest this: I'll ask officials to look into it, to contact him, and to see if there's something they can do to help to expedite it. We'll certainly follow up, but nobody here is aware of the specifics of the case.

Ms. Chartier: — No. And I hadn't had an opportunity to send it to you in advance.

But I guess my question more generally . . . So obviously some doctors are fee-for-service and some are contract. But even so, when you've got long waits for someone like a dermatologist . . . So obviously this individual's condition is difficult, but who dictates to, in this case, the fee-for-service dermatologist what work he or she can or can't do?

Hon. Mr. Reiter: — Sorry, can you just help me to clarify? The doctor he went to first, what had you . . . Because you made a comment, I think, when you were reading about the quality of care, said they couldn't direct a specialist or something along that line.

Ms. Chartier: — I will pass this on to you. She says the call to the Health Authority quality of care coordinator, they said private dermatology clinics are not part of their jurisdiction. So then she called the College of Physicians and Surgeons, and they said they can't dictate how things are triaged.

And the clinic to which her brother was referred, there's a posting on Saskdocs for this same clinic, where it says, employer: Saskatchewan Health Authority. So I'm just wondering, sort of in the chain of command and wait-lists, how all this works, how the quality of care coordinator couldn't help this individual.

Hon. Mr. Reiter: — So to your point on the quality of care coordinator, we're thinking an instance like this they should have been able to help. So you know, our officials, if we could get a copy of that, if we could — thank you — because it'll help them when they contact the person who'll look into this. But we think they possibly could have helped. Maybe there was a misunderstanding or miscommunication or something, but we think there's a number of things they likely could have done that may have assisted. And I'm just going to get Max to elaborate on that.

Mr. Hendricks: — Yes, just to support the minister's comments, the reason that the website would say that they're employed by the Saskatchewan Health Authority is that they actually are privileged by the health authority. And so the quality of care coordinator could have potentially used a couple of roads here. They could have spoken to the department head of dermatology and expressed the situation, if they're aware of it, and then also they could have phoned the physician as well and used moral suasion, you know, kind of thing. That's not completely unusual for quality of care coordinators to do that. I'd be happy to look into this case and see if something's been dropped here because this sounds unusual to me.

Ms. Chartier: — I guess it raises some huge flags for when someone does get a referral. I mean many of us have been referred to specialists and you don't expect when you call the specialist to be told that unless you have cancer, it's not urgent enough. So, I appreciate; I will pass on. But I guess I'm interested to know around dermatology then here in Saskatchewan, how many dermatologists do we have here in Saskatchewan practising right now, and where are they practising?

[15:15]

Hon. Mr. Reiter: — So I'm told that there are six in Regina; there's five in Saskatoon; and then there's some in training right now that I'm going to get Max to elaborate on.

Mr. Hendricks: — So I think it's fair to say that dermatology is a difficult-to-recruit-to specialty, and this has been recognized for some time. So several years ago the ministry, in collaboration with the SMA [Saskatchewan Medical Association], started purchasing seats for dermatology outside of the province. So just going back . . . And we've had some success.

So in ’09-10 we purchased two seats. Those physicians are now practising in Saskatchewan. In ’10-11, we purchased seats. Those physicians — because it comes with a return in service — are practising in Saskatchewan; ’11-12, so on. But part of our challenge in recent years . . . And like ’14-15 was the last year that we were able to match a residency position in dermatology outside of the province, and they’re still in training. But again, since ’14-15 we haven’t had uptake to that particular specialty. It’s very hard to recruit to. So we have a couple that are still in training and have return in service to Saskatchewan as well.

Ms. Chartier: — So ’14-15 you said was the last year you were able to match a residency position out of province, so . . .

Mr. Hendricks: — It’s the last year that a resident selected dermatology as their specialty and we sent them out of province.

Ms. Chartier: — Okay. So that was the last time someone from . . .

Mr. Hendricks: — Well we’re still making them available. It’s just there’s been no uptake, right?

Ms. Chartier: — Okay. In terms of those six in Regina and five in Saskatoon and then the students, are all of those fee-for-service, the six and five? Are any on contract?

Mr. Hendricks: — We have one that’s attached to the College of Medicine that’s funded through the academic clinical funding plan, and the rest are fee-for-service now, physicians in Regina.

Ms. Chartier: — Could one of the solutions as well . . . Perhaps having someone on contract, like actually . . . So you’ve got . . . I mean, lots of cosmetic procedures are becoming more and more common. And I know they identified at this clinic that, I mean, that’s part of their daily mix, which means people who have some more serious conditions than wrinkles are not getting triaged properly. So any other thoughts on solutions that could address that?

Mr. Hendricks: — So I think that, you know, over the last several years, since 2007, we had only five dermatologists in the province. And so now we’ve had 11. So through our practice of buying seats in other provinces, we have had some success over that time.

The number of discrete patients — so this isn’t the number of visits but the number of discrete patients — has increased by almost 7,000 as well. And so the patient load has also grown.

The notion of buying . . . or of putting people on alternate payment or salary or whatever, you know, is something that we can explore, and we have explored hard-to-recruit-to specialties. Sometimes income is a factor, what they’re making on a fee-for-service basis.

And you know, you mention the private work that they do do. In a few specialties, we do have situations where there’s uninsured work that falls outside of our payment schedule and physicians do that, or elect to do that on their own and are permitted to do so. So even an alternate payment physician or a contract physician could elect to do that on their Friday off or whatever. But you know, it’s certainly something that, you know, I think we would be open to look for, but you’ve got to have a willing buyer as well, right?

Ms. Chartier: — For sure, but obviously this is a very real issue. So I’ve highlighted here for you a young man who can’t work because he’s got a skin condition that he’s been told that he has to wait. We know that we have long dermatology waits. I’m wondering about, sort of, the levers that the ministry has. Is there an expectation around . . . So when a dermatologist, for example, gets privileges or privileged, you said, by the health authority, how much — I don’t know if output is the right word — is expected to be delivered when it comes to dealing with the ever-increasing waits in dermatology?

Mr. Hendricks: — So generally, in terms of getting privileged by the health region, there would be certain conditions. One would be, generally they participate as part of a call group if that’s required in dermatology. I don’t know if there is a call schedule for that off the top of my head. But you know, I think what we’re trying to do across all of our specialty groups is we’re trying to encourage physicians to work together as part of a pooled referral system so that physicians are kind of . . . They have a central intake and they’re triaging patients consistently. And so dermatology is one of the groups, unfortunately, that we haven’t worked with.

But I think the minister said in the House last week that one of the things that we would like to do with the Saskatchewan Medical Association, through the fee-for-service payment structure or other payment structure, is to try and look at what levers we might have to incentivize physicians to see people within a certain time frame. So again, this case really . . . It sounds unusual to me that a person would be classified as urgent. There’s other stuff besides cancer that are serious skin conditions. And I’d like an opportunity to check into it because it does sound unusual to me.

Ms. Chartier: — So you don’t . . . I think I want to get back to that idea of . . . So you said that one of the requirements when you’re privileged is to participate in a call roster if there is a call roster. Is there any . . . So I could be privileged by the health authority and for all intents and purposes have one day where I’m doing public work or fee-for-service work and do private stuff the rest of the time?

Mr. Hendricks: — So we were just actually looking. There is no call schedule for dermatologists. It’s not something that’s actually required that frequently.

But in answer to your question about privileges, like, obviously there are factors that go into that. You know, you have to be in good standing. You have to be licensed. You have to do all these things. But generally, a fee-for-service physician doesn’t sign an undertaking with the health authority that they’re going to do a certain amount of work or work a certain number of days.

This is one of the reasons that there’s a lot of interest in trying to look at alternate models of payment where you do have accountabilities and you say, you know, you clearly understand

that you're going to work four or five days a week in, you know . . . in the academic clinical funding plans you're going to do this much research, this much teaching. And so it's a place where we would like to go. But generally, like if you look at what these dermatologists' number of patients, output isn't the biggest concern here. They're seeing a lot of patients.

Ms. Chartier: — A lot of fee-for-service patients. They're seeing a lot of fee-for-service patients?

Mr. Hendricks: — Yes. Yes.

Ms. Chartier: — But the waits still though are . . . Where did that go? It's grown by I think 24 per cent year over year. My chart looking at, like . . . So dermatology from '15-16 to '16-17 had grown quite a bit. Let's see if I can find . . . Dermatology, this was through, I think we got this through an FOI [freedom of information]. Dermatology, so I had said at the beginning of our comments average waits in '15-16 were 104 days, and in '16-17, 131 days which is a 24.8 increase. So obviously dermatology waits are going up.

