STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

Mr. Dan D'Autremont, Chair
Cannington

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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: — Welcome everyone this afternoon to the meeting of the Human Services Committee, meeting May 1st, 2019. My name is Dan D'Autremont. I am the Chair of the committee and the MLA [Member of the Legislative Assembly] for Cannington. With us today we have, substituting for MLA Danielle Chartier, MLA Vicki Mowat; MLA Larry Doke; MLA Muhammad Fiaz; MLA Todd Goudy; MLA Warren Steinley; and substituting for the Hon. Nadine Wilson, MLA Warren Michelson.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Today we will be continuing the consideration of the estimates and supplementary estimates — no. 2 of the Ministry of Health. We will begin again with Minister Reiter and Minister Ottenbreit are here with their officials. And I would ask that the officials please introduce themselves before speaking into the microphones. Ministers, would you please introduce your officials and make your opening remarks.

Hon. Mr. Reiter: — Thanks, Mr. Chair, and thank you to members of committee. I'm pleased to have this opportunity today to speak about the Ministry of Health's budget. We have a number of ministry senior leaders here with us today. We have deputy minister of Health, Max Hendricks; Mark Wyatt, assistant deputy minister; Kimberly Kratzig, assistant deputy minister; and Billie-Jo Morrissette, assistant deputy minister. We also have a number of other senior officials here from Health, and if they have the opportunity to address questions we'll ask them to introduce themselves at that time.

This year's budget invests a record five and a half billion dollars in health care programs and services. This includes significant investments to support mental health and addictions and harm reduction; community-based, comprehensive, team-based care; and planning for future facilities in Prince Albert, Weyburn, and Meadow Lake.

Operating funding for the Saskatchewan Health Authority will increase to $3.6 billion, 113 million or 3.2 per cent increase from last year. This includes a $23 million increase for doctors, nurses, and staff to provide the best possible care for children at the Jim Pattison Children's Hospital, which is now 96 per cent complete and will open in Saskatoon this fall.

We've also allocated almost $8 million to the Saskatchewan Cancer Agency to provide more comprehensive cancer treatments and drugs to cancer patients. This additional investment represents a four and a half per cent increase in the Saskatchewan Cancer Agency's annual funding, for a total of $178 million. The new funding supports the addition of 18 oncology drugs to the formulary and the recruitment of additional oncologists. It will also help patients continue to have timely access to important cancer treatment, allowing them to achieve their best possible outcomes.

The Ministry of Health's '19-20 budget supports other key initiatives as well. These include investments in an organ donor registry, a satellite dialysis service in Meadow Lake, autism spectrum disorder individualized funding, and physician services. Seven hundred thousand dollars in new funding will support the creation of a satellite dialysis service in Meadow Lake. This will provide service closer to home for patients in the Northwest who currently travel to Saskatoon or other locations for treatment, and this expansion will enable the Saskatchewan Health Authority to provide treatment to 16 to 24 more medically stable dialysis patients.

In the '18-19 budget we committed to providing individualized funding for children with autism spectrum disorder. We continue to invest in this valuable program. Three and a half million dollars is being invested in '19-20 through the Ministry of Social Services, an increase of $700,000, to increase annual funding per child under six from 4,000 to $6,000.

The '19-20 budget is also investing an additional 15.3 million for increased use of physician services; 6.1 million in new funding will go towards hiring 15 new specialists and eight new primary care physicians. A $7.1 million increase goes towards increased use of fee-for-service physician services by Saskatchewan residents, and a $2 million increase will be allocated for out-of-province funding for physician services accessed by Saskatchewan residents.

Once again I'd like to thank the committee for the opportunity to be here today. We know how important the health care system is to the people of this province, and it continues to be a priority for our government. We're proud of this year's health budget, and we're confident it strikes the right balance as we work towards better meeting the health needs of Saskatchewan's residents. And, Mr. Chair, we'd now be happy to take questions.

The Chair: — Thank you, Mr. Minister. We will resume consideration of vote 32, Health, subvote (HE01), central management and services. Are there any questions? I recognize Ms. Mowat.

Ms. Mowat: — Thank you, Mr. Chair, and I would like to thank Minister Reiter and Minister Ottenbreit for being here, and for the deputy minister and the officials as well.

I would like to start with some questions directly out of the budget lines from Estimates. In (HE01), executive management allocation has increased. Can you explain why that's happening?

Mr. Hendricks: — So (HE01), central management and services, the funding has increased by 230,000 or 2.4 per cent. 244,000 of that is for salaries, primarily due to a ministry-wide salary reallocation to align with budget and actual staffing requirements. Goods and services decreased by $14,000 or 0.3 per cent, primarily due to a transfer of funding to the SHA [Saskatchewan Health Authority] for HealthLine Online and communication costs, and FTEs [full-time equivalent] decreased by 0.9 FTEs.

Ms. Mowat: — In (HE04) there's a reduction of $280,000 to Canadian Blood Services. Why was this funding cut from last year's spending? And is there any anticipated impact?

Mr. Hendricks: — The $280,000 decrease in relation to Canadian Blood Services is . . . $170,000 was a decrease. It was actually transferred out to the SHA budget for the crossmatch program. As well 110,000 was also transferred for perinatal testing to the SHA. So it's not actually a reduction in budget. It's just a transfer to the SHA, who is actually delivering the service.

Ms. Mowat: — Can you speak to the need for the increase in budget for immunizations?

Mr. Hendricks: — So the $780,000 net increase to immunization, there was a $900,000 increase to increase our antiviral stockpile, so in the event of a pandemic or something. And then there was a $120,000 decrease for the transfer of the STI [sexually transmitted infection] medication program to the SHA base as well.

Ms. Mowat: — Thank you. You've referenced a couple of times transfers to the SHA. There's significantly more money being allocated toward the SHA in this upcoming budgeted year. Can you speak to what some of the other areas for increase are?

[15:15]

Mr. Hendricks: — Okay, the budget to the SHA under (HE03) increased by 76.536 million or 2.2 per cent. 27.3 million of that represents an increase for the reallocation of existing funds to the SHA budget from other programmed areas, including 13.184 million for physician compensation; 8.356 million for emergency department waits and patient flow; 1.79 million for the transfer of the Physician Recruitment Agency to the SHA; 1.235 million for connecting care or hot-spotting; 1.232 million for net miscellaneous programs; and $800,000 for secure care.

As well $500,000 was transferred for veterans' beds at Wascana Rehabilitation Centre. 500,000 was a transfer to the SHA base for cardiac surgery pressures, and this was offset by a $264,000 transfer to eHealth for HealthLine, which I mentioned earlier. As well there was a $23 million increase for the Jim Pattison Children's Hospital to continue the phased increase of physician and operating capacity, for a total of $44.2 million over the last few years. $13.643 million increase for operating funding at the Saskatchewan Hospital North Battleford; 9.943 million of that was a transfer of incremental funding for corrections patients, and 3.7 million was for 18 new mental health beds.

There was a $10 million increase to address the SHA's operating and service pressures; a $1 million increase for Canada Pension Plan rate increases; $620,000 for the Physician Recruitment Agency of Saskatchewan operating budget; $375,000 for the provincial harm reduction program; $250,000 for the multiple sclerosis clinic nursing supports; $191,000 for the trauma pilot project in Regina; and $124,000 increase for a 1 per cent increase on salaries for community-based organizations.

Ms. Mowat: — There's also a funding increase for the Sask Cancer Agency, which was mentioned in the opening remarks. Can you provide a breakdown of, between salaries and drug funding, what this increase is required for?

Mr. Hendricks: — So the $7.6 million increase: 5.7 of it was increase for new drugs, oncology drugs, and programming; and then $2.2 million was for oncology physicians and service expansion.

Ms. Mowat: — It's also showing up that there's no allocation for the provincial laboratory this year. Is it the case that that's been folded into the SHA?

Mr. Hendricks: — That's correct, yes.

Ms. Mowat: — Okay. Debt charges for 2019-2020 are estimated at $7.5 million when the estimate from 2018-2019 is zero. Can you provide some clarity on what these debt charges are?

Mr. Hendricks: — So the $7.5 million in debt charges is in relation to the Saskatchewan Hospital North Battleford, which you're aware is a P3 [public-private partnership] project. And this amount is a determination by the Ministry of Finance as an appropriate accounting treatment for P3 contracts across government.

Ms. Mowat: — Thank you. In (HE08) there's substantially more money being spent on the drug plan and extended benefits. Can you speak to this increase? Is it primarily due to drug costs or increased utilization?

Mr. Hendricks: — So the overall (HE08) increases by 10.026 million or 2.6 per cent. The Saskatchewan drug plan will increase by 2.9 million or 0.9 per cent. This is a $3 million increase for the pharmacy proprietor agreement and this is offset by a $100,000 decrease due to transfers to appropriate subprograms for HIV [human immunodeficiency virus].

The Saskatchewan Aids to Independent Living program increases by $2 million or 4.9 percent; $1.771 million of that increase is to reflect program growth. $250,000 is an increase for the paraplegia program. And $69,000 is an increase of 1 per cent for community-based organizations funded out of this subvote.

Supplementary health program goes up by 4.611 million, a 19.4 per cent increase. 4.376 million of this is an increase to reflect program growth, and 235,000 is an increase for podiatry and audiology fees for those providers.

The family health benefits program increases by 179,000 or 4.4 per cent; 164,000 of that is to reflect program growth. And again there's a $15,000 increase for podiatry and audiology fees. There is no change in the provincial HIV assistance program, and benefit plans program support increases by $246,000 basically due to salary reallocations based on actual requirements.

Ms. Mowat: — Thanks. And when we're talking about program growth, are we talking about . . . Pardon me? . . . [inaudible interjection] . . . Increased utilization. Okay.

All right, in terms of overall spending, typically there's a positive relationship between per capita health spending and a government's fiscal position or economic growth over time. According to a CIHI [Canadian Institute of Health Information] report on national health expenditure trends from 1975 to 2018, the report shows that Saskatchewan was the only province to see a decrease in per capita health expenditures, and this is between 2017 and 2018. The decrease was minus 1.1 per cent. In 2017 that same report showed that Saskatchewan had the smallest per capita increase in health spending of all the provinces of 0.2

per cent.

I'm wondering if you have a table of per capita health spending from 2011 onward that you could share with us or, if not, if you could make it available.

Hon. Mr. Reiter: — Just to clarify. Sorry, what was the time period that report referenced?

Ms. Mowat: — So the overall trend that it looks at is 1975 onward.

Hon. Mr. Reiter: — Okay.

