STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Lloydminster

[The committee met at 17:01.]

Chair Weger: — Welcome to the Standing Committee on Human Services. My name is Mike Weger, and to my right I have Mr. Barret Kropf, Mr. Kim Gartner, and Ms. Colleen Young. And to my left I have Ms. Meara Conway chitting in for Mr. Noor Burki.

Pursuant to rule 148(1), the following estimates and supplementary estimates no. 2 were committed to the Standing Committee on Human Services on March 27th, 2025 and March 19th, 2025, respectively. 2025-26 estimates: vote 37 and 169, Advanced Education; vote 5, Education; vote 32, Health; vote 20, Labour Relations and Workplace Safety; vote 36, Social Services.

2024-25 supplementary estimates no. 2: vote 37, Advanced Education; vote 5, Education; vote 32, Health; vote 20, Labour Relations and Workplace Safety; vote 36, Social Services.

I would like to table two lists from the Law Clerk and Parliamentary Counsel of regulations and bylaws filed with the Legislative Assembly between January 1st, 2024 and December 31st, 2024, which have been committed to the committee for review pursuant to rule 147(1). The documents are HUS 4-30, Law Clerk and Parliamentary Counsel: 2024 regulations filed; and HUS 5-30, Law Clerk and Parliamentary Counsel: 2024 bylaws filed. The Law Clerk and Parliamentary Counsel will assist the committee in its review by submitting a subsequent report at a later date, identifying any regulations that are not in order with the provisions of rule 147(2). However the committee may also decide to review any of these regulations or bylaws for policy implications.

General Revenue Fund
Ministry of Health
Vote 32

Subvote (HE01)

Chair Weger: — Today the committee will be considering the estimates and supplementary estimates no. 2 for the Ministry of Health. We will begin with consideration of vote 32, Health, central management and services, subvote (HE01). Minister Carr is here with her officials. I would ask that the officials please state their names before speaking and please don't touch the microphones. The Hansard operator will turn your microphone on when you are speaking to the committee. Minister, please introduce your officials and make your opening remarks.

Hon. Lori Carr: — Thank you, Mr. Chair, and to the members of the committee. I'm pleased to have the opportunity to highlight significant investments we're making under the portfolio of Mental Health and Addictions, Rural and Remote Health, and Seniors.

The ministry's senior leadership team joining me here today include Tracey Smith, deputy minister of Health; assistant deputy minister Norm O'Neill; assistant deputy minister Ingrid Kirby; assistant deputy minister James Turner; assistant deputy minister Chad Ryan; and assistant deputy minister David Matear. Other senior officials from the Ministry of Health are joining us as well. I will ask them to introduce themselves as they are called upon to address the committee.

We are also joined by Andrew Will, the chief executive officer of the Saskatchewan Health Authority; Deb Bulych, the president and chief executive officer of the Saskatchewan Cancer Agency; Mark Anderson, chief executive officer of 3sHealth [Health Shared Services Saskatchewan]; and Terri Strunk, the CEO [chief executive officer] of the Saskatchewan Healthcare Recruitment Agency.

I want to express my thanks to the Ministry of Health officials, our health partner agencies, and health care staff across the province for their commitment and hard work serving the people of Saskatchewan.

A record investment this year will support mental health and addictions. We are continuing to take strides to improve patient access to professionals and services, and support a recovery-oriented system of care.

We are all highly concerned over the increase in overdoses in Saskatoon and the impact on individuals, families, communities, and our emergency responders. Every life lost due to an overdose is a tragedy. My sympathies go out to anyone who has lost a loved one to a drug overdose. The Government of Saskatchewan is committed to helping residents get the services and supports they need to overcome their addictions and live healthy lives.

In 2024 Saskatchewan saw a decline in the number of overdose deaths compared to the previous year. While this was encouraging, it's premature to determine if this is a trend. We must continue with our ongoing work to further expand addictions services across the province and provide recovery-oriented care.

Increasing treatment options and expanding addictions services remains a priority for our government. Guided by our mental health and addictions action plan, we will continue taking necessary steps forward to help people gain access to services and get the help they need to recover.

The action plan revolves around three important pillars: building capacity for treatment, improving the system, and transitioning to a recovery-oriented system of care with a focus on treatment and recovery. This plan includes steps to create a path forward into treatment and recovery with the end goal of living a long and healthy life.

I am pleased to provide an overview of our record investment of nearly $624 million to support mental health and addictions, including 487 million for mental health and 137 million for addictions. This year's budget represents a 53 million, or 9.2 per cent increase over last year. This increase includes 20.1 million in new targeted funding to expand services and improve mental health and addictions care for Saskatchewan people, as well as 6 million in new capital funding to expand complex-needs emergency shelters to new communities. The remaining 27 million is for increased utilization of hospital-based services, physician visits, and prescription drug costs. Of the overall health budget, 7.7 per cent is directed to fund mental health and addictions initiatives.