Mr. Hendricks: — And so I've outlined that we do have a strategy to try and interest people in the field of dermatology, but it is an extremely difficult field to recruit to.

One of the other factors obviously that would drive an increase in wait times is with an aging population, more skin diseases, illnesses, that sort of thing. But you know, it's something that the ministry's acknowledged and that we have program in place to try and recruit more. And we can look at, you know, alternate payments but, again, in certain specialties we've had more luck in alternate payments than we have had in others, and dermatology's been one of those.

[15:30]

Ms. Chartier: — I'm going to suggest though, so you have a strategy and that strategy sounds like it helped initially. You said you'd . . . But if '14-15 was the last year you were able to recruit students into . . . So if that's your strategy for increasing dermatologists and the waits are growing, obviously there's more that should be done.

Mr. Hendricks: — Just to clarify, I'd mentioned that there are two in training. So in this fiscal year, we have one that will complete their training at the end of the year and will have a return of service to Saskatchewan. And then again in the following year, we will have another one that will complete training and begin practising in Saskatchewan to fulfill their return of service. So we've got a couple more that are coming on stream. So you know, like in a fairly hard-to-recruit-to specialty, going from 7 to 13 by the end of two years from now is a pretty . . . like almost doubling the number of specialists in that field.

Ms. Chartier: — In 11 years, or it'll be 12, in 12 years.

Mr. Hendricks: — Yes, but we've doubled, and our population hasn't doubled, you know. And it's just, it is a challenging field to recruit to.

Ms. Chartier: — So is it that students aren't picking, or you're not able to buy those seats anymore for dermatologists?

Mr. Hendricks: — I might just clarify that in the last couple of years we haven't been able to buy seats. We've asked other medical schools to buy seats, but they're holding on to them themselves. And we don't have a training program in dermatology here.

Ms. Chartier: — Okay. So I would suggest then, maybe if that was the strategy, then again thinking about the alternate payment method, or ways that you can have a designated dermatologist actually doing mostly public work, I think would be beneficial to reduce these waits, it sounds like.

Mr. Hendricks: — To be clear, these doctors are doing mostly public work, right? They would be spending . . .

Ms. Chartier: — Do you have those numbers for me?

Mr. Hendricks: — I don't know what they're doing in the private sector. But I would assume by their incomes that they're doing a fair amount of work in the public sector.

Ms. Chartier: — Yes. What I do see is numbers increase, a 24.8 per cent increase in wait times, and a case of someone who's struggling with a condition that needs support. And so clearly there are issues. But I appreciate your time on that, and Mr. Mooney I'm sure will appreciate some contact and some support in trying to figure out his issues with being bumped on his . . . or not being able to get to see the dermatologist unless he has cancer.

I'm going to change gears here a little bit, well actually completely. I just want to ask about, some questions have been raised for me about the cannabis bill and its implications in the health sector. So when it comes to the definition of a private place — so obviously I'm expecting that there's been some conversation between Justice and Health — but in terms of the definition of a private place where cannabis will be allowed, does that include long-term care homes and special care homes?

Mr. Hendricks: — So the decision about how exactly this will apply to marijuana is still being discussed. But we would anticipate that, based on the legislation, that it would mirror policies for smoking, where allowed, and where certain spaces are permitted outside of a long-term care home, provided that the resident is appropriately supervised and safe. Some have smoking areas. I think that there's a possibility that cannabis might be used in those areas. It might already be used for medicinal marijuana. So I think it's something that we will be clarifying in our guidelines as we know more about this and how it rolls out.

Ms. Chartier: — Just to clarify then, so smoking in long-term care homes right now, you can't smoke in your own room, but there are designated areas in long-term care facilities?

Mr. Hendricks: — Outside.

Ms. Chartier: — Outside.

Mr. Hendricks: — And there are a couple of regions, I just think of the Saskatoon Health Authority that had a policy about

smoking on their property. And I would have to just clarify whether there was an exemption for long-term care, you know, where they could smoke in a designated spot on the property.

Ms. Chartier: — So there might be an exemption in Saskatoon because I know there was some challenges around the Dubé Centre and smoking and that.

Mr. Hendricks: — Yes, so I just don't want to say it was a universal policy because some regions did have a policy that you couldn't smoke on their property at all.

Ms. Chartier: — Okay. So is there any way to clarify this?

Mr. Hendricks: — Yes, we can clarify that. We're checking into it now. But you know, even affiliates like in long-term care, the majority of Saskatoon homes are affiliates and they wouldn't have necessarily that Saskatoon Health Authority policy apply, right? Or the former Saskatoon Health Authority.

Ms. Chartier: — Okay. How about personal care homes?

Hon. Mr. Reiter: — Sorry, they're just checking. We'll have an answer for you, hopefully shortly. But in the interest of time, if that's okay, we can come back to that.

Ms. Chartier: — Okay, that sounds good. Sticking to the cannabis theme here. So currently you can vape in public places if you're vaping nicotine. But I think some municipalities have banned vaping, but the province hasn't banned vaping. But the bill bans consumption of cannabis in all public places. Does that include, like I'm assuming that includes vaping because you can vape cannabis, but you can't tell what you're vaping.

So I'm wondering about the intersection of Health policy and Justice policy around cannabis. So if we haven't banned vaping of nicotine or tobacco — forgive my ignorance here — but they've banned vaping of cannabis, or your government has . . . Help me understand how we're going to enforce that.

[15:45]

Mr. Hendricks: — Okay, we have the intersection of a couple different things happening here. So as you're aware, the federal government introduced vaping legislation and we understand it was given Royal Assent today. So that will put certain restrictions on the age at which people can buy it, that sort of thing, how it's produced, promoted, all of that. In terms of . . .

Ms. Chartier: — On tobacco?

Mr. Hendricks: — On vaping generally, right, like it extends beyond necessarily nicotine-based because it's saying it doesn't allow candy kind of flavoured stuff. Like they're trying to reduce the attractiveness of young people getting involved with it.

But our presumption, and we need to clarify, is that because smoking of cannabis would be restricted in public places, much like smoking is now, that smoking cannabis via an e-cigarette or a vape would also be illegal because you're still smoking cannabis in a public place, just via a different method.

Also municipalities are able to, you know, introduce bylaws further restricting it, where it's done, like Regina — in parks, on pathways, that sort of thing. And so there are several mechanisms.

And this is kind of an evolving thing which is, you know, the whole de-normalization of tobacco, vaping as well, you know, trying to make sure that it's not done publicly in view of children or where it can harm others with second-hand smoke.

Ms. Chartier: — I still don't think I have a clear picture of that then. So if the cannabis bill bans consumption of cannabis in public places, will that . . . I think enforcement will become incredibly difficult, because how do you tell the difference between someone vaping cannabis versus nicotine? So is the plan to perhaps ban vaping altogether? I mean, because I think it's going to be completely unruly when it comes to enforcement. How do you enforce that?

Hon. Mr. Reiter: — You know to your point on enforcement, that's a valid concern. But you know, I would say it's not unlike the issue that enforcement agencies have right now with alcohol. You know, people can . . . It's illegal to drink alcohol in public places, and yet if somebody put alcohol in a different container, how do officials know, right? So your point's valid. But it would be . . . I would say it's a similar concern that we have with alcohol.

So you know, this is a work-in-progress. We may end up making changes down the road. It's uncharted territory, not just for Saskatchewan but for all the provinces. But you know, your concern I think is very valid. But we're going to end up working through this.

Ms. Chartier: — So there is no plan to ban vaping to address that concern then at this point in time?

Hon. Mr. Reiter: — You know, while it's always difficult to predict what the future holds, to my knowledge no other province has banned vaping. The federal government hasn't. And I think the argument, while there's obviously some real concerns with it . . . I can see you're about to disagree with me. I may stand to be corrected. To my knowledge there wasn't though, so maybe it has, but I think the counter-argument in some cases are saying that there can be some benefits to it. It can be used as a smoking cessation product. So I think that's probably part of the counter argument.

Ms. Chartier: — I just, from my understanding, vaping nicotine in public places has been banned everywhere except Alberta and Saskatchewan.

Hon. Mr. Reiter: — I wasn't speaking just in public places. I meant banned outright.

Ms. Chartier: — Yes, oh no, and I'm not talking about banning vaping outright. I'm talking about banning it public places and cannabis . . .

Hon. Mr. Reiter: — Oh I see, okay.