Ms. Mowat: — But it looks at the last reported period of time, which was from 2017 to 2018.

Hon. Mr. Reiter: — '17-18. Okay.

[15:30]

Mr. Hendricks: — So we don't have them quite laid out, the figures quite laid out the way that you do, but our figures show that in '17-18 the CIHI information that you're referencing is based on a forecast. The actual number for '17-18 will be finalized in November by CIHI. Our sense is that it will not show a decrease when the actual number comes out.

I would just caution a little bit on some of these and the interpretation of per capita health expenditures. We've been in a situation in this province where we've seen our populations growing and at the same time health expenditures have been growing. But it also depends on the population, in what demographic it's growing in. So if you have a younger population and those are people that are coming to Saskatchewan or are born here, they don't tend to use as many health services, as say the elderly. And so there is a little bit of a science to interpreting this information.

And just to add, we're kind of in the middle of the pack provincially in terms of provinces.

Ms. Mowat: — Yes, I was referring to the growth, the percentage. And point taken. Like I realize that in the report they also use that same . . . they want to take it with the same grain, which is why they don't do a direct comparison between provinces, because of course we know that it's like comparing apples and oranges. But they do say that there's merit to comparing the percentage of growth.

In terms of the numbers that are finalized then, can you provide from 2011 onward what the per capita health spending has been for each of those years?

Mr. Hendricks: — You asked from 2011. In 2011-12 our per capita expenditures were 4,303 compared to a Canadian average of 3,832; 4,330 in '12-13 compared to the Canadian average of 3,885; 4,497 in '13-14 compared to a Canadian average of 3,930; 4,534 in '14-15 compared to 3,998 in Canada. In 2015-16 ours were 4,664 compared to 4,153 for Canada; and in '16-17, the last year that's not a forecast, our per capita expenditures were 4,738 compared to a Canadian average of 4,173.

Ms. Mowat: — Thank you. In terms of amalgamation of the SHA, there was an expectation that we would see cost savings with amalgamation. I'm wondering if that's being tracked and if we can see that show up in this budget, if we can point to cost savings due to amalgamation.

Mr. Hendricks: — So in terms of senior management salaries, to date we've saved $10.7 million or reduced the spending line by that amount in the SHA. The board of directors, the cost reduction in terms of reducing from 12 boards to 1 board is $855,000. And then there have been some central functions that have also been consolidated as a result of the SHA that have resulted in savings of $3.1 million.

One of the other areas that we talked about savings was in information technology as the result of moving to a provincially consolidated IT [information technology]. And in '17-18 the cost savings and cost avoidance was $4.7 million, $6.5 million in '18-19, and then in '19-20 it was $9.2 million. Of those I said cost avoidance because there are certain expenditures that didn't have to be made as a result of the consolidation. But in terms of total net savings, dollars saved, in '19-20 we're estimating $4.9 million, and that's largely in relation to things like reduced grants for Microsoft licensing, that sort of thing; like, we've consolidated licensing agreements for software. We've been able to reduce FTEs in moving to two data centres versus 15. We've been able to save cost savings there as well in terms of storage and that sort of thing, security. So in total the hard savings are 4.9 million, but we would also say that we've avoided costs by making this move as well.

Ms. Mowat: — Thanks. So 4.9 million is your estimate of what you will save in 2019-2020?

Mr. Hendricks: — '19-20, yes.

Ms. Mowat: — Okay, thanks. And the figures that you provided at the beginning, was that total since amalgamation? Like, was that for the two years?

Mr. Hendricks: — That's annual savings, realized savings.

Ms. Mowat: — Another question regarding amalgamation, I understand there was a patient survey that was rolled out through the health regions. We've heard some concerns that there would be a loss of patient feedback with amalgamation. Does the patient survey still exist?

Mr. Hendricks: — So a few years ago as a province we had an in-hospital survey that we administered to people who were leaving one of our hospitals. And you know, I think that it's fair to say that I personally had concerns with the methodology. In order to score, basically, that you are achieving good patient satisfaction, the patient had to rate the experience at 10. And we want that of course. But my bigger concern with the methodology was that we weren't rating experience in a number of different places.

So more than hospitals, people encounter our primary health care system. We have people in long-term care, you know, a wide range, home care. And so one of the recommendations out of the advisory panel that looked at restructuring of the health authority into a single health authority recommended that we look more

broadly at a patient experience tool and administration of that with the SHA. We haven't gotten to that yet. That doesn't mean though that we aren't still recording patient experience, but not maybe in some sectors in a consistent fashion.

[15:45]

So there's some of it happening in primary care. You're aware that we've introduced family and resident surveys in long-term care. As well we continue to use patient and family advisers on a number of our . . . when we're developing projects, when we're looking at new initiatives, that sort of thing. So we do have that feedback. But I will tell you that it is a goal of the health system, the SHA, and the ministry, to have a more broad-based patient experience survey or some tool that we introduce in the future. We just need to find one that kind of is more representative of entire system performance.

Ms. Mowat: — We've also been hearing concerns about the recent announcement about managers being hired through the SHA. So there's concerns about whether this is going to lead for better outcomes for patients. There's a lot of calls for more front-line staff right now, both from the staff themselves and from patient advocates talking about patient experience, you know, saying that the folks who are working in the front lines are doing great work but there aren't enough of them. Where are we at in terms of the hiring of more front-line staff to improve patient care?

Mr. Hendricks: — So at the beginning of your question, you — and correct me if I'm wrong — you stated that, you know, there's this perception that a lot of managers are being hired, then we're not hiring in-scope staff. And there might be some confusion about that because as we've reorganized into a provincial Health Authority, basically what happened is we looked at our VP [vice-president] level, all our CEO [chief executive officer] level. We reduced the number of CEOs. They reduced the number of VPs, executive directors, directors. And so out there it looks like there's hiring going on potentially to some people, but actually this is a reduction. We're making people in certain areas that will be centres in the province apply for their jobs, and so these are people that were previously managers. So it's not new hiring per se; it's actually reducing the numbers but making sure that we're getting the most qualified person.

Our statistics show that in '17-18, which was kind of the first year after, well, first quarter after the SHA was stood up, that the number of in-scope positions increased by 0.5 per cent, from 30,223 to 30,371. And this is paid FTEs for system-wide SHA and SCA [Saskatchewan Cancer Agency]. During the same period the number of out-of-scope, which would typically be your management positions, decreased by 2.3 per cent from 3,087 to 3,016.

Ms. Mowat: — Thanks. Do you have a forecast of what those numbers will look like in the next year?

Mr. Hendricks: — I don't have a forecast, but I do know that they're still continuing to work through the director level, manager level in the Health Authority. So I expect that the number of out-of-scope positions in the Health Authority will continue to decrease somewhat. Our experience over the last number of years, if I look back 10 years, the number of in-scope staff in the Health Authority and the SCA has increased by 17.8 per cent. So we've seen significant FTE growth and we have not seen a year of negative FTE growth in the system in the last 10 years of front-line staff.

Ms. Mowat: — Okay. So is there an intent to take on a hiring effort of front-line staff then?

Mr. Hendricks: — So there's no, I won't call it kind of an overall initiative, to hire a bunch of people, you know, just anywhere in the system. But more directly, the other night we detailed a number of investments that we were making in mental health and addictions, including increased staffing for our community recovery teams. In addictions, we're expanding the number of beds, which obviously will have staff allocated with that. We're expanding our presence in the CBO [community-based organization] sector as well.

But there are other specific initiatives, for example the children's hospital. We're hiring 70 additional physicians for that. But what's not talked about as much is that there's a pretty significant additional increase in the number of FTEs attached to that facility because of the larger footprint and the expanded programming.

Similarly for SHNB [Saskatchewan Hospital North Battleford], we're expanding the programming there. We're expanding the number of beds in that facility, adding a corrections mental health component. And so there's additional hiring going on there.

In Connected Care again where we've received federal funding, we're expanding programming and staffing in palliative care. We're expanding programming in home care and community support. So there's a lot of additional dollars for hiring additional health workers in the system attached to specific programs that have been announced in this budget.

Ms. Mowat: — I have some questions about ambulances now. It's been 10 years since the 2008 ground ambulance review. Can you provide an update on where we are at with that?

Mr. Wyatt: — Hi. I'm Mark Wyatt, assistant deputy minister. Just in terms of where we're at in responding to various EMS [emergency medical services] reviews, I would say probably the focus of our work in more recent times has been sort of based on the report of the advisory panel on health restructuring, which provided some recommendations around looking to consolidate EMS services and bring more standardization to and improvement in the delivery of ambulance care in the province.

So based on, I guess, based on the recommendations made in that review, over the last couple of years we have developed, and are in the process of introducing with private operators in the province, a standard performance-based contract using a single template. The SHA is in the process of negotiating with some of the private operators in order to introduce better contract management, better performance management. And that will really become sort of the basis for a lot of the improvement work that we're also introducing into the system with EMS operators across the province.

Along with that, there are a number of other priorities that we're pursuing right now, related to things like community paramedicine. We have community paramedicine services in a

number of locations already, but a strong interest in being able to expand those into different communities across the province to be able to take advantage of the resource the paramedics bring, in some cases where they're not deployed on a call and others where you may have targeted the paramedics who are assigned to those initiatives.

There are a handful of other priorities that we are pursuing right now through the EMS service but, as I said, largely based on the more recent report that we received from the advisory panel on health reorganization, as opposed to going back to the 2008 review.

Ms. Mowat: — Thank you. And there have been some serious concerns in the former Cypress Health Region and the Southwest about ambulance shortages and lengthy waits for service. Can you speak to what has been done to address these concerns?

[16:00]

Hon. Mr. Ottenbreit: — I'll just start off, and if Mark has anything to add in he can get in as well. We've been working very, very diligently with the EMS group, specifically through SEMSA [Saskatchewan Emergency Medical Services Association] and some of the public operators, as well as identifying some of these problem areas. And we have identified that area through a lot of consultations with not only the private but the public providers in finding out we're not meeting some of their criteria and the responses that we'd like to.

We are doing quite well in a lot of the different areas when it comes to rural response times in under 30 minutes, urban response times in less than nine minutes. But in those areas that you did identify, Ms. Mowat, we've been working with those individuals to try and find ways to respond quicker. What they've identified is when you look at the previous regions, the previous boundaries, that would kind of impede service from time to time because we had a provider in a certain area that might be the closer car but not able to respond because they weren't from that area. So that's one area where the single SHA has helped kind of break down some of those boundaries.