We are seeing areas of good progress in mental health supports. There are notable reductions in 30-day readmission rates to mental health in-patient units, reported rates of self-harm, and in the number of mental health presentations to emergency departments over the past year. I believe there is hope for recovery and help through treatment. Our commitment to expand access and recovery-oriented care is making a difference.

Of the 20.1 million targeted mental health and addictions investment increase, 15.8 million will deliver on our commitment to add 500 addictions treatment spaces across Saskatchewan, which is double the amount available before this commitment. Adding treatment and recovery spaces in seven locations stretching from Estevan to Pinehouse will help people get the help they need closer to home.

In the past fiscal year nearly 70 spaces have been opened, bringing the total number of operational spaces to 221. This means spaces are now available across the province. Sixty treatment spaces in Lumsden through Willowview — this currently stands at 20 in-patient treatment spaces and 40 intensive day treatment spaces, although the end goal is for 60 in-patient spaces upon the building updates.

Thirty-two intensive out-patient treatment spaces through the Possibilities Recovery Center in Saskatoon; 26 post-treatment spaces at St. Joseph's Addiction Recovery Centre in Estevan; 15 in-patient treatment spaces at Muskwa Lake Wellness Camp near Pinehouse; 15 in-patient treatment spaces and two withdrawal management spaces at Thorpe Recovery Centre near Lloydminster; 15 withdrawal management spaces at Onion Lake; 14 in-patient addiction treatment spaces at Battlefords Treatment Centre in North Battleford; and 42 virtual spaces through EHN Canada.

With these 221 addiction treatment spaces now operational, we will move forward with plans to have up to 400 of the 500 dedicated spaces ready by the end of 2025-26.

The remaining 4.3 million targeted investment increase will be directed towards several initiatives. One million to develop a central intake and navigation system for addictions services where patients can self-refer for mental health and addictions services to make the system more accessible. The initiative will help people find and connect to services, reduce barriers, and provide support in a timely manner.

One million to increase access to addictions medicines across the province by implementing a new virtual access to addictions medicine, otherwise known as the VAAM program, and adding supports for existing opioid agonist therapy, otherwise known as OAT, program in the province to improve service delivery for individuals accessing addictions care. These investments will enhance services that help alleviate opioid dependency.

One million additional funding to support Homebase hubs to deliver core services, including during evening and weekend hours. The budget will fully fund the core operations of four Homebase hubs. Homebase hubs in Humboldt, Moose Jaw, and Regina have recently opened their doors, and a fourth hub in Sturgeon Lake First Nation will be opening a permanent location in the coming months.

Homebase integrated youth service hubs deliver supports to youth — people from ages 12 to 25 — and their caregivers through in-person or virtual services. The program provides co-located access to mental health and addictions services; physical health services; peer supports; education, employment, and training supports; cultural and traditional supports; and social and community supports.

561,000 for Health to annualize operational costs for two five-bed mental health youth homes in partnership with Social Services for youth with chronic mental health and addictions issues in Saskatoon that will be provided by Egadz. 500,000 to facilitate the transition to a recovery-oriented system of care with a focus on treatment and recovery.

We are confident that improving access to treatment spaces can significantly improve the chances of living a full life in recovery, which not only saves individual's lives, but also helps families and strengthens communities. The recovery-oriented system of care recognizes that everyone's path to recovery is different, and people may need care for different lengths of time to reach a point where they are stable in their recovery.

Our government will also provide 200,000 in new funding for the BridgePoint Center for Eating Disorder Recovery to offer additional adult and youth virtual services and for dedicated youth programming. We recognize the importance of programs like the offering that BridgePoint facility has which help people manage disordered eating through holistic wellness. Virtual programming has made BridgePoint services accessible to many more Saskatchewan residents.

We also recognize the necessity to meet the needs of younger patients who may be experiencing disordered eating. Participants of the current program stay at the BridgePoint facility for the duration of their program and receive support 24 hours a day, seven days a week. A virtual support program has also been launched and will be further enhanced in '25-26. BridgePoint offers a stepped-care model that is designed to meet the needs of patients whether they are in recovery, including supports for parents and caregivers.

As mentioned earlier, the '25-26 budget will provide 6 million in new capital funding for expansion of complex-needs emergency shelters in new communities. Complex-needs emergency shelters are medically supervised secured facilities that provide individuals in crisis with a safe place to stabilize while being monitored for the negative effects of drugs or alcohol. Two 15-bed facilities are currently piloted in Regina and Saskatoon. These facilities have proven to be effective in protecting and supporting individuals who are intoxicated and exhibiting behaviours that present a danger to themselves or others while enhancing community safety.

The initiative is part of the government's provincial approach to homelessness announced in October 2023. These facilities support individuals in crisis and enhance community safety. They are a safe alternative to holding intoxicated individuals in police cells with limited medical assistance or taking the individual to an emergency department. Those brought into these facilities receive basic health services in a 24-hour support environment.