Ms. Chartier: — The interplay of how this cannabis legislation . . . So Alberta and Saskatchewan are the only two provinces

that haven't banned vaping in public spaces. So I guess what I'm hearing is that . . . Have you talked to Justice about this? Like have you had conversations? Obviously there's public health interest here and enforcement issues that'll come into play. Have your ministries spoken with each other about this?

Hon. Mr. Reiter: — I certainly haven't at the political level but I'll just check if there's been discussions at the officials level.

Ms. Chartier: — Thank you.

Mr. Hendricks: — Just to clarify, you're questioning whether we've had discussions with Justice with regards to vaping.

Ms. Chartier: — Vaping in public places and the interplay with nicotine and cannabis. Because cannabis is, in fact, banned in public places which will mean you can't vape, but we currently can vape nicotine in public places. So I'm wondering if . . . There's an interplay of nicotine and cannabis here, and one is going to be disallowed, but you can do the other.

Mr. Hendricks: — I think there's several factors here. Like you know, we do have a tobacco control Act in Saskatchewan that stipulates you can't smoke in a car with a minor or a person under 16 years of age. It says that you have to be a certain number of feet from a doorway or an air intake. And then we've left it to municipalities to further define what public places are. You know, some provinces actually have just attached or mirrored their cigarette legislation or their tobacco control legislation, and attached vaping to it.

But there are a couple of things. First of all, we knew that the feds were working on a bill around vaping. We didn't know what it was going to say until very recently. Also we don't have a final bill on . . . a federal bill on marijuana and some of the amendments that might've been attached by the Senate. So you know, some of this is not jumping too quickly into an area that we don't fully understand yet.

You know, I think there's also the issue . . . You know, you mentioned vaping. So this federal legislation doesn't allow for oils to be used in the initial tranche, like that's coming down the road. So presumably to vape, it would have to be in a liquid form or whatever, right. That would make it an illegal substance at that point. So it's not even legal in Canada yet as a liquid product, as an oil, right?

Ms. Chartier: — But that doesn't mean that it won't be . . .

Mr. Hendricks: — I know, I know. But these are evolving things and, you know, I think generally society is becoming much less tolerant to tobacco use in public and that sort of thing, and vaping or whatever, and second-hand effects of that. So you know, legislation and rules are evolving.

Ms. Chartier: — And I know the minister mentioned harm reduction. I've met constituents who have stopped smoking and vape now. But I've also met kids who've started vaping and start smoking.

And that's why the feds are banning flavoured tobacco, where we haven't gone. And I know that there's been . . . Many organizations have asked the province. I don't think since . . . It's been two ministers ago since there's been any tobacco control changes. I think it was under Mr. McMorris, minister McMorris, around the banning . . . So it's been a few ministers ago and a few years ago, and vaping has sort of picked up steam. Excuse the . . . that wasn't on purpose. But it's happening more often. I have a kid who is 10. I know that kids in elementary school are vaping.

And now we have cannabis legislation here in Saskatchewan. We have cannabis legislation here in Saskatchewan that says that you can't consume it in public places, which will include vaping. So I'm just trying to . . . What's the holdup? And I know municipalities have been, they've looked at the Cancer Society's report card and seen how we do. And they know, they've looked at polling from citizens and how people feel about tobacco, increasingly. And municipalities have moved on banning many things in public spaces, or tobacco, and have pushed that envelope a little bit further. But I'm wondering what the holdup is here.

[16:00]

Hon. Mr. Reiter: — I think it's fair to say, you know, the position's been that we have allowed municipalities to make that decision. Some of them have. You know, as far as sort of items of interest on the cancer front, you mentioned about some of the changes to smoking under minister McMorris. It's not just smoking. You know, under Minister Duncan, there was the youth tanning . . .

Ms. Chartier: — We had discussions here in committee prior to him doing that. Yes.

Hon. Mr. Reiter: — Yes. So certainly, you know, these are the kind of decisions that I think . . . It's always a work-in-progress, right? We want to discourage youth smoking. We want to discourage everyone smoking obviously. But that's a position we've taken. Obviously there's still far too many people smoking, far too high of rates of cancer, but Saskatchewan's not alone in that. Obviously rates of smoking are too high, I would say, everywhere in Canada.

Ms. Chartier: — But I believe we have some of the highest youth smoking rates in the country. It just absolutely amazes me that you'd start smoking, but clearly there are factors and things that contribute to that. But what I'm pointing out here is that we have a piece of Justice legislation that will have interplay with Health here and I was trying to figure out if at the . . . So you've said at the ministerial level there hasn't been any conversation. So I was wondering at the . . . you'd said you were going to check at the deputy minister, or at any level, whether or not these conversations between Justice and Health have happened around vaping in public spaces, particularly around cannabis and nicotine

Hon. Mr. Reiter: — So as you're well aware, the impetus for this wasn't the province. It was federal legislation that drove this, so we're obviously — as every other province is — just attempting to react to it. So there is an inter-ministry committee of officials, and I'm just going to get Max to elaborate on that.

Mr. Hendricks: — Yes, well a couple of things. We would want to check with our officials who have attended that

committee, but obviously that was a multi-ministry. It involved Health, Justice, SLGA [Saskatchewan Liquor and Gaming Authority], Policing, you know, Agriculture — everybody and their dog who could possibly be attached to cannabis. And so there were several things discussed at that committee. And you know, I attended a few of the meetings, but I don't necessarily recall whether that was raised specifically at a meeting I was at. But I can check with officials and it would just be a recollection, right, of what . . .

Ms. Chartier: — Again, I'll move on here, but I just want to flag this, that this might be something that you work on here as we go down this road. Looking at the tabled documents, a couple of things, and I'll have to review my list. But a couple of things that are missing at this point was the waits to see a child and youth therapist in the mild to moderate, unless I'm missing something on my tabled document. When can I expect to have that?

Hon. Mr. Reiter: — Sorry, my understanding . . . And actually this is the first chance I've had to see even too. Officials have been working on it; they've tabled what's complete. But the rest of the questions that aren't here, we'll get them to you as quick as we possibly can.

Ms. Chartier: — Okay. I'd like to priorize that one.

Hon. Mr. Reiter: — Sorry, which one was that?

Ms. Chartier: — Around children and youth actually being offered, not just the first appointment . . . The waits to see a counsellor or a therapist for the mild to moderate children and youth.

But also I know the severance payments, we talked about the severance payments at the end of last week. So I would have expected that that might have been something that, in light of the amalgamation and coming into estimates, that you might have had readily available?

Hon. Mr. Reiter: — So those weren't tabled, but I understand Max is prepared to do those verbally now. He can . . .

Ms. Chartier: — Okay. So I had asked the 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 not yet been paid. So do you want to break that into pieces?

Mr. Hendricks: — Okay.

Ms. Chartier: — Should we . . . Well tell me what you have on severance.

Mr. Hendricks: — So total severance for '17-18 in the RHAs and the SHA [Saskatchewan Health Authority] was $3.606715 million, so 3,606,715. And your second question was?

Ms. Chartier: — Okay. The number of employees severed?

Mr. Hendricks: — Okay just wanted to make sure I get this right. So as of today we've had four CEOs [chief executive officer] that have been paid. One has signed a settlement agreement but is still working. And one is still under review. Ten vice-presidents or their equivalents, sometimes they go by different titles in smaller regions or former smaller regions, have received severance. The number that have been terminated where severance is to be paid is three.

Ms. Chartier: — So terminated with severance to be paid, they haven't been paid yet?

Mr. Hendricks: — Because they haven't reached a settlement or they're challenging the settlement or I mentioned one case where the person, his last week, is continuing to work for a period of time.

Ms. Chartier: — I have a couple of questions about that in a moment. And you said one was under review?

Mr. Hendricks: — Yes.

Ms. Chartier: — And what does that mean?

Mr. Hendricks: — That they've challenged what we've offered them. So there's legal proceedings or stuff like that going on.

Ms. Chartier: — The CEO has challenged what's being offered?

Mr. Hendricks: — Yes.

Ms. Chartier: — And three VPs [vice-president] that have challenged or haven't received their settlement yet?

Mr. Hendricks: — Yes, they just haven't been . . . the severance hasn't been paid out yet.

Ms. Chartier: — Because they haven't reached a settlement yet?

Mr. Hendricks: — Yes, it's pending still.

Ms. Chartier: — Okay. The one that has the commitment to carry on, I know you talked about sunsetting agreements and things like that. How do you decide, how did you determine that that one individual should stay on?

Mr. Hendricks: — Well they were involved in what was, you know, a considerable project to the province, an important project to the province. It's also time-limited. And you know, that person did not apply to be the CEO of the SHA, and so they were accepting of the fact that they were going to be severed. But through mutual discussion, decided that we would keep them on for a very important project, just to make sure that that went ahead.