So through work with them, going through the . . . Of course Mark talked about the performance-based contracts. It's all part of the work that we're doing with them in identifying some of these ways that we can get either the nearest car to respond, helping us identify through their input, identify areas that we need to maybe add more resources, as well as identifying areas where we have to increase resources and services specifically around advanced life support. We know in that area there is a shortage of advanced life support as well as in the La Ronge area. So those are two of the areas we're focusing on right now and putting advanced care paramedic services in in the next little while and expanding out from there. So we can identify some of these problem areas and build out those services from there.

Ms. Mowat: — We also know that there are significant challenges in Regina and Saskatoon with the EMS being stuck waiting in emergency departments. How is this information tracked?

Mr. Wyatt: — In response to the question around delays in offload of patients in emergency departments from ambulances, it's information that, through our relationships that we have with providers, if they are identifying a concern they will share data with, in the past with the regional health authority — sorry, with the health region — and now with the Saskatchewan Health Authority to, you know, to substantiate concerns that they may have if they are experiencing higher offload delays.

And so we, you know, we have had data shared with us previously. I mean it's an issue that is being addressed through a number of different means. There are times in the past when Saskatoon in particular has added additional funding and staffing to put additional cars or paramedics on the road. The bigger strategy though really, you know, is trying to improve the flow through the hospital and through the emergency department because the reason those ambulances are waiting to offload a patient is because either the beds or the emergency department staff are not available, which leads to a whole, you know, the whole range of issues around patient flow through both emergency department and the broader hospital itself.

Ms. Mowat: — Thank you. So reporting is on a voluntary basis when a problem arises?

Mr. Wyatt: — Yes. Effectively it's being reported through the health authorities and from the health authorities to either region or currently the authority, to the ministry at points where there is, you know, a specific concern that they have shared with the authority and then relayed on to the ministry.

Ms. Mowat: — Thanks. And we know that Medavie tracks zero alerts, times where there's no ambulances available. How many zero alerts have existed in Saskatoon over the past year?

Mr. Wyatt: — As an ministry, we wouldn't have that information.

Ms. Mowat: — That's not information that they've shared with you?

Mr. Wyatt: — No, I don't believe so.

Hon. Mr. Reiter: — We're just following up. Officials will check with SHA if they have those and we can get it to you if they do. Okay?

Ms. Mowat: — Thank you. It strikes me that it's important information just to be able to access to know when there aren't ambulances available. You know, it's been in the media and there's quite a bit of public concern over it.

We'll move to emergency department waits. So we know that this has been an ongoing struggle and that targets to reduce emergency department waits have changed over the years within the ministry in terms of the ministry's annual plans each year. The initial goal was to reduce waits to zero, then it became to reduce wait times to 60 per cent, then to 35 per cent. It looks like the goal for 2019-20 is to see some reduction and that there doesn't appear to be a per cent measure included in that.

Can we have an update as to the most recent emergency department room wait data for each major centre, for each category? So it might be something that's provided in table form; I don't know if we can verbally get all that information across.

But I'm talking about average length of stay, length of stay for CTAS [Canadian triage and acuity scale] levels, emergency department time to physician initial assessment, and emergency department time to in-patient bed for the major centres, so Saskatoon, Regina, Prince Albert, Moose Jaw, and Swift Current.

Mr. Wyatt: — Hi. So we do track emergency department wait times under those four main headings around physician initial assessment, time waiting for in-patient bed assignment, and emergency department length of stay for both admitted and non-admitted. We have it for Regina, Saskatoon, and Prince Albert. And North Battleford, Lloydminster are combined in one data point. So we have discrete numbers for Regina, Saskatoon, and Prince Albert, and then a combined number for Lloydminster and North Battleford. So what I can share with you is for starting with physician initial assessment, if you want us to begin there.

Ms. Mowat: — Sure. Is it possible to just have it tabled so that we don't have to scramble to write down all of the numbers at once?

Hon. Mr. Reiter: — Sure. There's a lot of notes and stuff on there, but we can get you a copy for sure.

Ms. Mowat: — That would be great.

Hon. Mr. Reiter: — We'll follow up with you. Yes.

Ms. Mowat: — Okay. And so just to clarify as well, so there's no data for Moose Jaw and Swift?

Mr. Wyatt: — Moose Jaw and Swift Current don't report into the same database, and so the data that we would have for smaller centres I don't believe we have in the same level of detail as what we have for the larger communities.

Ms. Mowat: — Would you be able to provide the detail that you do have for those centres?

Mr. Wyatt: — Certainly, yes, whatever we can find for the smaller centres, we could provide.

Ms. Mowat: — Okay, thank you. In terms of health research, I know that, you know, as we work to modernize our health system, a key piece of the puzzle is innovative health research. I know that the Saskatchewan Health Research Foundation falls under the Minister of Innovation, but I'm wondering if you can speak to what role the Ministry of Health plays in encouraging the development of health research in Saskatchewan.

[16:15]

Mr. Wyatt: — So the involvement of the ministry, and I'll say the Saskatchewan Health Authority, in health research takes a number of forms. As you've mentioned, we have the Saskatchewan Health Research Foundation. The ministry continues to have a representative on the SHRF [Saskatchewan Health Research Foundation] board and continues to have, you know, a collaborative relationship with SHRF in terms of the different funding programs and initiatives that they would be involved in.

You see across the system, you know, a lot of . . . There is research that is directly conducted by the Saskatchewan Health Authority. There have been research teams that have worked predominantly in the larger regions in Regina and Saskatoon. And so that research continues directly overseen within the SHA. Obviously the College of Medicine is a large source of health research as well. And then I think the other significant initiative over the last I'll say four or five years, three or four years, is the Saskatchewan Centre for Patient-Oriented Research, which goes by the term SCPOR. It was successful in receiving a large matching funding grant through the Canadian Institutes of Health Research.

And so that organization has been basically establishing itself over the last few years. And it is taking a much more significant role in terms of new health research while it's still in its formative stage. It does have some significant funding coming forward to lead health research and work with both Health and academic and communities around targeted research that's, as the name suggests, oriented towards patients and perhaps less so around some of the more basic science research that you might see conducted through the College of Medicine.

Ms. Mowat: — Thank you. And how do we work to ensure that that research is applied, that we see the benefits of that research happening?

Mr. Wyatt: — I'll speak specifically to the SCPOR or patient-oriented research initiative. I think the whole concept of patient-oriented research is to try to undertake research that has more direct impact on patient care and on the delivery of services to patients. So as we were developing the proposal that went to the CIHR [Canadian Institutes of Health Research] from Saskatchewan, it ensured that we had both health system representation, strong health system representation sort of representing the priorities of the health system in identifying what are, you know, the priority areas for some of those funded initiatives and funded programs. That then translates through to some of the programming, the research that they're undertaking, to make sure that we have both patient involvement in the development of a research proposal and patient involvement in sort of the commissioning of the research itself.

The other thing I would say about SCPOR in Saskatchewan is that there's been a real strong emphasis around building capacity in the province for how to involve Indigenous communities in research and helping researchers themselves better understand what, I guess, the expectations and some of the requirements are when you're engaging communities in research. And so I know that, you know, there's an emphasis, a focus within the early work that's being done around trying to build that capacity and make sure that we are involving communities with, as I said, an emphasis around Indigenous communities in the province.

Ms. Mowat: — I want to shift gears a little bit to talk about some health outcomes. There's a health scorecard put out by The Conference Board of Canada back in 2015, and according to that scorecard there were a number of different measures. Saskatchewan ranked D-minus for infant mortality, placing it lower than the lowest ranking peer country, which is the United States. We also ranked D for premature mortality and life expectancy, which is the lowest grade that was received by all the provinces, and D for mortality. Primary care initiatives, such as prevention and monitoring disease, are listed as the best way

that Saskatchewan can improve its D rating on the health scorecard. What tangible primary care initiatives are being introduced in 2019-2020?

[16:30]

Ms. Morrissette: — Good afternoon. Billie-Jo Morrissette, assistant deputy minister for the Ministry of Health. So I think your question really was around, you know, what are some of the kind of things that we're doing to address our higher rates of infant mortality in the province, around primary care or disease monitoring. And I think what we'd say about that particular issue is it's a very complex issue. I think due to the nature of the makeup of our population, it takes a lot of concentrated effort to work with a number of different partners to address really some of those underlying issues that would result in some of those rates.

And so, you know, it is partially a health issue, but there are many other issues that are underlying that with respect to kind of those social determinates of health. And so we would, I think, with respect to the response that we have, it's an ongoing response and one that involves really working with a number of our partners in those targeted areas where we would see those rates standing out. So things like working with some of our partners, like NITHA [Northern Inter-Tribal Health Authority], with the federal government, certainly with some of our human services partners around some of the targeted measures that are required.

And you know, we do have a series of things that we monitor of course with our population, and so that is ongoing efforts as well. With respect to kind of, you know, the types of things that we monitor across our populations that have to do with life expectancy, you'll be familiar with some of the other indicators, and we talked about them kind of at different committees around, you know, some of HIV rates, some of our tuberculosis rates, some of our immunization issues. And so we do monitor those province wide and amongst specific population groups. And then we do, where required, kind of take necessary targeted actions, and so lots of those issues would have targeted initiatives associated with them.

Ms. Mowat: — Thank you. And I'm glad you bring up determinants of health because that definitely ties into a lot of this. We also know that one in four kids in our province and six out of every ten First Nations kids lives in poverty, and we know that poverty is a determinate of health. What role does the ministry see itself having in addressing where child poverty rates?

Mr. Hendricks: — So in terms of the determinants of health, as you recognize, the Ministry of Health, the health system is at kind of one end of the spectrum in terms of the determinants of health. And obviously there are a number of factors that contribute to the health of the population, how they use our health system. And so very much the things like education, housing, and those sorts of things contribute to your use of health care but also other social factors as well.

The Premier of Saskatchewan has actually tasked the human services deputy ministers — so this would be myself, the deputy of Social Services, Education, Corrections and Policing, Justice, and Government Relations — to work collaboratively to come up with cross-ministry initiatives to better support each other in achieving incomes that aren't just focused on a specific sector but actually recognize the fact that we have to get upstream on a lot of these problems. So issues like poverty, you know, it would be looking at the things that affect the rate of poverty in Saskatchewan and how we as human services ministries can be more impactful if we work together.

So you know, in the past the ministry has participated in initiatives like the poverty reduction strategy as a member of those committees. But I think what we're being asked — well I know what we're being asked to do from the political — is to be much more active and intentional about how we address those social conditions, kind of more deliberately and collaboratively.

Ms. Mowat: — Thanks. And does that — is it a working group; I don't know? — have a name?