[17:15]

Clients are connected to follow-up services such as addiction treatment, housing, and income assistance supports. The facilities are staffed with nurses and support personnel with experience in detox and withdrawal management, and security staff to ensure client and staff safety. The facilities keep the individuals in crisis safe and help transition them to support services and programs.

Complex-needs emergency shelters offer a holistic approach, integrating basic health services and navigation to other wraparound supports. Individuals are provided a discharge plan connecting them to appropriate services and supports.

Saskatoon Police Chief Cam McBride said that the facility is working very well and he thinks individuals who are utilizing the centre are getting a far better opportunity to overcome a critical incident or a critical circumstance in their life. We are exploring other potential locations that are best served by these facilities, as several Saskatchewan communities are interested in creating a complex-needs emergency shelter to help individuals struggling with addictions and in need of these interventions.

Providing quality, safe care and supports to seniors, whether at home or in a long-term care setting, remains a priority for our government. We have added new long-term care and alternative-level-of-care beds in Saskatoon and Regina, and we have now fully delivered on the commitment to add 300 continuing care assistants. The 2025-26 budget provides increased investment of 7.1 million to strengthen continuing care programs and provide residents with increased support to remain at home and in their communities as long as possible.

A $4.7 million increase will fund continuing care services for all ages, from children with complex medical needs to seniors. This funding will deliver additional programming and resources. For children with complex medical needs, it will enhance facility-based care and home supports. For seniors, this funding will add more home care assessors and schedulers and new inspectors for long-term care and personal care homes. It will also support a dementia-friendly community program in Yorkton that provides support to dementia patients to participate in activities in the community as well as respite to families.

A $2.4 million investment will be dedicated to operations and staffing of 115 established long-term care and convalescent beds to support the Saskatchewan capacity action plan for alternative-level-of-care services. The 50 long-term care beds and 65 convalescent beds located in Saskatoon will assist with patient flow complexities. This investment supports adding community-based care beds and staff to transition patients out of acute care when it is no longer the most appropriate space for the patient and will improve capacity in acute care.

When it comes to rural and remote health care, we continue to make significant investments to improve access to health services for residents outside of urban centres. Rural and remote areas of Saskatchewan received important focus again this year in all key areas of the budget.

HealthLine 811 will receive 6.6 million to increase support for the expansion of the successful virtual physician program to a minimum of 25 communities. This program supports emergency departments in rural and remote communities that are at risk of service disruptions due to physician unavailability. To date this service has been rolled out in 20 communities where it has shown great results. Since July of 2023, over 1,000 ER [emergency room] service disruptions have been avoided thanks to the made-in-Saskatchewan program.

Increases to EMS [emergency medical services] will improve response time and stabilize services across the province, including rural communities. Minister Cockrill will speak to this in more detail tomorrow.

Investments in primary care are also benefiting rural locations. A $5 million increase in this budget supporting primary care improvements includes the expansion of the new model of care called Patient's Medical Home, replicating a successful pilot in Swift Current. This investment supports our government's commitment to work to ensure everyone in Saskatchewan has access to a primary care provider by the end of 2028.

The Patient's Medical Home enhances access to high-quality primary care services by supporting clinics to care for additional patients due to the extra capacity the team creates, with each provider working to their full scope. Physicians are supported by nurse practitioners and allied health professionals which may include registered nurses, dieticians, medical health therapists, social workers, physiotherapists, pharmacists, and others, delivering appropriate care more efficiently with capacity for more patients.

A $2.3 million investment will advance commitments for nurse practitioner expansion. This funding supports the addition of more than 27 new nurse practitioner positions to improve access to primary care services in rural, regional, and remote communities. As primary care providers, nurse practitioners work with family physicians and other health care providers in collaborative teams to provide quality care to Saskatchewan patients. Also they contribute to achieving the goal that every Saskatchewan resident has access to a primary health care provider.

This year's key health human resource action plan investments also provide strong support to rural and remote communities through a range of attractive incentives and retention initiatives.

Continued funding of 8.7 million is provided in the 2025-26 budget for the Saskatchewan rural and remote recruitment incentive program. This includes investments for an additional intake round of at least 180 new applicants and continued funding for existing recipients completing their second and third year in the workplace. The rural and remote recruitment incentive has directly benefited over 50 communities across the province with more than 400 hard-to-recruit positions successfully filled.

Retention of health care staff remains a priority, particularly for rural and remote locations that are confronted with staffing shortages. This year's budget includes 33.8 million to continue supporting 250 new and enhanced permanent full-time positions in high-priority occupations to stabilize staffing in rural and northern areas.

New funding of 4.9 million will support 65 new and enhanced

permanent full-time registered nurse positions to stabilize nursing in 30 rural and northern locations. And Minister Cockrill will provide additional detail tomorrow regarding the HHR [human health resources] action plan investments across the province.