Ms. Chartier: — And forgive my ignorance here, but do they work at . . . So they're severed?

Mr. Hendricks: — Yes.

Ms. Chartier: — But what's the expectation of them in terms of the work?

Mr. Hendricks: — So the person is working 50 per cent time. They're not working full time. And they're working at their current salary but as of the beginning of June, they will be severed.

Ms. Chartier: — Okay. Okay. Well I will come back to that, I think, a little bit later, but I think I'll pass it on to my colleague here.

Mr. Meili: — Okay. Thank you, Danielle.

The Chair: — Just . . . You don't just start asking questions. I have to recognize you. I recognize the Leader of the Opposition, Mr. Meili.

Mr. Meili: — Thank you for the recognition, sir. And thanks very much, Danielle. Hello to everyone this afternoon, and all the officials, thank you for being here.

I just had a few questions about some things that are going on in emergency medicine around the province, in particular at RUH [Royal University Hospital] and St. Paul's, wondering what's going on in terms of tracking of the number of patients within the emergency rooms who are admitted already to hospital and are occupying beds, so the BC4s [bed called for] or BNAs, whatever the terminology would be.

I guess the first question would be, how is that being tracked? Are we tracking the percentage of beds that are in an emergency room that are filled by patients that are already admitted and waiting for beds on the ward?

Hon. Mr. Reiter: — Our Assistant Deputy Minister Mark Wyatt will give you the details on that.

Mr. Wyatt: — In relation to Regina and Saskatoon, both regions track this on a daily basis. And in Saskatoon's experience, they actually update a web page where they post a number of different wait time metrics, including the number of patients who are in emergency waiting for an in-patient bed. And so that is regularly tracked and, in this case, publicly reported.

In Regina I don't believe they have the same equivalent website but will do the same kind of . . . I think at least twice a day they will do that assessment around the number of patients who are admitted in the emergency department waiting for an in-patient bed. And with Prince Albert, they're doing a similar kind of assessment each day.

[16:15]

It's part of the bed management process as they're trying to find available beds for patients and look at where patients can be admitted to an available bed in an appropriate unit within the hospital.

Mr. Meili: — And would you have that broken down by hospital site in Saskatoon as well? Or just city-wide?

Mr. Wyatt: — The data in Saskatoon is broken down by hospital site. So we should be able to look at both RUH and St. Paul's and be able to present on a daily basis what their capacity's looking like.

Mr. Meili: — Though in terms of those numbers, maybe just to try and get a sense of exactly the pressures, how many days in a year would those sites be with over half of the beds occupied by patients that have already been admitted?

Mr. Wyatt: — Sorry, could I just ask you to reframe that question for me?

Mr. Meili: — Sure, sure. So if you're looking at say, RUH, how many days in a year would you look at that emergency room and say they've reached over half of the beds being occupied by admitted patients?

Mr. Wyatt: — In answer to your question, I don't know that we can provide you with the information here on the spot around, you know, the number of days over the course of a year where you would have capacity in the emergency department exceeding 50 per cent, or any threshold level, on a daily basis.

Again, I mean we can look at the . . . I've got the printout. I believe it was for today, and it will tell you that at RUH today there were — and this was printed out earlier this afternoon actually, so it would be some time midday — that there were 27 active patients, 5 patients who were waiting for consults, and 22 patients who were identified as bed called for, the BC4 category. So out of a total of 54 patients, 22 were in the BC4 category. As I say, we don't have that on a run chart or just captured for an entire year-long period.

Mr. Meili: — Yes, so today you'd have that snapshot moment where there was about 40 per cent of the patients who were already admitted. And what we're hearing from providers within the emergency room, in particular RUH, is that it's a very frequent occurrence that you would actually get 100 per cent of the beds being filled. You wouldn't have any way to tell me how often that's happening at this point.

Mr. Wyatt: — No, I can't tell you the frequency at which that would take place.

Mr. Meili: — Perhaps we'll ask you to . . . If we could ask you to please look into that and see if that's information you could provide later, so we have a sense of how often we're reaching full or even beyond capacity.

The other question and a related question would be, how often, I guess, are you tracking? How often do you have patients being treated in unconventional situations? So whether that's care within the hallways, care within converted spaces that were intended for other uses such as a janitor's closet, or patients being treated while they're still seated in the waiting room chairs.

Mr. Wyatt: — Again I can't give you a, you know, a picture over the full year, but again coming back to the daily reports that we see, one of the categories that is reported on a daily basis is over capacity in various units across the hospitals. So in RUH, again looking at today will tell you that there is, you know, there is an over-capacity patient on a 5th floor unit, a 6th floor unit, another 6th floor unit. And so that information, it's tracked, it's presented routinely through these daily reports and

over capacity on different units is part of the data that's captured and publicly reported by the Saskatchewan Health Authority now under the previous . . . previously by the health region.

I mean, I think we are aware that there has been a continual over-capacity problem with RUH. It points to the various strategies that we are introducing to try to deal with patient flow, to try to both bring down the over-capacity rates within the hospitals by bringing down over capacity within the hospitals. That's the way by which we should be able to relieve some of the pressure in the emergency department.

And so that strategy, those various strategies including, you know, some of the work we're doing — not in RUH as yet but in St. Paul's — looking at the introduction of accountable care units as one of the ways of trying to more effectively manage the patient flow, reduce length of stay, improve the transitions of care, reduce the number of readmissions. That's certainly one of the main areas where we are focusing with the wait time reduction funding that we've had over the last couple of years.

And the other area would be the emphasis around trying to deal with the problem, not in terms of, you know, once patients have reached the hospital, but trying to prevent some of those admissions moving into the facility and also to be able to pull patients out of the hospital more quickly by increasing the home- and community-based services that are available.

I think most people recognize that the problem that you see in the emergency department or even in your in-patient beds is often a product of issues in your home- and community-based capacity rather than necessarily finding that solution within the walls of the hospital. And I think we're trying to work on both avenues, both patient flow within the facility as well as the investments that we're making into home- and community-based services.

Mr. Meili: — Options to keep them out in the first place and get them back home sooner. That makes a lot of sense in a bottleneck situation.

I'm just going to come back a little bit to the previous question around . . . You talk about the over capacity and the way that those are identified and tracked. Would that include the sort of thing . . . again reports that we're hearing from practitioners of patients with CTAS [Canadian triage and acuity scale] 2 level chest pain being assessed while they're still sitting in a waiting room chair. Would that be tracked in the over capacity? Or would that be missed in that tracking?

Mr. Wyatt: — I don't believe the . . . certainly the daily reporting that we see gets into that level of detail in terms of the patient condition. It will show you, you know, where there is a patient in over capacity. So by looking at the unit you may be able to determine the type of unit, whether it's a medical unit, whether it's a surgical unit. There are also identified pods within the hospital, which is one of the areas where patients, over-capacity patients are admitted to those pods. And you know over time they have been able to staff those in a way that they're not putting an additional burden on a particular unit by having pods that are anticipated to be used for usually medicine patients who are in an over-capacity position.

Mr. Meili: — I realize you don't have the information for the whole year at your fingertips, but just to clarify, when you look at either the over capacity or the percentage of patients that are within an emergency room waiting for admission, or admitted and waiting for a spot on the ward, is RUH your toughest spot? And are there other hospitals outside of Saskatoon and Regina that are facing similar levels of pressure, Prince Albert or other sites?

Mr. Wyatt: — I would say RUH is probably our toughest spot when it comes to over-capacity patients. So you know, again just to give you a snapshot of today, the number of "admit, no beds" — they're either known as "admit, no beds" or "bed called for" — Regina would have two at RGH [Regina General Hospital] and three at the Pasqua. So very small numbers right now. Obviously that fluctuates on a seasonal basis. If you were looking at, you know, a period in the height of flu season those numbers are going to be higher.

Saskatoon at RUH on the other hand, in the range of 27 "admit, no beds," "admit, no bed" patients, so it is most definitely the biggest pressure point in terms of that over-capacity situation. In the case of Prince Albert, they move in and out of over-capacity situation and so we most definitely do have times where Prince Albert will be in that same position, again not at the same magnitude of what you would see with RUH. And across the province for the most part we haven't seen significant wait time pressures in the emergency and the same kind of backlog. There are occasions where some of the regional hospitals will move into over capacity but nothing as a chronic problem as we've seen with Saskatoon and RUH in particular.