Mr. Hendricks: — It's the deputy ministers of human services are the ones that are working on this.

Ms. Mowat: — So it's just the task that has been received there?

Mr. Hendricks: — Or DM [deputy minister] committees, and it's one of them, yes.

Ms. Mowat: — And is this seen as a permanent shift, a permanent initiative or task, or something that there's a time frame attached to?

Mr. Hendricks: — No, the Premier has asked for some, I think, some immediate actions. I think that he would like to see us make some progress fairly quickly. But this isn't just kind of, you know, accomplish a few things and go away. He wants to see us permanently shift the way that we work so that we are working more collaboratively.

So we have taken forward some ideas to government. We're fleshing those out, looking at implementation time frames, and these will be in areas that we think that we can have a significant impact working more collaboratively together. But I would just say though that what historically has happened is it's been difficult to work across sectors. And we've been challenged as deputies to get rid of those barriers.

Ms. Mowat: — Have any recommendations been received yet then?

Mr. Hendricks: — So I think it would be premature at this point to signal any specific initiative or activities. You know, obviously we need to make sure that we have, you know, worked the details out and that sort of thing. So I think it's a little bit early at this point.

Ms. Mowat: — Okay. How long ago was that task received?

Mr. Hendricks: — I don't want to suggest that we haven't ever worked together. We've had various cross-ministry initiatives. We've had the child and family agenda, a shared agenda, where we have achieved success on a number of things over the last several years. But I would say that the work has been slow, slower than I think many people would like to see, including our Premier. And so he, specifically last fall, brought the human

services deputies together and said I want to see more activity in this area.

Ms. Mowat: — We also have the highest diagnosis rate of HIV, which is more than double the Canadian average. We know that four out of every five people who are diagnosed identify as Indigenous. We haven't had an HIV strategy in Saskatchewan since 2014, and we know that the number of people who are newly diagnosed has steadily increased since 2015. Is there any look at developing a new provincial strategy?

[16:45]

Mr. Hendricks: — So there are a number of activities that are taking place on the HIV front. We have invested some additional funding this year, and I'll talk about that in a minute. But in terms of progress, we continue to do and participate in education and engagement to reduce the stigma and discrimination. We've been very, very focused on improving the access to testing for HIV, and in fact HIV tests have increased by more than 6 per cent in 2018 from 2016. And when we look back to 2008, our HIV testing is up 81 per cent, which is significant because detection is an important part of reducing the spread of HIV.

Expanded case management, so this includes peer-to-peer outreach approaches to address the complex health and social issues that are related to HIV. We're providing free formula to prevent HIV transition from mother to children, a social marketing campaign which includes online advertising and wallet cards relating to living with HIV and promoting HIV testing. We provide a provincial pre-exposure prophylaxis guideline in terms of educating people on the use of antiviral or antiretroviral medications when they have a potential or known HIV case. And then of course we're building primary care capacity to deal with this as well.

You know, one of the key issues is 67 per cent of the people that have HIV are injection drug users, and so a big part of our focus this year has been on harm reduction. And so in this budget we're increasing funding by $450,000 to harm-reduction programs, resulting in an annual investment of 1.1 million.

Currently there are 30 fixed and three mobile sites that are attached to harm reduction, and so we're really focused in this area. And I'd also like to have one of my ADMs [assistant deputy minister], Billie-Jo Morrissette, talk a little bit about some progress we're making in terms of Sanctum and the work that's being done there.

Ms. Morrissette: — Hi. As Max previously mentioned, one of the key investments in this year's budget is some funding to be allocated to support the operations of Sanctum 1.5. And so that, Sanctum 1.5, is a facility that opened in October of this year. It's a 10-bed supportive housing facility for pregnant women who are at high risk of prenatal HIV transmission. And so they did start operating this year and we have, as I mentioned, $300,000 in our budget going into next year to support those operations. It is also being funded through Social Services. So this is one example of where we are really working together to serve a shared kind of client base who is, in this case, women at risk of transmitting HIV to their expectant babies.

And so it has been operating for some time, and I think we're quite pleased with some of the early indicators coming out of this program. As of March 27th, for an example, there have been 13 women admitted to Sanctum 1.5. Three women have completed the program. One left before she had her baby, and there are currently nine women residing there. And I think the really good news here is that a total of eight babies have been born while their mothers were living at Sanctum 1.5 and all of those babies are in good health and are HIV and hepatitis C negative.

And so that is one initiative that we're really pleased to see working well in terms of achieving the program objectives that we had set out and worked with Sanctum to provide. And so that is one area that we have invested in for next year.

Ms. Mowat: — Is there any look at expanding that type of model into the North?

Ms. Morrissette: — I think one of the things is we wanted to kind of see how the program was going in this area. I think that is something that certainly we would monitor over time just based on the different needs of the population and where we're seeing the need for that type of a service. So just to wrap up, as I mentioned, this is something that we are pleased with initially and we'll continue to monitor it, and if we continue to kind of see positive outcomes that is something that we can explore in the future.

Ms. Mowat: — Thanks. Yes, it's certainly a great program. In terms of the question of an overall strategy, is there an overall guiding strategy that is working toward reducing these high rates?

Ms. Morrissette: — All right, so as Max alluded to, you know, there is lots of work that is ongoing out of the HIV collaborative. But I think just from kind of an overall perspective — what are our goals in this area and how are we working to achieve them? — I think it's fair to say that we're still sticking to the United Nations program 90-90-90 targets. And so those are 90 per cent of the people with HIV are diagnosed, 90 per cent of those diagnosed are in treatment, and 90 per cent of those on treatment are virally suppressed. And so those continue to be our goals.

I think the work of the HIV collaborative continues. As we've mentioned, we do have some key initiatives in this area that we think will help us get there, one of them being around those targeted investments in Sanctum, some target investments around harm reduction.

And then I think the other thing that is maybe an important piece is that we will be working with our colleagues in the SHA around those targets. Every year when we start doing our planning with them, we set kind of, you know, some objectives in terms of some of the priorities that we want them to work on, and this would be one of those areas. And so we have set and communicated that the 90-90-90 is our goal. And so we'll be working with them over the next little while to kind of really get down into that more like, you know, some of those more targeted actions, whether that be provincially, provincial actions, or actions kind of targeted geographically, or just certain kinds of demographic groups. And so certainly that is a priority for us and for our SHA colleagues.

Ms. Mowat: — How are we doing on the 90-90-90 targets?

Ms. Morrissette: — So currently we are sitting at 70, 91, and 77.

Ms. Mowat: — Okay. Saskatchewan also ranks D on the Conference Board of Canada's health scorecard for mortality, primarily due to the prevalence of diabetes. We know that 29 per cent of people in Saskatchewan are living with diabetes or prediabetes. It's forecasted that in the next decade that number will increase to 37 per cent diagnosed. The number increased 59 per cent between 2006 and 2016. According to the Conference Board of Canada, currently diabetes costs Saskatchewan's health care system $96 million a year.

In terms of these costs, I know there's been some advocacy on behalf of Diabetes Canada that wrote a response letter to the 2019-20 budget called "Important action for diabetes management and support missing from Saskatchewan budget." So they wanted to highlight their concerns that steps are not being taken to curb the diabetes epidemic in our province. A key recommendation coming out of that is to fund insulin pumps beyond the age of 25 years for all medically eligible individuals with type 1 diabetes. And they also recommend the government develop a mandatory standard of care for children with type 1 diabetes at school. Is there a plan to implement either of these recommendations?

[17:00]

Hon. Mr. Reiter: — The insulin pump program, periodically we've looked at it. Obviously it would be great to expand it. There'd be a cost there. We've had some recent discussions about that, and there's a possibility that we'll consider that going through the budget cycle in the upcoming budget. For your question about in the schools, I find that one very interesting because I think you were probably at some of the same receptions I was at with the Diabetes Association speaking to the issues in the schools.

In 2015 I'm told the Saskatchewan School Boards Association developed, they called it *Managing Life-Threatening Conditions: Guidelines for School Divisions* policy, which includes diabetes. I know from talking to the folks at that reception though, it seems to be a little bit sporadic, depending on the different schools. I know I've had a conversation with the Education minister about that; I think they're having discussions in Education on that. I don't know how far along that would be. You know, that question could be put to the Education minister.

Ms. Mowat: — In terms of cardiac care, Saskatchewan is performing below the national average according to a CIHI report from 2017 called *Cardiac Care Quality Indicators Report*. This report says it's the first of its kind and claims to be a starting point for discussion. We have higher mortality and readmission rates than other provinces, most often above the national average following cardiac care incidents.

So specifically they outline a number of different measures: the highest rate of 30-day in-hospital mortality after PCI [percutaneous coronary intervention], better rates after CABG [coronary artery bypass graft] in Regina General but still not looking as good at RUH [Royal University Hospital], second-highest mortality rates after AVR [aortic valve replacement], third-highest rates after CABG and AVR, and the highest readmission after PCI. What is being done to address these concerning mortality and readmission rates?

Mr. Wyatt: — Hi, I'm Mark Wyatt. I think the answer, so the answer speaks to probably a range of factors that would play into longer term outcomes for cardiac patients. One would, I think one would be the issues that we've been talking about before, and that is the overall health of the population that takes you into, you know, issues around poverty, issues around determinants of health. And I think that certainly is a factor when it comes the heart health of the population.

Once you start to specifically look at patients who have had a procedure, we do know that our wait times for surgical procedures for cardiac procedures in the province are actually fairly short. We consistently meet the target time frames for surgical, for CABG surgeries for example. And so I mean when you look at, you know, long-term outcomes, it speaks to both the follow-up care the patients are receiving and the, you know, the primary care support in the communities for those patients.

One of the big initiatives of the Saskatchewan Health Authorities and working with the ministry and a key part of our health system strategy for 2019-20 is around the development and, over time, the enhancement of primary health care networks. And I think, you know, a lot of the ongoing care of those patients moves back into the community once they return home, and I think that becomes a critical part of making sure that we have strong primary care teams, primary care physicians in all parts of the province, and you know, enhanced supports for those patients once they return to the community post-surgery.

Ms. Mowat: — So this report came out in 2017. Do we know how we compare to other provinces today?

Mr. Wyatt: — That's not information that we have as a ministry. We would probably have to return to CIHI and see if they've done any updating of the data since the last time they reported.

Ms. Mowat: — Thank you. A few questions now about tobacco control. According to the Canadian student alcohol and drug survey 2016-2017, Saskatchewan had the highest youth smoking rates for grades 10 to 12, at 21 per cent. Our overall smoking rate for those 15 and older sat at 18 per cent. Do we know what our current smoking rates look like in the province?