Through all of these budget investments we continue to deliver for Saskatchewan people. We recognize more work remains to be done, and we continue to tackle the challenges facing health care in our province, and we are committed to doing so. My officials and I will now be pleased to take your questions. Thank you very much.

Chair Weger: — Thank you, Minister. And I'll just recognize that we have Mr. Keith Jorgenson sitting in for Mr. Brent Blakley and Ms. Betty Nippi-Albright sitting in for Ms. April ChiefCalf.

I'll now open the floor to questions. MLA [Member of the Legislative Assembly] Conway.

Meara Conway: — Thank you, Chair. It's a pleasure to be in estimates. I've recently taken over the file of Rural and Remote Health, so bear with me as most are new faces. And just by way of a road map, I'll be asking questions for a little over an hour. I'll pass it over to my colleague Ms. Nippi-Albright to ask questions on addictions and mental health. And then Mr. Jorgenson will be asking questions regarding his portfolio, which is seniors.

An hour is not a lot of time. I'll try to keep my questions constrained. If I don't get to things, I may try to summarize them at the end and put them in a letter to you, Minister, and you can hopefully respond to, you know, what you are able to respond to at that time.

Service closures in rural Saskatchewan have been consistently growing in recent years. I have before me a report that was prepared, which analyzes raw data from the SHA [Saskatchewan Health Authority] between August 2019 and July of 2023. And it contains the number of disruptions — 952 — over a certain number of days and a certain number of facilities. So I anticipate that this is data that SHA collects.

So what I'm asking for today is an update on those numbers, specifically from August 2023 to present — the number of disruptions across the province, the nature of those disruptions, the length of those disruptions, and the number of facilities impacted. And if it's going to take a significant amount of time to amass that data today, a commitment to providing that within a certain time frame that you feel is reasonable.

Hon. Lori Carr: — Just one quick question. At the top you said that you got these numbers from a report. Can you tell me what report you got those from?

Meara Conway: — Sure. I believe we FOI'd [freedom of information] these numbers directly from SHA, but it's also contained in a report that was prepared as a partnership between the Saskatchewan Population Health and Evaluation Research and the University of Regina. It's called *The Current State of Healthcare in Rural Saskatchewan*, and it's the final report dated April 2024.

[17:30]

Ingrid Kirby: — Hello, I'm Ingrid Kirby, assistant deputy minister. So I will read out the list of facilities that have had a disruption. I will note this is for fiscal year so April 1st, 2024 to March 13th, 2025. We don't have data with us tonight that goes all the way back to 2023, which was what your question was. So I will answer based on fiscal year.

Meara Conway: — Sorry to interrupt, Ms. Kirby. Given that you don't have all the data I've asked for, and given that I'm sure there are dozens of communities on that list, Minister Carr, can you please commit to simply tabling this information at a later date, given that the information . . . It sounds like you just have facilities, don't have the complete data, and I'm not sure it's the best use of our time to read in . . . I mean there were 51 facilities that were interrupted in the last period that I asked for so unless you're planning to follow up with more complete data tonight, I'd ask that you simply table this data if it's going to be incomplete in any event.

Ingrid Kirby: — So I can give you kind of a high level of what disruptions we have seen over the last fiscal year. So we've had disruptions primarily due to physician, registered nursing, or CLXT [combined laboratory and X-ray technologist] shortages. The majority have been less than 24 hours in duration. And then it runs the gamut from a number of rural facilities from All Nations' Healing Hospital in Fort Qu'Appelle, Arcola Health Centre, Biggar & District Health Centre, Broadview Union Hospital, Canora, and so forth. And again most of them are due to physician, nursing, or CLXT. There are a couple that were due to equipment malfunctions or infrastructure that needed some repair.

Hon. Lori Carr: — And then I guess I would just add that with those disruptions, we have taken some pretty significant initiatives, that we have been able to help mitigate several disruptions that have been happening. One of those would be our virtual physician program and this program is a model, is 24-7 service that enables nursing staff at hospitals to call the virtual physician for further assessment when a patient presents at the emergency room and local physicians are not available to provide that coverage.

For the period from April 1st, '24 to March 15th, '25, this program helped avoid 1,210 emergency room disruption days. Since the program's inception in July of '23, this expanded to 21 communities across the province, and we're hoping to have seven more sites added in the spring of 2025.

We also have something called point of care testing. As of January 2025, the point of care testing program has prevented a total of 79 potential service disruptions. This program is currently helping to stabilize ER services in Leader, Maple Creek, and Wynyard during times when laboratory staff is unavailable.

Thirty-seven per cent reduction in chronic vacancies due to improving workforce stability. So this strategy has delivered tremendous success, achieving a 37 per cent reduction in chronic nursing vacancies province-wide and a 50 per cent reduction in chronic nursing vacancies in rural and northern locations. Chronic vacancies are defined as a position that remains unfilled for 90 days. Most importantly this program enhances service

stability for patients and has reduced the use of contract staff and has had no impact on the SHA staff vacation utilization.