Mr. Meili: — One of the things that I've noticed or been hearing about is the practice in RUH in particular of specialists who are on service, maybe they're on a CTU [clinical teaching unit] medicine service, and they use that time to also see some patients and use emergency beds to assess patients. So patients who are outpatients aren't going to be admitted but are basically having a specialist clinic visit in the emergency room. Is that a practice that's being tracked and is there a plan for how to make better use of those emergency room spaces?

[16:30]

Mr. Wyatt: — The situation that you've identified where a specialist will ask a patient to meet him or her in the emergency room, we're certainly aware that it takes place. I don't have data here today. I'm not sure whether it's something that the hospitals themselves tracks. They're, I guess, routinely called the to-meet category of patients, where the patient is to meet the specialist in emergency. It's, I guess as we understand it, it's usually a case where a patient may not be, you know, may not be a high-acuity patient but there is some underlying concern where they want to, or the specialist wants to get that patient in to usually have some diagnostic workup as soon as possible. And so the idea of having them meet a patient in the emergency rather than their clinic office leads to these patients being seen in emergency.

It's certainly something that I know that the hospital administration has identified as a concern. I know that there have been some considerations around whether they can create,

you know, a clinic setting where rather than having to wait and wait for an office consult, again at a more considerable wait time or where the specialist doesn't have some of the diagnostic tools available to him or her in their office, providing another, you know, another ambulatory clinic type setting in the hospital.

It would allow them to see those patients in the facility, take advantage whether it's, you know, whether it's cardiology or neurology or whichever specialty area, and allow them to move into the facility, you know, have the access to some of that diagnostic testing on a shorter time frame than what might otherwise be available without putting that pressure on the emergency department itself. Because those patients do end up taking up some of the space and some of the capacity of the emergency even if they are under the care of the specialist.

Mr. Meili: — That strikes me as something that likely should be tracked in order to actually direct whether or not you want to open up a different unit, whether you want to have a different model. Likely those are numbers that should be flagged in a way. And if, as you look further into your available data, if you find anything that does indicate that that is being tracked, we'd certainly appreciate that information.

Another concern brought to my attention is around Royal University Hospital's staffing overnight. As you know, the pediatric emerg shuts down overnight. But you also have a period of four hours where you only have one emergency physician on staff. And with the way that shift change, etc., happens, that often means you've got one physician as the only intake physician for six to even eight hours.

I'm just wondering, you know, with our biggest tertiary care centre, our top trauma centre in the province, how it's determined that that's the level that's safe for patients and safe for the provider as well.

Mr. Wyatt: — The decision around the staffing for the emergency department at each facility would be made by the health authority administration. And obviously, you know, one of the key considerations is going to be looking at the number of patients who are presenting at different times of the day. And we know from the longer term data that usually it is those evening hours that are typically, you know, the highest demand times of the day. And then as the patients are seen and either admitted or discharged, the demand drops off in the overnight hours.

I mean, in response to your question about, you know, how the decision is made, clearly the demand on the department is going to be one of the most important factors in determining the staffing level.

We're just looking into, and haven't yet been able to confirm, just what the staffing is for the overnight period at RUH and St. Paul's. We'll need to follow up and get back to you in terms of just what the, you know, whether we can confirm that there are times when they are working with a single physician in the emergency.

The other thing that I think is worth noting is that over the past year we have introduced a pilot. It began with a pilot in Regina, now has moved to Saskatoon, with a trauma team and a designated trauma team lead. And so in a situation where you are working with, you know, one physician in the . . . If it's one physician in the overnight or two physicians in the overnight period or other times of day when the demand is higher, the purpose of the trauma program — and we're piloting it right now in Saskatoon — is to have a trauma team lead who is available.

They would be able to respond within a 20-minute period to a trauma situation and be able to relieve some of the demands on the physicians who are staffing the emergency department. They obviously have their existing patient cohort that they are working with, trying to move through the different stages of care. And so when a trauma comes in, it certainly does place a lot greater demand on those emergency physicians and, you know, generally slows down the overall flow of patients through the emergency department.

So as I say, the trauma pilot that we've introduced in both Regina and Saskatoon, we haven't completed the evaluation as yet, but our expectation is that, you know, we would be looking to see that the demands and the ability to maintain the operations of the emergency department can continue by virtue of having an emergency . . . by having that trauma team lead, who would then come in and assume the responsibility for a patient coming in in a trauma situation.

Mr. Meili: — Very good point. Having the trauma team there is a good way to take that really high-pressure patient away from the clinical officer and allow them to focus on the rest of the emergency room.

You noted that you are planning to look into what the exact staffing situation was overnight. I would suggest looking in at the same time — and perhaps we can come back with that question — to the number of patients being seen by that physician in the period where there is a solo physician, and see what the trend is there.

Continuing with the overnight questions. Pediatric emergency. Just want to clarify that when the new children's hospital opens that there will be 24-hour pediatric emergency coverage with a pediatric emergency physician. So not the current situation where the adult docs are covering overnight.

And I guess I'll put my follow-up in there just before you go into conference. Assuming that's the case, how many docs will be required to maintain that? And how many do we currently have in terms of pediatric emergency physicians able to provide those services?

Ms. Lautsch: — Hi. Karen Lautsch, Ministry of Health. So in response to your question, yes, there will be 24-7 peds coverage in the new children's hospital, and there will be pediatric emergency physicians available. The plan is to have a total of 7.5 pediatric physicians available for the hospital. There are currently about 4.5 FTEs [full-time equivalent] available, and we're going to recruit an additional three.

Mr. Meili: — Nice to see you again, Karen. How are you doing? I will just follow up with some pediatrics numbers. How many general pediatricians do you have now working in

Saskatoon, and how many full-time equivalents, just to be sure of the full capacity?

[16:45]

Ms. Lautsch: — Hi. So what I've got for you is, I don't have the specific for Saskatoon, but what I do have is the general ped number for the province. So general pediatricians in Saskatchewan, there's about 80 licensed right now. For the children's hospital specifically, the plan is to have 10.8 general pediatricians working specifically at the hospital. There are currently 9.8 working — those are FTEs — and there's a recruitment currently under way for the one outstanding FTE.

Mr. Meili: — Thank you. And continuing with emergency room questions. I understand from earlier this month that the overall time waiting to be seen by an initial physician from '13-14 to the present day is up by 9 per cent. That's for the province as a whole. Down 16.7 for waiting for an in-patient bed, down 7 for the length of stay in the emergency room, and then up 5.6 per cent for the length of stay in the emergency department when not admitted. I'm just wondering if you could give me a breakdown on those numbers for Saskatoon as well and, if possible, right down to the facility level. It'd be good to know in RUH what those data points would give us.

Mr. Wyatt: — Okay, in response to your question, just looking for information specifically related to Saskatoon in terms of their wait times in those four categories.

Under the first category of emergency department length of stay for admitted patients, the percentage change, year over year, for Saskatoon from '17-18 compared to '16-17, provincially was a reduction of 17 per cent. In Saskatoon it was a 22 per cent reduction.

Moving to the next category, which was the length of stay for non-admitted patients, in Saskatchewan the overall change was a 1 per cent increase. In Saskatoon it was a 3 per cent decrease.

Moving to the physician initial assessment, year over year, '17-18 compared to '16-17, again in overall Saskatchewan it was a zero, no change. In Saskatoon it was minus 12.

And finally in terms of the time waiting for an in-patient bed, the overall change in Saskatchewan, year over year, was a reduction of 18 per cent. And in Saskatoon that was an increase of 5 per cent.

Mr. Meili: — Thanks very much. Just to clarify, I'd asked about the change from '13-14, which was the start of the current initiative. So that would be helpful to have. And if that chart from which you're drawing is something that could be tabled, that would be really helpful to be able to look at that in more detail.

Mr. Wyatt: — Okay.

Mr. Meili: — But if you are able to give me the numbers from '13-14, what the change has been in Saskatoon, that would be most helpful.

Mr. Wyatt: — Okay. It might just take me a moment here. Under those same four categories, if we go back to the baseline of 2013-14 in Saskatoon particularly, we will have seen an increase in all four categories, starting with the physician initial assessment.

Coming back to Saskatoon for the physician initial assessment, it's gone up from 2.4 hours to 2.9 hours, which represents a 20 per cent increase. For time waiting for an in-patient bed, it's gone up from 21 hours to 23.8, so a 13 per cent increase. For ED [emergency department] length of stay for admitted, that has gone up by 15 per cent, and for non-admitted, that has gone up by 12 per cent in Saskatoon. So I mean the trend over the longer period of time does see increases across the board in each of these categories in Saskatoon.