Ms. Morrissette: — So I think just to confirm, the data that you were reading from I think was the Canadian Student Tobacco, and Alcohol and Drugs Survey data. So we actually when we do monitoring of youth smoking rates, we actually use a slightly different survey. And the reason really is just because the data produced that you're speaking to, we interpret with caution just because of some of the sampling variability.

And so usually when we monitor this, we look at the Canadian Community Health Survey. And so I do have some data for youth smoking rates from that survey. I have data from between 2007-08 to 2013-14. It's a little bit old just because this data comes in two-year cycles and then once they actually do it, it takes them a little while to kind of actually publish the data.

So using that data source, what we see is that the provincial youth smoking rates, so that would be ages 12 to 19, in Saskatchewan in 2007-08 were 18.1 per cent; in 2009-10, 12.9 per cent; '11-12,

11.9 per cent; and then ’13-14, 10 per cent. So we do see a decrease over time in our youth smoking rates. We are, as you noted though, still slightly above the Canadian average, which in this survey is 8.3 per cent for Canada in 2013-14. So certainly something that we continue to monitor, but we have been seeing a downward trend in that data.

Ms. Mowat: — Thank you. In terms of strategies for working to reduce those smoking rates, can you speak to what initiatives exist within the ministry?

[17:15]

Hon. Mr. Reiter: — So we’ve done a number of things over the last number of years. Tobacco cessation products Champix and Zyban were added in 2010. Legislation was passed in 2010 that made it illegal to smoke in school grounds, in a car if there’s a child under 16, and near the entrances of buildings. In 2011 we banned the sale of tobacco in pharmacies, and as of October of last year pharmacists can now prescribe smoking cessation products. We had a meeting sometime in the last number of weeks with Canadian Cancer Society to discuss vaping and whether there needs to be some changes there as well, so that’s kind of under active consideration right now.

Ms. Mowat: — Thank you. And in terms of targets, are there specific targets that you’re working toward? Have you adopted the federal targets?

Hon. Mr. Reiter: — I think you’re probably speaking to the 5 per cent target from the FPT [federal-provincial-territorial]. We’re part of that committee, so absolutely we support that. We’re always looking at things that we can do better and obviously we’d like to improve on that if we could.

Ms. Mowat: — Thanks. So I’ll hazard a guess that likely you don’t have access to the most current vaping data in the province?

Ms. Morrissette: — We do have some data with us that’s a little bit more current than ’13-14 for e-cigarette usage. And so we have it for youth. And so we have data from ’14-15 and ’16-17 and for the age group of 15-plus years. So that would include some portions of youth but also adults.

In ’16-17, 15 per cent of people have tried e-cigarette use and 3 per cent in the past 30 days. For the age group 15 to 19, 23 per cent of those have tried it and then 6 per cent have used in the last 30 days. In ’14-15 the numbers were pretty similar for the 15-plus age group: 13 per cent had tried it and 3 per cent had used it in the last 30 days. And then again, in the 15 to 19 age group, 23 per cent had tried it and then 6 per cent over the past 30 days.

Some of the national rates and the comparisons between Saskatchewan and Canada I also have. And so for e-cigarette use for grade 7 to 12 . . . And again this is data that’s not as well developed as the previous data that I was speaking to, and so these are really just kind of, you know, help us get an initial sense of the nature of the problem with respect to vaping. In Canada 23 per cent of grade 7 to 12 students had tried e-cigarette use, and then 10 of them in the last 30 days. And for Canada that is a little bit higher: 29 per cent of students in grade 7 to 12 had used it, and 11 in the last 30 days.

And so I think that data signals a little bit of what we’re hearing in terms of the discourse around vaping and some of the issues that are coming forward. We have lots of people who participate in kind of, you know, pan-Canadian discussions about public health. We monitor what’s going on in other parts of the world, and we know that this is an issue that is emerging. And this is kind of some of the early data that would signal, you know, something that we have to keep our eye on.

Ms. Mowat: — Thanks. Yes, and I’m sure you’re aware there’s an extensive study called the *Public Health Consequences of E-Cigarettes* that came out in 2018. It uses US [United States] data, but there’s a number of recommendations that come out of their . . . conclusive evidence that, in addition to nicotine, most e-cigarettes contain and emit potentially toxic substances, that there is substantial evidence that it results in symptoms of dependence on e-cigarettes as well.

So glad to hear that that is being looked into as well, and acknowledging the fact that, you know, these rates will have changed drastically in the past, in the recent years too. So despite the fact that we don’t have those numbers in front of us, you know, knowing that they have increased drastically. And you know, we all know people in our lives that have access to e-cigarettes. So yes, I think it’s important to think about what we’re doing in terms of regulation on that sense as well.

I want to switch gears a little bit and talk about the deaf and hard-of-hearing community. In conversations that I’ve had with folks in the community, there was particular concern about the options that are being provided to parents at the time of a child’s diagnosis. So there’s a recommendation from the Saskatchewan Human Rights Commission that parents be provided with a full range of options, including learning American Sign Language and going along the path toward cochlear implants. I understand that SPARC [Saskatchewan Pediatric Auditory Rehabilitation Centre] formally states that American Sign Language is appropriate for some children, but I’m wondering if you have any tracking or formal evidence that this option is being provided to families. Like is there any tracking mechanism that demonstrates that?

Hon. Mr. Reiter: — So officials are telling me they don’t believe that we’re doing any tracking in Health right now, but they would like to look into it further. They’d also like to check with Education in case there’s some tracking done there. Could they do that and we’ll follow up with you?

Ms. Mowat: — Sure, that sounds fine. We’ve just been hearing concerns that ASL [American Sign Language] isn’t being recommended as an option. And considering the importance of language development to cognitive development at an early age, there’s concerns that if children aren’t able to communicate, that their cognitive development will be delayed as a result. So if you could look into that, that would be excellent.

Hon. Mr. Reiter: — Just to clarify though, when we follow up, you’re hearing that ASL isn’t being, you know, suggested as an option by who?

Ms. Mowat: — By SPARC, the clinic — S-P-A-R-C.

Hon. Mr. Reiter: — Let us follow up on that.

Ms. Mowat: — Sure. In terms of . . . This was also pointed out to me. So there's a report, a sobering report called *The Silent World of Jordan* that came out by the Children's Advocate in 2016, that investigates the death of a young First Nations teenager that they called Jordan, who has significant hearing loss, who is largely unable to communicate, and died while incarcerated at a provincial youth facility. So one of the findings was:

> . . . that there was no overarching provincial health policy for the Ministry of Justice, Corrections and Policing . . . while there was provincial policy pertaining to Admissions that provided some health-related guidelines, Prince Albert Youth Residence did not develop local procedures to ensure youth have access to health services.

Can you speak to what role the Ministry of Health has had in helping to develop an overarching provincial health policy for the Ministry of Justice or with the Ministry of Justice since this report, or what actions have been taken within the ministry in the aftermath?

[17:30]

Mr. Hendricks: — So currently in Corrections and Policing in provincial penal institutions, when they're responsible for hiring or contracting with physicians and nursing staff or what other health providers to provide services within the facility, those health providers, if they determine that a service that isn't available in the facility needs to be provided to the incarcerated individual, they'll make arrangements for the Health Authority to transfer that patient out. So for example, for surgery or other services they would be transferred to the Health Authority, usually under . . . supervised by Corrections and Policing. We, you know, kind of in the wake of that, the report from the Children's Advocate, there's been . . . And I won't say that it's advanced at this point, but there was an exchange regarding, you know, whether the Health Authority now — it wasn't the Health Authority then, and that's part of the reason we probably haven't advanced as much on this — should take over direct responsibility for the provision of services in correctional facilities versus Corrections contracting with physicians and nursing.

And you know, I think it's something that as we start to form up the SHA and think about . . . And you know, when it's in a position, you know, I guess organizationally I think that's something that we can discuss.

I'll just say that I've been in medical services or involved directly with medical services from prior to being a DM, and this has been an ongoing discussion for decades actually, is the best way to provide services to inmates that are incarcerated, so . . . or to inmates. And so it's not a new conversation.

And I think it's kind of something that we would be very willing to entertain. And I think, you know, if I extend that to SHNB, not only will we be providing mental health services to the Corrections inmates in that facility, but we'll also be providing general health care to them because we're responsible for the facility. And so I think it could serve as a model potentially to look at other provincial institutions and whether that would work there.

Ms. Mowat: — Thank you. According to the Saskatchewan physiotherapists' association, physio can help with a range of issues and can play an important role in primary health care. Where are we at with looking at publicly funding or expanding our public funding for physiotherapy, particularly in light of the role that opioids are playing in pain management?

Hon. Mr. Reiter: — So certainly I agree with you. We recognize the importance of physios in the system. Of course we're always . . . You have to make choices in the system, right? What you can cover and what you can't cover. As you know, some physiotherapy is covered. In just a minute I'm going to get Max to speak to a little bit further on what we are doing for chronic pain management. But just out of interest's sake, on the number of FTEs in physio, just randomly I'll pick some years — 2010, there was 217; 2013, there was 248; up to '17-18, there's 268.72 FTEs. So we have been increasing in that end, and I'll just get Max to speak to what is kind of happening in different areas of the province on chronic pain management.

Mr. Hendricks: — I think that there's a general recognition that to reduce the dependence on opioid prescribing, that you need a multifaceted approach. And we do have several initiatives, so the Wascana Rehab Centre, the Wascana Physiatry physical medicine and rehabilitation specialists are working to address acute and chronic pain with patients through a multidisciplinary approach that includes physiatry as well as psychology and physiotherapy.

Patients can receive a referral to the chronic pain education program that is offered at Wascana. Also the Meadows primary care clinic in Regina, there's a physician there that's working on chronic pain management and can provide access to a physician, a nurse, but also addictions counselling, pharmacy, psychology, and physiotherapy. There's an online therapy unit at the University of Regina that helps to address self-management of chronic pain through a cognitive behaviour approach, which is shown to be effective with some people that have challenges managing pain.

We have a thing called the RxFiles, and what this does is it educates physicians on alternatives to opioid prescribing. So you know, whether it be the use of physiatry, physiotherapy, that sort of thing, but also alternatives in terms of pharmacy as well. And so there are some other initiatives, but I would say this is a growing area as we struggle with opioid prescriptions.

Ms. Mowat: — Thanks. Switching gears a little bit again, I know that the Health Quality Council did some work in 2015 in developing an appropriateness-of-care framework. Can you speak to what work is ongoing within this framework, what the current system priorities are, and what opportunities exist for us as well?