And lastly the strategic recruitment initiatives: the SHA has prioritized domestic and out-of-province student recruitment, successfully hiring over 960 new nurses since April 1st of 2024. The Government of Saskatchewan's rural and remote incentive has been instrumental in reducing reliance on contract staff, with 254 registered nurses, 26 registered psychiatric nurses, and nine nurse practitioner incentives awarded to date. These incentives have been highly effective in recruiting and retaining both new graduates and experienced nurses looking for work in Saskatchewan.

Meara Conway: — So I'll just return to my question. My understanding is this is data SHA tracks. Can you provide the data points I asked for, and if so, when can you provide that?

Hon. Lori Carr: — She's just going to double-check on what exactly we can get based on your question, so if you want to actually move on to your next question while she's doing that, we're good with that.

Meara Conway: — Great. In terms of service disruptions, I appreciated the high-level summary that many of these closures are 24 hours or less. My understanding is that SHA doesn't or no longer posts those closures publicly. My understanding is they only post disruptions that last a certain amount of time or more, maybe seven days.

Given that of course in a medical emergency, time is of the essence and knowing that your local health care hub is closed may be the difference between life and death — which is indeed the case with some of the families I've spoken to — why on earth does SHA not post all service disruptions in real time so that the people of Saskatchewan know where they can access life-saving treatment?

Ingrid Kirby: — Thank you. So in regards to your question regarding getting the data back to August 2023, we are able to go back to November 2023. Before that it becomes very, very manual. To go back to November 2023 it would take probably about a month in order to pull that report together.

Meara Conway: — So by May 1st? Great, thank you, Minister.

Hon. Jeremy Cockrill: — Just speaking specifically on, you know, the communication around disruptions, I think it's important to remember that, as Ms. Kirby outlined in a previous answer, most of the disruptions we see are less than 24 hours in length. The reality is that many disruptions are fluid in nature, you know, especially if they're staff based or even if they're based on challenges specific to specific equipment that's used in the facility. Sometimes it's short notice that we find out that someone might be sick or someone might not be able to be at work. So we have to keep that in mind.

And the other piece of that is that even, you know, if we expect to see a disruption later that day or tomorrow, it doesn't mean that the SHA stops trying to fill that shift or get somebody to cover that particular position. So again that speaks to the fluidity of the disruptions and trying to address those challenges.

You know, just last week we had a situation where we expected a disruption at a rural facility, but we were able to activate the virtual physician program and make sure that that disruption did not occur for that community. So again, that speaks to kind of the fluid nature.

[17:45]

In terms of notification, you know, when the disruption is logged, there's a process to notify the local community so that local community leadership can be aware of that. And then obviously when the disruption is logged, that's also provided to 911 dispatch so that in situations where you know someone might be calling in or EMS might be determining where to take a particular patient, that information does flow to the communities, does flow to EMS operators, again in an effort to try and make sure that . . . Recognizing that these situations can be fluid and usually are, that both community and first responders can be as flexible and responsive as possible.

Meara Conway: — So, Minister, I don't want to get into too much of a back-and-forth on this, but the average service disruption, based on this report: seven days. So these disruptions are significant, even a 24-hour disruption. I'm not asking that SHA post expected disruptions. I think it's important to post real disruptions. The difference between making the trip 50 kilometres down the highway or 100 kilometres, knowing that can be life-saving.

How this appears to people because disruptions are getting worse? I have the chart; every year the number of disruptions increases. The length of disruption increases. The seriousness continues to concern people. So the way this is perceived is that it simply makes your government look bad, and so you've stopped a practice that existed before. You've changed the practice, and it actually puts people at risk.

So I'm going to urge you to revisit this. As easy as sticking a paper notice on the door, it's just as easy to publicize that disruption on a website in this day and age, in 2025. There's absolutely no reason that we are not making this information as transparent as possible to the people that it affects on the ground.

I've spoken to paramedics who show up at Shellbrook. They show up and there's a notice on the door that they weren't aware of. So come on. We can do better. We need to do better. In fairness to you, I can give you a chance to respond or I can move on to my next question.

Hon. Jeremy Cockrill: — Yeah, you know, Ms. Conway, I'll just mention I appreciate that you're quoting from the SPHERU [Saskatchewan population health and evaluation research unit] report. I would just, you know, remind all committee members that the SPHERU report, the time frame ends in 2023.

As Minister Carr outlined in a previous answer, there's been several ongoing initiatives with the Saskatchewan Health Authority to reduce rural disruptions. I think overall we're seeing the trends pointing in the right direction. That doesn't mean that there don't continue to be challenges, but you know, to quote a report that finishes in 2023 and communicate that as current state, I don't think is fair or reasonable, you know. And obviously we'll endeavour to provide the data that you request.

Meara Conway: — Yeah, obviously I don't have that data, Minister. Only you do and I'm seeking it. So certainly the feedback I'm getting on the ground is that this is still very much a concern for rural communities, that many of the incentives that have been undertaken are not working, that there are lots of concerns across the board in many communities. So it'll be great when we can actually have this conversation based on some real data.