Mr. Meili: — One other question regarding emergency rooms. City Hospital, as you know well, closes overnight. Hearing of a number of occasions on which you've got patients who are, I guess, in that BC4 category, but there's nowhere to admit them at that hospital. So they're actually having to stay in emergency overnight. And there's some concern there in terms of safety where there's no longer a physician on staff that's able to accommodate or cover those patients, where the nursing staff is perhaps or perhaps not the ideal level of training to be supervising that emergency patient overnight, that patient ill enough to be admitted.

And then I guess the other piece there would be you're having to have additional staff on site, you know, a minimum of two staff members on-site overnight to be following just a single patient. So I'd be interested to know, is that situation being assessed? What's the added cost of those overnight patients, and are there any concerns regarding the safety in terms of coverage?

[17:00]

Mr. Wyatt: — I guess the frequency with which you would have a patient remaining in the care of the City Hospital emergency department, we don't receive data that tracks that. We do not have that data from the Health Authority. I mean we do know that there are times when Saskatoon City can serve as a relief valve. I guess the most visible example of that would've been the recent Broncos' bus crash where they were in a position to keep the emergency open for an extended period of time and take some of the pressure off of the other two hospitals. But otherwise it's not something that we track.

And obviously, you know, again looking at the overall pressures on the Saskatoon emergency departments, we recognize that that is, as we've talked about, the area with the greatest additional challenge with the added number of patients who are coming into the emergency department, and the demands that are placed on RUH in particular. And so, you know, our overall strategy is trying to relieve some of those demands on the emergency department and to try to ease the expectations on St. Paul's and RUH and eliminate the requirement that City Hospital is used as a relief valve.

Mr. Meili: — And again that looks to me like a piece of information that would be important to look into and try to obtain how often is that situation occurring where you've got a patient overnight, as well as what the associated cost and the

risks are, whether we are able to be really confident in the safety of that situation.

Jumping a little bit out of the emergency room, looking at pediatric audiology. We are understanding that the waiting lists for pediatric audiology have increased significantly and also that we've had some changes in staffing, the one audiologist working at Royal University Hospital having now left for the private sector, and also the one ear, nose, and throat physician who was doing cochlear implants in Saskatoon having left the province.

So I guess my question would be, just to sum up, have we got someone else doing that service or have we lost that service entirely with the departure of Dr. Shoman? Do we have the audiologist at RUH and what kind of waiting lists are we facing in terms of audiology services?

Hon. Mr. Reiter: — There was several parts to your question there. So Mark's going to do the first part; Kimberly will do the second part. Okay?

Mr. Wyatt: — I'm going to answer the questions related to the departure of Dr. Shoman and the issue around cochlear implants. Right now there is an active recruitment under way to replace Dr. Shoman. While there are other ENT, ear, nose, throat specialists in Saskatoon, he was the only one who was doing that particular procedure around with cochlear implants. And so that position is posted on the Saskdocs website. They are trying to replace that position.

With his departure, there was a plan that involved redirecting patients either to other ENT specialists within Saskatoon where they could perform the procedure, for which they were waiting for Dr. Shoman's services. Or in the case of many of the cochlear implant patients, they were moved to a specialist in Alberta who agreed to accept a number of his patients moving from . . . who were waiting for either the consult or the actual procedure itself.

So I guess to answer the question, we have not yet replaced an ear, nose, throat otolaryngologist who has that ability to do those procedures. But the Saskatchewan Health Authority is recruiting to that position. And I'll ask my colleague to answer the second part of . . . or it was the first part of your question.

Ms. Kratzig: — Hi. I'm Kimberly Kratzig, an assistant deputy minister at the Ministry of Health. And I guess I just want to clarify this specific question. You sort of had a couple of elements to that, so I want to make sure I'm answering the right one.

Mr. Meili: — Sure. So one is to look at what the waiting list is now in Saskatoon for pediatric audiology services. And also we understand that the main pediatric audiologist who was at Royal University Hospital has left that facility to work in the private sector, and what the impact of that will be, both on the waiting list but also on the universal screening program.

Ms. Kratzig: — Sorry, I don't have the specifics on the audiologist that left that you're referring to. I can tell you that we have been working with Saskatoon and Regina audiology programs on their waits and access. So Regina does not have a wait at all for pediatric audiology and Saskatoon does have a wait. So we've been working with the Saskatoon team and the Regina team and the Ministry of Health to assess what's happening in each of the sites to determine again why one has a longer wait than the other.

A few of things that we are looking at doing is . . . and this has been follow-up from the events we had with the teams. I'll just walk through some of the improvements that we're looking at. One is around education and public information to families. So looking at things like creating videos for families so they know what to expect when they're coming to an appointment so they could have done any of the pre-work that's been required. Notifying families when we do have a receipt, or pardon me, when a referral has been made. So double-checking that they're available to attend an appointment to eliminate no-shows rather. We are looking at designing various brochures and resource material. Again we had families who were with us in our improvement event to look at reducing the wait times and this is one of the things that they identified: more information for families who are coming in.

Another area that we're looking at is streamlining the referral process. So again ensuring that appropriate referrals are made at the right time and that families are able to meet them. Making sure that people who are referred to this program don't actually need to be going to an ear, nose, and throat doctor. So there was some confusion about referrals, I think, at some point.

They are also looking at short-term load levelling. So when we have in Regina no wait and in Saskatoon a long wait, looking at would there be families who would want to be referred to the Regina clinic for pediatric audiology testing. Longer load levelling would be including looking at tracking information provincially, seeing where those resources are and better understanding the private sector capacity. So that has been another area that the ministry's been looking at in terms of who in the private sector is able to do pediatric hearing tests and how they can be utilized as well. So those are some of the areas that we are looking at.

[17:15]

Mr. Meili: — And just what was that wait-list in Saskatoon? What was the wait?

Ms. Kratzig: — The wait-list in Saskatoon . . . if you just give me a second . . . There are 526 people waiting in Saskatoon for pediatric audiology evaluation and the wait in Regina is nil.

Mr. Meili: — So what would be the average time of wait then if you've got 526 waiting? When would a child referred now be likely to be seen?

Ms. Kratzig: — A point of clarification on the number of people waiting: 183 of those have already been seen and they're waiting for, like sort of ongoing follow-up. So it's not a first hearing test. I just wanted to clarify that's been flagged for me.

In terms of the actual wait our data is, from what we can tell, you could be experiencing up to a 24-month wait. But we're not sure exactly who those people would be because we know that there's also prioritization within that list. And again, people in

Regina would be seen within three to five days.

Also, information that I have does say that Saskatoon was operating with a vacancy from July 2017 to March 2018. So that implies to me that there may have been a second audiologist hired, which again we'd want to follow up, based on your information that someone actually left. So we can follow up on that.

Mr. Meili: — Thanks very much. And that's a pretty big difference; three to five days to two years, that's definitely worth some attention.

I'm going to just thank the ministers, thank all of the officials for your time. Thanks to the committee members, and Mr. Chair, and I'll pass the mike over to my colleague. Have a good evening.

The Chair: — I recognize Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. So we're going to change gears here and talk about eHealth a little bit. So eHealth had a pretty substantial expenditure, there's a pretty big increase in eHealth this year, going from 64 million basically to 102 million, closer to 103 million. But I do note that there's an entirely new board, and there are many, many interim positions. So, I understand, an entirely new board as of January. Interim positions, we've got multiple interim positions, and then I think Mr. Hendricks actually is the acting CEO.

Hon. Mr. Reiter: — That's right.

Ms. Chartier: — So I'm just wondering, like I'd like to get a little bit more perspective as to what's going on at eHealth.

Hon. Mr. Reiter: — Sure. I'll start, and then if I miss something or something specific like, just follow up.

There is almost a new board; I believe one existing person. The CEO position is vacant. There is a search going on right now, as we speak, and Max is interim CEO. What did I miss? Sorry, what else were you checking into?

Ms. Chartier: — There's several other interim positions listed on the website as well.

Hon. Mr. Reiter: — Right.

Ms. Chartier: — So, interim directors . . .

Hon. Mr. Reiter: — So to the interim positions, yes there's more positions interim than I certainly would like to see and that I think would be appropriate. We're in a situation right now . . . There's been an interim CEO for quite a period of time, and so I think a lot of those decisions probably have been put off.

Max is interim while we do the CEO search, while the board does the CEO search. But certainly I've asked him — he's not just going to be a caretaker, you know — I've asked him to do whatever he feels is appropriate, including with positions. And I think he'll be looking at a number of those positions and, I would assume, making a number of them permanent or making some changes as he feels necessary.

Ms. Chartier: — Okay. Was there not a CEO in place for a short while in 2017?