Mr. Wyatt: — It's Mark Wyatt. The framework you're referring to is one that was developed through a collaborative group that included, certainly included the Health Quality Council, the Ministry of Health, and the health authorities, health regions at the time, and a number of clinical leaders were instrumental in developing that framework.

Based on that, we've seen appropriateness activity move at two different levels. At a provincial level we've had a couple of

initiatives that I can come back to, and then also encouraging the health regions and local health physicians in practice, both in speciality or acute care as well as primary care, to undertake appropriateness-of-care initiatives at a more local level.

The other important part of it has been training, and through something called the CQIP [coordinated quality improvement program] program, we are training I believe it's in cohorts of approximately 20 physicians and some other providers to be able to lead and conduct appropriateness-of-care initiatives within their own practice area. And so we've seen a number of those physicians who have gone on — as part of the CQIP program they are required to — to complete a quality-of-care improvement initiative. Many of them do have a focus on overuse, underuse, misuse of care which is how we often define appropriateness of care.

[17:45]

Just coming to the provincial initiatives. The main and the first initiative that followed from the development of that framework was around lumbar back pain and the use . . . And I think there's literature that would indicate there's a high overuse of different types of imaging, MRI [magnetic resonance imagining] and CT [computerized tomography] imaging for low back pain. And so they began work on developing an appropriateness checklist for MRI referrals for lower back pain. And through that they were able to show that there was a significant reduction in . . . Once they began implementing the checklist both initially and in a pilot, and then it's moved province-wide, we have seen a pretty significant reduction in the number of MRI requisitions

The pilot showed, for example, during a one year period — the pilot goes back to 2014-15 — pre-implementation there were 4,628 MRI requisitions, and during the post-implementation time frame there were 3,758, so a reduction of 19 per cent. A reduction of 19 per cent in the number of requisitions in one year before and after the implementation of that checklist.

What they also found at the time was that they saw some growth in the number of CT tests that were being ordered as the number of MRIs were coming down. So they wanted to ensure that as we were creating more appropriate criteria and referral patterns for MRI requisitions, that we weren't just seeing the shift into inappropriate CT testing.

And so they then began work on a CT appropriateness-of-care project. It took a similar approach, developing a checklist, and it became evident that it made the most sense to merge those two checklists together. And so we've seen now anyone who was being referred for imaging related to low back pain, the physician would go through the checklist, identify what the appropriate presentation is for either MRI or CT or it could well be X-ray or it could be no imaging at all. And so I think that's been a really good example of being able to take a provincial approach and moving this across the system.

I'll just mention that the other provincial initiative that has been initiated relates to preoperative testing. Again it's an area that is identified as, I guess, a high potential for overuse of preoperative tests — asking people to come in and have tests performed before they go in for minor surgeries. And so there's been a focus there around . . . The initial work was tested in North Battleford and Lloydminster in 2018, now moving into Meadow Lake and Saskatoon, focusing there around elective hip and knee surgeries. And we have seen some positive results as well there in terms of reducing the number of preoperative tests that may not be clinically indicated.

Final thing I'll say just in this area is that nationally we've seen . . . Choosing Wisely is sort of the body that is advancing the world of appropriateness, clinical appropriateness on a national scale. The province has partnered with the Saskatchewan Medical Association to help fund Choosing Wisely's presence in our province, and we expect we will continue to work with Choosing Wisely. They're in the process of selecting some projects that they want to undertake across the country, and so we do expect that there will be some additional provincial priority areas defined through our relationship with the SMA [Saskatchewan Medical Association], the Health Authority, and Choosing Wisely.

Ms. Mowat: — I'm just looking at the time and trying to figure out what we have time to get through. So in terms of the PET scans, the positron emission tomography scans, we heard concerns about the disturbances earlier in the fall. I'm wondering if there have been any problems since December.

Mr. Hendricks: — So since December, the PET has been . . . not the PET itself, but the PET has not been able to provide services for nine days, and it's not because the PET scanner has malfunctioned. It's actually because the cyclotron that produces the isotope FDG [fludeoxyglucose] 18 has had some malfunctions. The challenge with FDG 18 is that it has such a short half-life. It's roughly 109 minutes. You can't actually secure it reliably from another jurisdiction when you can't produce the isotope.

And so what the Saskatchewan Health Authority, in conjunction with the university, is looking at doing is developing another storage unit so they can actually produce more FDG 18 at one time and schedule more PET scans within a single period, so that if there is an issue in terms of the cyclotron not being available, it has less of an impact. And so this would be one of the strategies to mitigate challenges there. The other is that, you know, I think if we were looking to expand and create a redundant B-line there would be a lot of costs associated with that. But just so that people understand, it's not so much that our PET is having issues. It's just, you know, an issue securing the isotope.

Ms. Mowat: — Thank you. And can you speak to what the current wait times are and how many people are on the wait-list?

Mr. Hendricks — So since 2017-18, 2,050 patients have received a publicly funded PET/CT [positron emission tomography/computerized tomography] scan in Saskatoon. So that kind of gives you an idea of the volumes that we're dealing with. If you look at the supply, in December 2018, as of that date, 9 out of 10 urgent patients received their PET/CT exam within 17 days, with an average of 14 days. The wait time for semi-urgent requests in 2018 was about 80 days for 9 out of 10 patients to receive their PET/CT exam. So the urgent ones were done very quickly, within 14 days.

As a result of the lack of availability of the isotope — it would be prior to February 27th — 20 patients were impacted by that

and had to be rescheduled, and those had all been completed by the end of February 27th. So what they do is when they have to close down the PET because they don't have the isotope, they reschedule the patients. And when the cyclotron is up and running and producing FDG, they produce more and push those patients through.

In the last few weeks there was a period where it was down for a while and so I'm not sure that those patients that were impacted by that shortage have been addressed yet. And I don't want to make this sound like it's just okay. We understand this does have an impact on patients, a lot of whom are very, you know, in a difficult situation and wanting answers quickly. So we're looking at everything we can with the SHA to make sure that this service is more stable in the future.

Yes, ADM Wyatt just pointed out that there have been 10 extended shifts completed since 2019 that have allowed for the imaging of those patients that were impacted by these shortages.

Ms. Mowat: — Thank you. I'm wondering if it would be possible to get those emergency department wait times. We're about to recess so I was wondering if it's possible to bring them back to the committee after to be tabled, just in case I have follow-up questions at that time. We've got a little bit . . .

Hon. Mr. Reiter: — We'll check and we'll follow up with you right after the break, okay?

Ms. Mowat: — Okay.

The Chair: — Okay. We are approaching the time of agreement to recess so we will take a recess until 6:30 p.m. sharp. Thank you.

[The committee recessed from 17:58 until 18:30.]

The Chair: — Okay, welcome back to the Human Services Committee. We have received some documents from Health which I would like to table: HUS 49-28, Ministry of Health: Responses to questions raised at the April 29th, 2019 meeting. Those are tabled.

Do we have any further questions? I recognize Ms. Mowat.

Hon. Mr. Reiter: — Just before we go to the next question, Ms. Mowat had asked for some information on emergency department wait times. We have that as well.

Ms. Mowat: — Does it get tabled now? . . . [inaudible interjection] . . . Thank you. I look forward to receiving that. I appreciate the ministry's cooperation.

I think we'll move on, I've got a few questions about eHealth. In terms of contracts for external consultants, what's the policy on hiring outside consultants?

Mr. Hendricks: — So for the last several years eHealth has been deliberately trying to reduce its use of outside consultants for the primary purpose that it generally costs less to have those services in-house. But that's not to say that they don't have consultants in specific areas that assist them with work. And generally it's when the standard work, when there's excessive work, that they can call on these consultants to provide certain services. And so my recollection from the time that I was acting CEO is they'll have contracts with a consultancy group in Regina or Saskatoon or wherever, and these are like long-standing contracts. They do take them to market every few years to make sure that they're securing the best price for the services available.

But this was also, I think, part of the work around procurement that was done and suggesting best practices and new approaches by eHealth. And as you know, the Provincial Auditor was in at eHealth to do an audit of the procurement practices. One of the things that she was looking at is that there be a code of conduct — conflict of interest, all of that sort of thing — and making sure that they're following best practices for procurement.

From what I've heard, you know, I think she's recommending that they look at the SaskBuilds process for procurement and model after that, which is fairly strong. And so last fall the board passed and updated a number of things to ensure that basically the code of conduct and conflict-of-interest guidelines were reinforced and that people were receiving and repeating that education on an annual basis. And so eHealth has been very active in this regard as of late.

Ms. Mowat: — How many external consultants that were hired or awarded contracts within the last year?

Mr. Hendricks: — I don't have that with me, but it's something that I would be happy to provide to the committee.

Ms. Mowat: — Thank you. Do you know how it compares to years past? If the goal is to, if you're deliberately trying to reduce reliance on external contracts, do you think that's being achieved?

Mr. Hendricks: — Yes, I've seen the numbers before. The consultant cost, the number of consultants has been reduced. We can provide you a retrospective look at that as well.

Ms. Mowat: — Sure. And was there some type of a shift in the organizational structure since 2013 towards relying on external work over internal expertise?

Hon. Mr. Reiter: — Sorry, can we just clarify? Your question was, was there more consultants used recently than in '13?

Ms. Mowat: — Just was there a shift in the structure in terms of relying on external work over internal expertise?

Hon. Mr. Reiter: — At any point in that time period, you mean? From '13 on?

Ms. Mowat: — Since 2013, yes.

Hon. Mr. Reiter: — Okay. I don't want to delay, in case you want more questions, but they're working right now to try to get the actual numbers for you. So we're hoping we can have that shortly, but I just thought I'd let you know in case you want to ask another question in the meantime and we can come back to that as soon as we get it.

Ms. Mowat: — Sure. That sounds good.

The Chair: — At this time I would like to table the following documents: HUS 50-28, Ministry of Health: Responses to questions raised at the meeting May 1st, 2019. As well we have a substitution: for MLA Warren Steinley, we have MLA Glen Hart. I recognize Ms. Mowat.

Ms. Mowat: — Thank you. In terms of CHIP, the citizen health information portal, there's an expenditure in payee disclosure for Telus Health Solutions in the last annual report for 1.65 million. Is any of it related to CHIP, and is this spending ongoing this year?

Hon. Mr. Reiter: — Yes. We have the numbers on the consultants for you — and I apologize; we were kind of working on that — Max will give those to you in a sec. And then can I get you just to repeat that question again, the one on CHIP?

Ms. Mowat: — Sure. So there's an expenditure in payee disclosure for Telus Health Solutions in the last annual report for 1.65 million. Just wondering if any of that is related to CHIP?