In terms of vacancy rates in rural and northern Saskatchewan, can you just fill me in on how you track those? Is that something that is available broken down by region and position, Minister?

Mike Northcott: — Good evening. My name is Mike Northcott. I'm chief human resources officer with the Saskatchewan Health Authority. So vacancy rates is a key metric that we track on a monthly basis. So each month we're reporting, we look at various classifications, so our hard-to-recruit, and look at our vacancy rate for permanent full-time, part-time chronic vacancies.

Meara Conway: — So if this is something you track monthly, what would be like the best practice to be able to compare vacancies over a period of time, say five years? You know, another thing I read in this report is that vacancy rates have doubled since 2019 or something like that, and certainly they've increased. What would be the best way of sort of assessing progress on vacancies in the health care system?

Mike Northcott: — Yeah so we compare it on a month-to-month basis. So we can compare March this year to March last year, and we go back a number of years.

Meara Conway: — Minister, can you provide the monthly vacancy rates you have every month, going back five years?

Hon. Lori Carr: — I guess, because we're talking budget and how the dollars affect the budget, I'm just curious about how that ties in to our budget this year?

Meara Conway: — It's a long-standing practice to get comparative data. You can't assess how you're doing this year unless you know . . . You don't know where you're going unless you know where you've been.

I'm new to the portfolio. I don't see this question's been asked in the past. So again, I think it's reasonable. Five years is not a long time frame. Then it captures COVID. Really it will get a sense of how those budgetary dollars are being allocated and whether we're seeing progress in this area.

Hon. Lori Carr: — Right now the information that we have tracked only goes back to 2022, so we could commit to giving you 2022 numbers forward.

Meara Conway: — Would it be difficult to go back five years? I don't need it tonight.

Hon. Lori Carr: — No, it would be very manual in nature and it would take an exorbitant amount of hours to be able to do that. So they have started tracking electronically since 2022. We can commit to that.

Meara Conway: — Is that correct? You've only started tracking this in a non-manual way since 2022?

Mike Northcott: — In this manner, yes.

Meara Conway: — How long would it take to manually go back five years?

Mike Northcott: — I'm not actually sure that we could get the data. So I would have to go back and talk to our data people. But I think it would take a long . . . like a lot of manual work, if it can be done even.

Meara Conway: — Okay. That's reasonable. I'll take from what you have starting when you shifted to not doing it manually. Tonight or tomorrow, Minister? Or when do you want to provide that? Do you have it here or in a manner that's shareable now?

Hon. Lori Carr: — Not right now.

Meara Conway: — Okay, so just in the next few days, that would be great. Okay, thank you, Minister.

I have a question about the SIPPA [Saskatchewan international physician practice assessment] program. I'm familiar with the SIPPA program. I've heard you all talk about the SIPPA program a lot.

My question is very specific. I'm wondering if you track the number of physicians who leave the community they're working with when the contract ends, and the number of physicians who go before that, actually buy themselves out of the contract. I'm wondering if that is something you track. And again I'll be hoping for some comparative data going back at least five years on that. So if you could speak to that.

[18:00]

Hon. Lori Carr: — Thank you for the question. I guess first of all the program has been a fantastic tool for rural Saskatchewan to be able to attract doctors and fill in gaps in spaces when they need that to happen.

So we have had 700 physicians have been assessed through SIPPA, and of that 261 have actually left the province. So we have those physicians that have successfully been to rural Saskatchewan and filled those gaps in the interim.

We do know, as you noted, that some doctors leave after their return-of-service and some doctors actually buy out their program. We don't have those exact numbers here with us, but what we do know is because of the time frame of the return-of-service and the ability to be able to buy out a contract and move to another location — some of them are just moving within Saskatchewan — it's probably not serving the purpose that we had hoped it would serve for longevity in these rural communities.

So we are actually doing a review of the program right now to see — kind of to your questions — like what has it done in the past and how can we make it better moving forward. And that assessment is just taking place at this point in time.

Meara Conway: — Sorry. You said 261 of 700, but I don't know

the time frame for that or what exactly you mean by that. So again . . .

Hon. Lori Carr: — Since 2011. It's a holistic number since the program started in 2011.

Meara Conway: — Okay. And as you're doing this review, can you provide some of that raw data in terms of how many doctors leave when their contract expires and how many doctors annually leave in advance of that? Do you have that data, and can you provide it?

Hon. Lori Carr: — I don't have that data right now. I'm sure as they do the review those numbers will come out. But I guess as we move forward with the questioning, if we could just, if we could keep it to the budget implications of what we're talking about in estimates that would be appreciated as well.

Meara Conway: — So, Minister, do you track this data and just not have it tonight, or does this data not exist?

Hon. Lori Carr: — No, they keep track of some of that information, and as they go through the review they're going to be analyzing that.