Hon. Mr. Reiter: — Well there had been a CEO until, I'm thinking, I'll say summer.

Ms. Chartier: — Susan Antosh was the CEO, but did someone not follow her in that position for a . . .

Hon. Mr. Reiter: — Yes, in an interim role though. That was interim. It wasn't permanent.

Ms. Chartier: — It was not a permanent position?

Hon. Mr. Reiter: — No, it was Kevin Wilson. He was in an interim position. That was right.

Ms. Chartier: — And when was Kevin Wilson in that role?

Hon. Mr. Reiter: — It was, we're guessing, around June or July of last year until April of this year.

Ms. Chartier: — Okay. I understand too that there's been . . . Sorry, backing up for one second. The board, I had understood there was an entirely new board, but you said that there's one consistent board member. And who is that?

Hon. Mr. Reiter: — Milo Fink.

Ms. Chartier: — Milo. From . . .

Hon. Mr. Reiter: — Dr. Milo Fink.

Ms. Chartier: — He's not listed in the 2016-17 board. When did he come on board?

Mr. Hendricks: — Milo's been on the board forever.

Ms. Chartier: — Okay. Oh, sorry. My apologies. Okay, so why the new board?

Hon. Mr. Reiter: — I'd say varying reasons. I think there were, if memory serves, I think some positions were expired or had expired. And frankly, much is changing in health care, including in IT [information technology], and eHealth is going to be responsible for IT for health care across the province. So obviously their role is going to be expanding, so it just seemed that it was an appropriate time for a bit of a change of direction.

Ms. Chartier: — So how many of those positions had expired?

Hon. Mr. Reiter: — I'll have to check. I'll just clarify to a previous question while they're looking for this information, just advise that when I had said about Kevin Wilson going in June or July, that is accurate. He did, but there was some overlap with the previous CEO, Susan, until I think it was September, October. So just so you're aware, what I said was, I believe, was correct but there was some overlap with the two as well. Okay?

Ms. Chartier: — Okay. Yes.

[17:30]

Hon. Mr. Reiter: — Can we follow up with you? We can probably have that for tomorrow. I think we can have that for tomorrow, if we could. As I recollect, there was some terms that either expired or were about to expire, and there had been some resignations. So there were some vacancies already, so it was kind of a combination of things. But if we can follow up, I should be able to have that for you at the start tomorrow.

Ms. Chartier: — Yes, that would be great. I know you just had said that much is changing in health, health care, and eHealth is going to be responsible and the board's roles are going to be expanded. So I'm wondering what in particular about the new board of directors, what qualifications they have that will help? Like where are they coming from that will help you in that regard?

Hon. Mr. Reiter: — So I would describe it this way: I'll start with the Chair, Tyler Bragg. He's a former CFO [chief financial officer] in a health region. He's also former Chair of a health region. He was also one of the panel that did the recommendations on the amalgamation of the health regions. His background, in my mind, is superb.

And then you've got the board members that were selected. It's a fairly diverse group, I would say, with the mix of different backgrounds, some private sector background. There's a member on there who's former head of a Crown corporation. So I think it's a pretty good mix. I can go into more detail if you like. The bios are on the website though. I'm not sure if you want me to spend time doing that or not, but I'll leave that up to you.

Ms. Chartier: — Not necessarily their bios but just in light of what you had said that health care is changing and that they're going to be responsible and the role of the board was going to be expanded. So I'm wondering a little . . .

Hon. Mr. Reiter: — Sorry. If I said that, I misspoke. I was talking about sort of the role of eHealth expanding. You know, the role of the board is your normal governance role.

Ms. Chartier: — Okay. Just getting back to the eHealth executives in terms of those who are in the interim positions. We've got listed on the website two interim VPs and an interim director. I'm wondering how long these folks have been in those interim roles.

Mr. Hendricks: — Okay, one of the interim vice-presidents, Shaylene Salazar, has been there for about a year and a half. Her home position is in the Ministry of Health and so she continues to be seconded to eHealth. So she's got the title, interim. Roxane Eberle who's interim VP of culture and collaboration, we need to check the exact date. We think it's about a year. Dean Marshall is a newly appointed vice-president. He's also interim and he just was appointed a couple of months ago, so he's not on the website as of yet. And then the director I think that you're referring to is Davin Church, who was appointed on an interim basis when the person, the incumbent in that position left a couple of months ago to go to the SHA.

Ms. Chartier: — Okay. And you said Dean Marshall is newly appointed and is in an interim VP position?

Mr. Hendricks: — Yes. He's formerly out of Regina, and as part of this whole IT transition that we're doing with eHealth where we're bringing resources in from the Health Authority, he's assumed that role.

Ms. Chartier: — Okay, so the person who's seconded, like can you give me a little bit more reason why they'd be interim positions? I know that you'd said that when Mr. Wilson was there from the summer until just a couple months ago, so that would have been opportunity to hire permanent folks. But can you just explain a little bit further why they're interim positions and if the plan is to fill them permanently?

Mr. Hendricks: — You know, I think part of it's at is, we've had some departures from the organization and just given the fact that, you know, you had an interim CEO, Kevin Wilson was over there and maybe a reluctance on his part to staff those permanently. So as the minister said, one of the things he talked to me about when I went over there was that I would take a hard look at these positions and decide whether there's somebody who's kind of in the role doing a good job, solid, and we can appoint permanently.

Ms. Chartier: — Okay. You said the CEO search, the board's conducting that right now. When does that close and when are you expecting to do the hire?

Mr. Hendricks: — So the board met with a recruitment agency a couple of weeks ago and they're in the process of canvassing stakeholders right now to kind of figure out, you know, skills, attributes that they should be looking for. And so I'm assuming it'll be two to three months.

Ms. Chartier: — Okay. Just with respect to some of those vacant positions, I understand that there were two people let go here in Regina, then one in Saskatoon. So I'm wondering — quite unceremoniously let go — and there may be in fact criminal charges pending. So I'm just wondering if you could speak to that.

Mr. Hendricks: — Yes, there were some people that were terminated without cause.

Ms. Chartier: — How many?

Mr. Hendricks: — There were two in Regina and one in Saskatoon and . . . Well sorry, with cause. Actually just a second please.

Sorry, I misspoke. They were with cause and so no severances were provided. I should clarify the one employee's not an eHealth employee. He was on secondment from the SHA, so I can't really speak to any of the details of these. These are matters that are still under review.

Ms. Chartier: — Okay. That's convenient. So the two folks in Regina, can you tell me when that happened? Just for clarity's sake, I had heard that two people were ushered out quite unceremoniously. So just if you could, I'm looking for a few more details on this. This is an organization, as you said, that's got some pretty big responsibilities, so I'm just trying to get a sense of what's happening there.

Hon. Mr. Reiter: — I understand that so I'll let Max handle that because it is personnel. But I just wanted to say, when you said "that's convenient," it sounded sarcastic to me. I hope it wasn't intended that way because this is the way personnel matters are typically handled in government. There's confidentiality involved and so our officials are trying to deal with it appropriately.

Mr. Hendricks: — So we have to check the exact date, but it was, my understanding was early April.

Ms. Chartier: — Were all three early April? Were they all connected around the same issues?

Mr. Hendricks: — They were all severed at the same time with cause.

Ms. Chartier: — And is it correct that there is a police investigation?

Mr. Hendricks: — So at the current time, the investigation is internal and if there's a determination . . . and we are using outside counsel to support our internal review. If it's determined that we think we have something that would be of interest to law enforcement, we would turn it over to them.

And I do want, I actually do want to go back to that thing. I'm not trying to avoid the questions here at all. It's just that actually when you sever a person with cause, anything I say about that situation could be used later by that person.

Ms. Chartier: — Fair enough. I'm just trying to . . . So we have an organization that has lost three people in recent times because of some potentially difficult issues, from what I've been told. We've got a brand new board with all except for one member. We have many interim staff. We've got an interim CEO. We had another interim CEO.

And this is an organization, an external organization that's taking on some really important work, and has just taken over a good chunk of money from the health regions to be responsible for IT, so I do have some very big concerns. IT is at the heart of everything that happens in health care. We need software and technology for everything that happens. And the organization, with all due respect, seems not entirely stable at this point in time.

Hon. Mr. Reiter: — I would say, you know, your concerns are valid. The fact that while we're doing the CEO search, we have what I think is an excellent board in place now. We're doing the CEO search. That's a reason. Max already has a big workload; I didn't make that decision lightly that it would make sense to have him over there in the interim CEO role. It's to address a number of the issues you just pointed out and to help get a new CEO in and have a firmer footing for the organization.