Mr. Hendricks: — So first I'll start out by answering your question on the consultants. So you had asked specifically '12-13, in that time frame. At that time the number of external consultants hired and/or awarded contracts was 243, and as of 2018-19 that number was down to nine. During that period it was declining every year.

Ms. Mowat: — Thanks. So this would include one-off consultants but also larger contracts as well. So like, I guess what I'm trying to get at is, is where is the work being done? So you can have nine contracts that include a lot of work, and you can have 243 contracts that are small one-off situations. So I'm just wondering about in terms of what that looks like.

Mr. Hendricks: — So I was referring to small one-off contracts, right, with nine consultants. But, you know, there are going to be obviously agreements with, you know, companies like Microsoft and that sort of thing for the provision of services, with whoever is providing our services, our network services. So things like that would be bigger contracts that are RFP'd [request for proposal].

Ms. Mowat: — Okay. And so would you say then that there is still an emphasis on utilizing internal expertise?

[18:45]

Mr. Hendricks: — Absolutely. But some of that stuff where you're securing a product, like you have to buy it from market, right, through an RFP.

Ms. Mowat: — Okay.

Mr. Hendricks: — Sorry, that took a little bit longer. So just in reconciling what eHealth's expenditure was related to that work and what Telus shows in the payee list, it was 1.651 million that eHealth paid Telus.

Ms. Mowat: — And sorry, is any of that related to CHIP?

Mr. Hendricks: — Yes.

Ms. Mowat: — Yes? Okay. Is this spending ongoing for this year?

Mr. Hendricks: — The spending is ongoing for this year, yes.

Ms. Mowat: — Okay. How much is it for this year?

Mr. Hendricks: — Well, actually in this year, I have to separate this. This year we're still implementing, and a good portion of the funding, as you know, for CHIP is coming from Infoway, the majority of the funding. And so eHealth's expenditures are 1.65 million related to CHIP this year, and Infoway is around 5 million.

Ms. Mowat: — Thanks. What is the contractual relationship between Telus Health, eHealth, and Get Real Health?

Mr. Hendricks: — So eHealth does not have a contract with Get Real. They have a contract with Telus, but Telus in turn has an agreement with or has a contract, I guess, or a relationship with Get Real. It's kind of the platform or the backbone of what runs CHIP. And so that's the relationship there.

Ms. Mowat: — And have there been any costs incurred since the six month pilot ended?

Mr. Hendricks: — Okay, so the pilot costs were 399,000. The total cost of $8.376 million has been incurred since the six-month pilot ended, of which 6.149 million has been paid by Canada Health Infoway funding. And then as I said, following the pilot this funding was for development of additional licensing planning and for potentially a future full provincial rollout.

Ms. Mowat: — Okay, so are there still ongoing payments then?

Mr. Hendricks: — So if you look at the performance plan, what it speaks to is, you know, we talk about expanding access to the citizen health portal to provide Saskatchewan citizens with access to their personal health information online. You know, how and when that's going to be actually rolled out has not been announced. But I can say that, you know, in '20-21 following this year, our costs actually do go down because we're through development phases. So now we would be in a licensing arrangement with Telus, depending on what the decision is going forward.

Ms. Mowat: — Thanks. And as part of the contractual relationship, what is the exact data that has been shared with Telus Health?

Mr. Hendricks: — So the only data that is shared with Telus is for patients that have registered as part of CHIP. And as part of the disclosure, Telus is not able to access, disclose, or anonymize the data in any way and so only that data which has been related to the pilot users has been shared with Telus. I want to clarify that no data has been shared with Get Real; it's only with Telus.

Ms. Mowat: — Can you just say that again? Sorry.

Mr. Hendricks: — No data has been shared with Get Real. It's only been shared with Telus under the secure arrangement.

Ms. Mowat: — Can you speak to the delay in moving to a second

phase of CHIP?

[19:00]

Mr. Hendricks: — So as part of this, after we went through the pilot . . . And I think it was recognized that the pilot was pretty popular, well received by patients that did use and access it. So on a go-forward basis we have our arrangement with Canada Health Infoway which lasts for, you know, basically funded the large majority of the development of this and funds us for the first three years. But I think the delay, if there was one, was to make sure that we understood what the out-year funding implications were and that we have cabinet approval if and when a decision is made to announce that.

Ms. Mowat: — Was it ever suggested by eHealth staff that the work to build CHIP could have been done internally instead of contracting it out?

Mr. Hendricks: — So you know, I don't doubt that somebody at some point maybe suggested that eHealth develop it internally. And in fact the manager for this area said, you know, they gave that some thought.

The general tendency in the IT sector is that if you can go to market and buy something that already has been developed or off the shelf rather than developing it internally, the costs generally are lower. The other thing too is, you know, we had requirements with Canada Health Infoway to satisfy and they had to be comfortable that we had a vendor who could deliver the product. And so as part of that there was an RFP and several vendors were considered. We believe we got the best technology solution for the money.

Ms. Mowat: — Is it costed out then in that situation to compare what it would cost internally to using an outside vendor?

Mr. Hendricks: — I think the bigger issue was that at the time, eHealth did not feel that it had the resources, given other priorities. And you know, I think I mentioned earlier, because the development phase of this project, you know, there is a lot of work involved in the development phase. But after that's developed, the work goes away. It's maintenance, it's registration, that sort of thing. So I don't know that they did a detailed workup of what it would cost to scale up for a pilot period to develop internally, and I don't even know whether in fact Infoway would have supported that type of approach when you can go . . . you know, your chances generally of going with a proven solution are better.

Ms. Mowat: — In terms of the payment for goods and services in 2017-2018 to De Lage Landen Financial Services Canada, is this a relationship that's ongoing this fiscal year?

Mr. Hendricks: — I'll have to check into that and get back to you on that one. I don't have that in the information that I have with me.

Ms. Mowat: — Okay, thanks. In terms of the nine consultants that were mentioned earlier, can you provide us with that list of who those individuals or organizations are?

Mr. Hendricks: — Yes. Can we provide that to you afterwards?

Ms. Mowat: — Sure. Sure, I thought you might read it.

Mr. Hendricks: — I've got the 243. The nine, I don't have the list of consultants specifically.

Ms. Mowat: — Okay, you have the number but not the list in front of you. Okay. And just to be clear, when we're talking about those nine, does this include vendors as well or is that a different . . . Like just in terms of lingo, I'm not sure if all vendors would be included in that.

Mr. Hendricks: — Well you know, anybody who sells you something is a vendor, right? But like my sense of these guys — and I looked at a few of the arrangements with them — these are smaller contracts. They're not like a big vendor like Microsoft or something like that, right?

Ms. Mowat: — Okay. The auditor mentioned that there were some changes to the way contracts are being tendered since some of the concerns about vendor-sponsored travel came to light. Can you speak to what changes to tendering processes have been implemented with eHealth?

Mr. Hendricks: — So in the wake of the issues that arose at eHealth, there have been a number of steps that have been undertaken by eHealth. One is that they have mandatory annual code of conduct training for all employees; that all employees, managers who are involved in procurement undertake mandatory procurement training. They've also updated the procurement policy and process to ensure that it aligns with applicable trade agreements and provincial procurement guidelines. And they've conducted a criminal record check audit on all employees. The biggest thing being, in terms of your question, is that they've updated the procurement policy, and that was approved by the board.

Ms. Mowat: — How may vendors were there in the last fiscal year, and how does this compare to years prior?

[19:15]

Mr. Hendricks: — Unfortunately we don't have that information. We can table it with you. It would be in the payee list, but it's literally in the hundreds of vendors, right. We can table that though. I think we have previously before.

Ms. Mowat: — Thank you. In terms of capacity and qualifications among the senior positions — so directors, executive director, management — how many positions are currently held within eHealth by individuals that have STEM [science, technology, engineering, and math] training?

Mr. Hendricks: — We can provide that and table that information. Again, I don't have director-up detail like that.

Ms. Mowat: — Okay. So based on the Provincial Auditor's report and the need for an approved and tested disaster recovery plan for systems and data, in March 2017 eHealth had detailed recovery plans for only four out of 39 critical IT systems. It was identified that without this, eHealth might not be able to restore their critical IT systems data. It was mentioned that there is a three-year plan in place. Is it possible to table that plan?

Mr. Hendricks: — I don't have the actual plan with me tonight but sure, I can table it. There have been a number of . . . You had mentioned there is a three-year plan to address the DR [disaster recovery] issue. So far they've made progress on several of those things. They've centralized, as I mentioned earlier I think, 11 of the 15 former data centres across the province in the North and South to SaskTel tier III data centres in Regina and Saskatoon. So that helps with failover between those two; they've created high-capacity links between Regina and Saskatoon to ensure all data is replicated between the two sites.

And they're currently in the process of disaster recovering and testing implementation of two applications. And you will recall that they had 30-some applications that they had to do disaster recovery plans for. You know, the plans will vary depending on the type of application. Some require immediate failover and, you know, if Saskatoon went down, they would need to failover immediately to Regina. There are other applications that aren't as time sensitive so they're going through, they're identifying the continuity plan for each of those. And they are on track with the March 2021 to complete this work. But I can give you the full plan.

Ms. Mowat: — That would be great. There's a significant line item increase in the estimates for eHealth. It's up $512,000. What does this funding allocation represent?

Mr. Hendricks: — So the $512,000 increase to the budget is due to two transfers. One is 322,000 due to a transfer of HealthLine, the referral management services, from the SHA to eHealth. And then the second one is a $190,000 increase due to a transfer of the minimum data set home care from SHA, targeted for licensing their Momentum Residential Care module.

Ms. Mowat: — Can you explain that second piece in layman's terms?

Mr. Hendricks: — Not really. I can try to find somebody. So I'm told it's the tool that they use to do quarterly information gathering on quality information in long-term care, so like the number of falls, the number of people in restraints, that sort of thing.

Ms. Mowat: — Thank you. So basically what you're indicating is that the line item increase does not reflect an increase in expenditures at eHealth.

Mr. Hendricks: — Plus transfers.

Ms. Mowat: — Okay. I'm going to switch gears a little bit and talk about organ donation. The Saskatchewan transplant program currently handles both sides of organ and tissue donation, causing a perceived bias by the public that their end-of-life care may be diminished. Is there consideration under way for a stand-alone agency for donation?

Mr. Wyatt: — So the issue around the separation of the donor program and the transplant program, we don't have a formal program in place per se and wouldn't rule out creating something more formal. But through the creation of the donor physician functions and the donor coordinators in Saskatoon, it's effectively what we're beginning to do, and I guess now moving ahead and doing in Saskatoon. It separates the role of those coordinators and the donor physicians from the transplant team.