Meara Conway: — So in terms of these comparative questions, again there's a long-standing precedent for asking comparative questions because of course we can't assess how the government is doing and how effective you're spending those budgetary dollars without knowing, you know, some data points in the past.

How far back do you feel is reasonable to provide in terms of the rates of SIPPA doctors on this data point?

Hon. Lori Carr: — I mean, once again it would be a very manual process. That's not something that we're tracking electronically right now, so we'd have to go back into the records and try and find that information. And I do believe that work is probably being handled by the review that is taking place right now. They'll be digging into that information.

Meara Conway: — So you can't provide me anything on how many doctors are leaving the SIPPA contract upon expiry of the contract, and how many are buying out in advance of the expiry of the contract? You can't provide me anything . . . [inaudible interjection] . . . Okay.

Hon. Lori Carr: — I guess within the scope of the review, as we're going through those, we will attempt to get those numbers to you over what they're doing the review on.

Meara Conway: — Okay, Minister. How much was spent on contract nurses in rural and northern Saskatchewan this past budget year, and how much is budgeted to be spent this coming year?

Hon. Lori Carr: — So for '23-24, contract nursing was at 91.7 million. But the '24-25 year, which obviously we're just ending, we're already trending about 30 per cent lower than that. And our target for '25-26 is going to be for another 30 per cent lower than that, so decreasing our reliance on contract nurses.

I would like to note that of all of our nursing across the province, contract nursing actually only accounts for 2 per cent of all nursing expenses that we have across the province. So if we keep that in context. As well as there are very strict parameters around when we can use contract nurses. Of course collective bargaining agreements and different rules in place, it's very stringent.

And if we didn't have the ability, you know, once it's okay that we're using them following the guidelines that are brought forward by the unions that we have and the contracts that we have out there, if we didn't have the opportunity to use contract nurses in certain situations — I guess less than 2 per cent of the time when it comes to nurses — then we would have more service disruptions if we didn't have the ability to hire these individuals. Whether that be in a rural and remote area, whether that be in a tertiary centre that is trying to do a surgery, name your instance where we have to use a contract nurse to fill a vacancy.

[18:15]

Meara Conway: — Minister, can you clarify that 91.7 million, that's for . . .

Hon. Lori Carr: — '23-24, so two years past. This year that we're just going to be ending — because the numbers aren't quite final yet — we are trending 30 per cent down.

Meara Conway: — Sorry, is that global or for rural and northern? Do you have it broken down or that's global?

Hon. Lori Carr: — It's global. We don't have it broken down into rural and remote.

Meara Conway: — Okay, and when do you anticipate you'll have that '24-25 number?

Hon. Lori Carr: — When we finalize the books and come out with them. I think it's in July that we actually come out with the final roll-up of the numbers. When is it? End of June, early July will be the . . .

Meara Conway: — Thank you. And of course nursing is not the only area that you're relying on . . . Like you know, we met with the medical technicians and technologists today. They were discussing LOUs [letter of understanding] that have been signed for contract positions in those areas. This is something that's relied on to address short-staffing.

Can I just shift gears to casual and part-time work? Not sure if I'm posing this question in a way that makes the most sense, and I'm happy to get at this some other way if this isn't the best way to ask it, but I'm looking for the percentage of hours or the hours worked in rural facilities by part-time and casual staff. Wondering if you track that in any way, or some equivalent data point to meaningfully get at the portion of work that's being done by part-time and casual positions. And I'm anticipating this is likely a question for the gentleman that was up here earlier from HR [human resources], but I'm not sure.

Hon. Lori Carr: — Okay. Thank you for the question. Unfortunately we don't track it by facilities by part-time and casual the way you're asking. So we're not able to provide that information. I think it's important to note that, I mean, situations where we might have a part-time or a casual they actually . . .

Some people want that type of work because it could be a family situation. And we try to accommodate, you know, the mothers out there that are working, only want a part-time job and want a job share, you know. So we want those part-time and those casual positions available so that we can keep them engaged so that when they are ready to come into the full-time work we're able to do that.

Meara Conway: — How do you track it, Minister? Not by facilities. How do you track it?

Hon. Lori Carr: — Just as a whole.

Meara Conway: — So can you provide that holistic data going back five years? Reliance on part-time and casual staff.

Hon. Lori Carr: — Okay. So if we go to 2019-20 — so that'll take us back five years — for casual in '19-20 it was 3,148. In '20-21 it was 3,034. In '21-22 it was 3,357. In '22-23 it was 3,587. And in '23-24 it was 3,843, and that's the most current data we have. So that was for casual.

Part-time in '19-20 was 9,529. In '20-21, 9,704. In '21-22, 10,021. In '22-23, 9,734. And in '23-24, 9,879.

And there is one other column I would like to read. It's the full-time equivalents, just so that we can compare them to what's going on out there with part-time and casual. Which I might note that it is something that, as we have been meeting with our union partners, that they feel that the casual and part-time complement that we have in place is important to help them be able to operate the facilities properly.