Ms. Chartier: — It's also been flagged with me — and I understand that, Mr. Hendricks, you're in an interim position — but the fact that eHealth is an independent organization from government, that it's been flagged with me as a concern that there's some potential conflict of interest with the deputy minister of Health stepping into the role of an independent organization.

[17:45]

Hon. Mr. Reiter: — I'm going to have to ask you to clarify. I don't understand that line of logic. It's a treasury board Crown. It's not independent. As minister, I'm the minister responsible for it. I don't . . .

Ms. Chartier: — People who work in this area have flagged this as a concern for me.

Hon. Mr. Reiter: — Myself and our officials, I guess don't see that.

Mr. Hendricks: — I would be interested in what the conflict is because I actually thought of this myself, and I said, are there any conflicts, you know, just in making this kind of decision to go over there? You remember that I served as the board of eHealth for several . . . or board Chair of eHealth for several years and so have some experience with that organization. So that was kind of the thinking that went into it as to kind of stabilize it a bit before the new CEO comes in. But I'm not . . . I can't think of a conflict of interest regarding treasury board Crown. In fact, the minister could delegate to me theoretically, but that's a possibility.

Hon. Mr. Reiter: — Yes. I would just reiterate, I'm not sure where there was a conflict of interest that they'd be referring to. If you could clarify that, that would be great. But I don't know what their concern would have been.

Ms. Chartier: — No, fair enough. I appreciate your comments. I wanted to chat a little bit. There is a few different parts and pieces here, and I don't know if we'll get to all of them here today. But today in the House when my colleague asked you about Telus lobbying the two ministers, and you pointed to CHIP [citizen health information portal] and talked about Infoway and that there was a federal RFP [request for proposal] that had gone out. If you would chat a little bit about that, that would be great.

Hon. Mr. Reiter: — The concern that was raised in the House by your colleague, I think, was that Minister Ottenbreit and I had met with Telus. So I'll address that, and then I'll get Max to address the RFP issue.

So as I recollect, I would guess, give or take, I would think the meeting would have been about a year ago. There was, I think, two or three Telus officials at the meeting, and it was a general discussion on CHIP, which was the program that we had talked about.

Now the specifics to the RFP, I'll let Max speak to that.

Ms. Chartier: — That would be great in one moment. But just following up on in terms of the lobbyists registry and what's registered and what's listed, what is being lobbied, description, "Telecommunications and data storage and technology solutions. Pursue opportunities to contract with Government to provide information and communications technology solutions." So that was just, you're saying, specific to CHIP?

Hon. Mr. Reiter: — I'm certainly not a techie, so in my mind that's a very key part of this. I understand that CHIP will do

more than just sort of what I described it as. It's going to be a significant platform, but I would think Max can probably do a better job of clarifying that as well.

Mr. Hendricks: — So just around the procurement process for CHIP, eHealth signed a phase 1 agreement with Canada Health Infoway that provided $825,000 to do the exploratory elements of a citizen portal. So there was a public procurement process in the form of a request for strategic partnership via SaskTenders.

There were several companies that responded to that. After an evaluation, the vendors were short-listed and went through a further evaluation, including a demo and scoring process, and Telus was selected on that basis. The evaluation included not only members of eHealth but also included patients and citizens, so it was kind of based on the merits of the project.

And so now, you know, the question will be whether we go into phase 2 with Telus, which is the expansion of the citizen health portal.

Ms. Chartier: — Did SaskTel bid on . . . participate in the RFP?

Mr. Hendricks: — I have no knowledge of that and I don't know that we're even able to discuss that.

Ms. Chartier: — Okay. So that was tendered federally then?

Hon. Mr. Reiter: — It was on SaskTenders, so that would allow national, international . . . That would allow everyone to bid on it.

Ms. Chartier: — Okay. So your conversation with them, with Telus, was strictly about . . . So again just reading the description that Telus itself listed, or the lobbyist listed, your conversation with Telus was just about CHIP, even though . . . So around the RFP?

Hon. Mr. Reiter: — So that meeting was after that RFP was awarded, right, so there was the phases. So sort of phase 1 was complete, so obviously they wanted to see phase 2 move forward. You know, the description you read in the lobbyist registry, I understand that it's fairly broad, but you know, I think I can address your concerns. Like it was pretty clear to me what your colleague in the House was addressing, that it was sort of a concern that somehow this was going to lead to sort of, frankly, discussions around selling a Crown. It wasn't.

Ms. Chartier: — I think it was major contracts being awarded to companies other than SaskTel, I think was sort of the gist of the questions.

Mr. Hendricks: — Actually, like as part of this, because this funding is coming from Infoway, Canada Health Infoway, we have to engage in a competitive process so there's no favouritism for, you know, a local firm.

Ms. Chartier: — So why would Telus then have to sit down and meet with you about phase 2 of CHIP if it's a federal . . . It was on SaskTenders, but the money from Infoway is contingent on a competitive process.

Mr. Hendricks: — So phase 1 — I'm just going to go over this again — so phase 1, which was kind of completed in January of 2016, you know, pilot phase, that sort of thing. I can't remember exactly how many citizens were given access to the portal. I've got it; it's pretty cool. But then there was this whole phase 2 decision and discussion. And part of the challenge of phase 2 is that while we were eligible potentially for Canada Health Infoway funding, once that funding had evaporated in about three or four years, the province would assume some ongoing costs. So there was, you know, through budget and that sort of thing there were some treasury board discussions that have to take place.

At the same time, you know, there was kind of some information coming from Canada Health Infoway that said, you know, we'd prefer that you partner with another province, that sort of thing. In the end they decided that wasn't a kind of deal breaker. And so, you know, discussions are continuing to go on about whether this province will assume the ongoing costs of this once the federal funding expires. But we can't sign up for the federal funding unless we kind of can commit to this for the long haul.

Ms. Chartier: — Yes. Oh, for sure, but that still doesn't explain why, for the three or four years that there's still Canada Infoway funding and it's an open tendering process, competitive process, why Telus would have to meet to talk about CHIP. And I think we should just put on the record what CHIP is.

Mr. Hendricks: — They had already won the RFP basically, right.

Ms. Chartier: — For phase 1, for the pilot?

Mr. Hendricks: — So phase 1, once you've selected your preferred vendor, the assumption is that they would be carried forward and still your phase 2 vendor, that they would be allowed . . . If they demonstrated successfully in the pilot phase that they were meeting the objectives, they would carry forward into phase 2.

Ms. Chartier: — So can you tell me again what the meeting . . . So your meeting was following phase 1, following the pilot, about them carrying on for phase 2?

Hon. Mr. Reiter: — Yes. Again this is quite a while ago, but as I recollect it was exactly that. They want to proceed with phase 2. The decision's already made who would . . . They had won the RFP. The decision that we needed to make and still haven't made is the point that Max had said. So in sort of the upfront years, Infoway is paying the freight, but there's still going to be some cost to the province in the out years. So we want to make sure we're doing our due diligence and not blindly jumping into a program because there's some upfront federal money.

Ms. Chartier: — Okay. So just when are we anticipating . . . CHIP is for people to be able to access . . . I can't remember what. It's for people to access their own health records.

Mr. Hendricks: — Yes, a citizen health portal. Right now it allows you to access your laboratory information online almost

within hours after you go to get the lab test, depending on the nature of the tests, your prescription drug information. Eventually it will be . . . And you can have allergy information, all that sort of thing, record your own personal health information.

And we will be adding diagnostic information if we do proceed forward to the next phases, so it will become a pretty comprehensive . . . And you know, you can access it off your iPhone or home computer, that sort of thing. So the idea would be to expand it beyond that pilot group if it proceeds.

Ms. Chartier: — Okay. So for those things that you just mentioned, those are only accessible for that pilot group, the 1,100 or . . . I know it's in your annual report. So when is phase 2 expected to . . . When will you make those decisions?

Hon. Mr. Reiter: — We'll need to make them fairly shortly. I can't give you an exact date, but we'll make a decision in relatively short order.

Ms. Chartier: — Okay. I think the Chair is going to pull the pin here on us, so we'll carry on . . . [inaudible interjection] . . . Yes, I could hear. I could hear him behind me. So we'll carry this on tomorrow. Thank you again for your time.

The Chair: — Okay. Thank you very much. Since we're coming back and doing this all again tomorrow, I won't worry about closing statements. We will reconvene at 3 p.m. tomorrow. We need a motion by Mr. Steinley to adjourn. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned till 3 p.m. tomorrow.

[The committee adjourned at 17:59.]