And so that concern around a conflict, again it's a perception; it's a concern. It's not something that, you know, I don't think it's something that people should be concerned about, where you have some of the same providers who are involved in the care of the patient, discussing with them the potential for becoming an organ donor, also being involved with the transplant team. And so moving to those donor coordinator roles is, among the many benefits, that is one of the benefits as it does start to create a clear distinction between the donor team and the transplant team.

Ms. Mowat: — Thank you. Considering the 2016 report from the Human Services Committee, recommendation no. 8 was to create targets and performance indicators and accountability measures. Have any of those been realized?

Mr. Wyatt: — One of the key metrics that's frequently cited is the organ donation rate in the province. And so we have set a target there, and the SHA was provided a performance target of improving organ donation rates to 18 donations per million population. That was in 2018-19, which would be an increase from 14.6 donations per million population in 2017. Moving beyond that particular indicator, the SHA is currently reviewing their program metrics and looking at what the appropriate set of ongoing metrics and targets would look like to measure the performance of the organ donation in the province and something that would be monitored going forward.

Ms. Mowat: — Thank you. How did we measure up in terms of that target?

Mr. Wyatt: — Sorry, can you repeat the question?

Ms. Mowat: — So you said that the target was 18 donations per one million for 2018. How did we measure up as a province? Did we meet the target?

Mr. Wyatt: — So how do we compare against . . .

Ms. Mowat: — Did we meet the target?

Mr. Wyatt: — Okay, thank you.

[19:30]

We don't have a full fiscal year result for 2018-19. The year-to-date information we had was that they were at a deceased organ donation rate of 13.7 donors per million population.

Ms. Mowat: — Thank you. In terms of the organ donation registry that was just announced, what's the timeline for implementation? I know folks are very eager to be able to register.

Mr. Wyatt: — The timeline that was announced in the budget was to have it completed and operational by the end of this fiscal year, so by March 31st.

Ms. Mowat: — Last year, I understand you hired nurse donor coordinators and donor physicians in Saskatoon. Are any of these planned for Regina to provide access for folks in the South?

Mr. Wyatt: — We don't have an exact set timeline for introducing those in Regina, but the intent is to follow up with the addition of donor coordinators that were brought into Saskatoon and to follow up by having them introduced in Regina as well.

Ms. Mowat: — Thanks. What about doing donation after circulatory death? I know Saskatoon's been doing it for a few years now, and Regina is only doing donations after brain death, which is limiting the amount of donors that can be found here.

Mr. Wyatt: — So following up on the introduction of the DCD, donation after cardiocirculatory death, program in Saskatoon, in December 2018 there was a meeting between Dr. Joann Kawchuk, the medical director for organ donation and donor physicians, with a group in Regina to discuss the establishment of a DCD program in Regina. There is certainly support for moving that forward among providers, and they are sort of reviewing DCD procedures for application within Regina hospitals. And physician education and DCD simulators are being planned for the early part of this year.

Ms. Mowat: — Thanks. We've been hearing from folks with chronic lung disease that managing the financial burden that comes with travelling for accessing treatment can be quite cumbersome. What type of supports are offered to patients who need to travel for, say, lung transplant therapy?

Mr. Wyatt: — So with respect to lung transplants, those are not provided within Saskatchewan, so that would be one of those procedures that patients would need to be referred out of province to receive. As a general rule, we don't provide coverage for out-of-province procedures. We, the Ministry of Health, will cover all of the treatment costs through reciprocal billing arrangements with the treating province, but travel cost is not part of the coverage that's provided when patients do need to leave for outside treatment.

Ms. Mowat: — Right. I understand that they also require a caregiver to be with them, which can be quite burdensome in terms of cost as well, especially if that individual is leaving a workplace to be a caregiver.

We've also heard in terms of the amount of oxygen that is supplied, we've also heard that with patients, that it's not sufficient for normal living and might result in people being housebound instead of going out and seeing the world because they're concerned that they would run out of oxygen. Can you speak to how oxygen coverage is estimated?

Mr. Wyatt: — We don't seem to have the answer to that question around how the amount of oxygen is determined for individual patients. So that would have to be something we would need to follow up on.

Ms. Mowat: — Thank you. I think from what I hear that it's something that warrants some consideration and looking into.

I've previously written Minister Reiter about the availability of the TAVI [transcatheter aortic valve implantation] procedures in Saskatchewan, TAVI or TAVR [transcatheter aortic valve replacement]. They're also called transcatheter aortic valve implantation procedures. So I'm waiting for some numbers back in terms of how many procedures have been completed. And I'm fine to keep waiting if that information is not available.

But I'm wondering what plans, if any, the ministry has to increase the number of TAVI procedures that are offered each year.

Mr. Wyatt: — When the TAVI program was established in 2017, we initially funded 25 patients for this new procedure, and since that time the program has been established. Last year in 2018-19, there was additional funding that was provided through the Saskatchewan Health Authority that supported an increase to 33 patients during that year. And I should also note that there are some patients who the ministry fund to go out of province if it's a case that is more complex than what can be provided in Regina at the program here.

On an ongoing basis I think we will, as with any service, we assess the demand for that service, the wait times for the service, and sort of look at the need to increase capacity. This is one that's relatively new so I think it's taken a little bit of time to understand both the demand and the output. And so as we continue to assess that, I think it's reasonable to expect that we will continue to develop the program over time.

Ms. Mowat: — Thank you. I shouldn't have said that I'm happy to keep waiting because it is a life-and-death situation; it's the lateness of the hour. But I think that there is a sentiment from folks that this should be prioritized and, you know, I think this procedure has been around for 15 years. So yes, I think that it's something we should be looking at for sure.

In terms of pediatrics, what's the number of beds for pediatrics at the new Jim Pattison Hospital compared to the old hospital?

[19:45]

Ms. Morrissette: — Okay. So I think the question was the number of pediatric beds in the Jim Pattison Children's Hospital?

Ms. Mowat: — Compared to the number of beds that are available right now at the old hospital.

Ms. Morrissette: — Perfect. So what I might do is I might just run through the kind of total beds and just write them down by the type of beds from the current to the new, including the pediatric beds because there was a few different kinds.

So in the current facility we've got 139 beds; the new facility will grow to 176 in total. And in the pediatric and observation category, it moves from 43 to 55; so I think that might be the beds you're asking about. In the PICU [pediatric intensive care unit], we went from 6 to 8, and the NICU [neonatal intensive care unit] . . . And sorry, that's pediatric intensive care unit. And the neonatal intensive care unit, from 32 to 48. And then in pregnancy and childbirth, from 58 to 65.

Ms. Mowat: — Okay. So you're saying that there's . . . So for pediatrics there are 43 beds in . . .

Ms. Morrissette: — Growing to 55.

Ms. Mowat: — Growing to 55. Right. Is that estimated to be an

appropriate number? We hear a lot of concerns that right now there's regularly more need and that children are doubling up in rooms, but that in the new hospital, there won't be the capacity to double up in rooms. They'll only be able to support single occupancy. So that's where the question arises from.

Ms. Morrissette: — So when the planning for the hospital was done, these were . . . We understand that needs to be adequate numbers, and we don't really have any evidence that would suggest that these are not adequate going forward.

To your question about kind of . . . Just to confirm that the new space in the children's hospital, they are single rooms. They are obviously much bigger rooms and built to kind of a more modern standard of care. So they're not designed to have more than one occupant in them.

Ms. Mowat: — Okay, thank you. We have been hearing some concerns in terms of the lack of a widespread practice on using liquid-based cytology for pap smears. So I'm just wondering if you can identify whether the ministry is considering transitioning to ThinPrep, which I understand is recommended by physicians in both Saskatoon and Regina. And it seems the current system is set up for that to happen and that it provides a much better sample because it transports the sample basically in water and it's less likely to be damaged.

Mr. Hendricks: — So the issue of how Saskatchewan does its testing for cervical cancer . . . In many places across the country, they use liquid-based cytology to do that. We still use standard slides and transfer the smear onto that for analysis. What I'm told is, while we have not yet decided to move to the liquid-based cytology, our testing, there is actually a new technology that's now emerging that might be a better opportunity for us. And so we're having those discussions with the Cancer Agency about where we go with that.

Ms. Mowat: — Can you speak to whether there were guideline changes that were preparing for liquid-based cytology back in 2011 or 2012?

Mr. Hendricks: — I understand that there were some guidelines that were prepared or proposals, suggestions, that sort of thing, to move to that technology, but at that time it didn't go forward. It just wasn't something that would move forward.

Ms. Mowat: — Okay. In terms of specialist waits, what was the average wait time for the top 10 specialties in 2018-2019 using the 55B data? And as well I'd like it broken down for pediatric specialties in particular.

[20:00]

Mr. Hendricks: — Okay, so there are some . . . Just before I talk about this, you just have to know that there are some limitations to this data. First of all, the way that we are calculating wait times by specialty is using a pretty old system, and so these are not specialist-to-specialist wait times, so when an internal medicine refers to, for example, a nephrologist. It also doesn't capture where a person has been referred to more than one specialist from a general practitioner. They're automatically dropped out. So it's a subset of the wait times. And so the top 10 list is: physical medicine with an average wait time of 163 days; cardiology, 133; respirology, 128; gastroenterology, 125; neurosurgery, 111; internal medicine, 105; neurology, 104; orthopedic surgery, 103; and nephrology, 103 as well.

Ms. Mowat: — Do you have the rest of them as well?

The Chair: — We have passed our time for adjournment, so if you have some documents, can you table them with the committee to be distributed.

Mr. Hendricks: — We can follow up. I don't have it in a form that can be shared tonight.

The Chair: — Okay. Thank you very much to everyone for participating this evening. Do the ministers have any closing remarks?

Hon. Mr. Reiter: — I'd just like to thank Ms. Mowat for the questions over the last number of hours. I'd like to thank the committee members and of course the staff, and all the officials that are here as well. And of course, thank you to you, Mr. Chair.

The Chair: — Ms. Mowat, do you have any closing comments?

Ms. Mowat: — Thanks to the ministry and all officials for being here tonight, and to all the committee members.

The Chair: — Okay. Thank you very much. Seeing no further questions, we will now adjourn consideration of vote 30, Health. I would ask that a member move the motion of adjournment.

Mr. Michelson: — I so move.

The Chair: — Mr. Michelson has moved adjournment. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned until Monday, May 6th, 2019, at 3 p.m.

[The committee adjourned at 20:03.]