So on full-time equivalents, in '19-20 it was 21,034. In '20-21 it was 21,883. In '21-22 it was 22,545. In '22-23 it was 22,280. And lastly in '23-24 it was 22,958. I guess just to show that the complements in all the areas are going up proportionally.

Meara Conway: — Minister, what are the units you're quoting? Like the . . .

Hon. Lori Carr: — Full-time equivalents. Full-time equivalents.

Meara Conway: — But the other ones, like 3,048. Positions?

Hon. Lori Carr: — Those are number of casual positions.

Meara Conway: — Positions?

Hon. Lori Carr: — Full-time equivalent. Full-time equivalents. FTEs.

Meara Conway: — I see. Okay. I see you're reading from a table there. Can you table that table?

Hon. Lori Carr: — No, it has a bunch of other information on it, so just the numbers that I read into the record is what you'll get.

Meara Conway: — Can we get a copy of that table . . .

Hon. Lori Carr: — Redacted?

Meara Conway: — Yeah, where we don't have the other . . .

Hon. Lori Carr: — Sure.

Meara Conway: — Thank you. This is a simple yes-or-no question. The vacancy question I asked before and you undertook to provide the data that you have going back to 2022, will that include . . . We hear a lot about staffing shortages in acute care and in-patient. It's sexier; it gets a lot more attention.

Of course there's a lot of issues with out-patient staffing shortages. So I hear from a lot of rural physicians who will, say you know, refer a patient to an OT [occupational therapist] or a physiotherapist and to a health network and one of the primary care teams. And they'll get an answer back: we just don't have one. Will the numbers that you're providing on vacancies, will they speak to those vacancies in the health networks or not?

[18:30]

Hon. Lori Carr: — No.

Meara Conway: — I'll send a follow-up letter, Minister. I do want to pass it on to my colleague. I didn't cover a few things like the government's plans for an Estevan MRI [magnetic resonance imaging] and whether that's in the budget, whether there's any funding in this budget for a CT [computerized tomography] scanner in Moosomin. Just some specific questions that I'll maybe put in a letter to you, Minister.

But before I pass it along to Ms. Nippi-Albright, I do have a question about northern Saskatchewan. The SHA has committed to closing the gap between Indigenous and non-Indigenous individuals in Saskatchewan. Of course we've seen many health scares and crises that speak to that gap actually widening. I think of outbreaks in rural and northern communities in pneumonia, scurvy, measles, tuberculosis, etc.

I guess on this I'm wondering if you could speak to any funds that were diverted to deal with these health crises that disproportionately impacted Indigenous communities and what plans are being made going forward. And then whether there is anything in this budget that differentiates between recruiting and retaining in our northern communities versus rural communities because there are unique challenges. So if you could speak to that or follow up in a letter to me, I would appreciate it.

Hon. Lori Carr: — I guess just when we're talking about specific situations, regardless of where that community is in Saskatchewan the Saskatchewan Health Authority will always endeavour to work with those communities and try and find ways to help mitigate any circumstances that might be happening.

We have the recruitment fund for communities which are hard to recruit, and I know that we're going to be adding more communities to that coming soon. We haven't announced who they are yet. There will be some more in the North, what you would consider northern Saskatchewan. We just haven't announced them yet so I don't want to, you know, scoop other people this evening. But that will be up and coming. So yes.

Meara Conway: — That's all for me. Thank you, ministers and staff and officials.

Betty Nippi-Albright: — Thank you so much. Oh, I was way down on that seat; now I'm way up. I feel good.

Thank you so much for taking the time to listen to our questions and also answer our questions. So just for time, if there's questions that need more collaboration with your team, if that's something that could be given at a time just to try and get as many questions in, that would be really helpful to me.

So I'll just get straight into the questions I suppose here. So the percentage of health care spending in this budget is up, but within that spending, percentage for mental health and addictions is down. Why is this government decrease the percentage of their health care budget assigned for mental health? Sorry, let me rephrase that. Oh, I have to wear my glasses. That would help.

So the percentage of health care spending, the budget is up. However within that spending percentage, mental health and addictions is down. So why did the government decrease the percentage of their health care budget assigned for mental health and addictions?

Hon. Lori Carr: — So within the budget for mental health and addictions, the 2024-2025 estimate is 571 million. And '25-26 we're planning on spending 623.8 million. So that is $52.8 million more than we spent last year, so that is an increase.

Betty Nippi-Albright: — Okay. Thank you. So I'm going to move on to another question here. So the government stated there is 221 in-patient treatment spaces that are operational for addictions. So 60 of those treatment spaces, of that 221, are at the Willowview Recovery Centre in Lumsden. We do know that there's only 20 of those beds that are accepting . . . They only have 20 in-patients that they're accepting at this time.

So how much are the 40 empty beds at Willowview costing the taxpayers in this province?

Hon. Lori Carr: — Okay, well thank you very much for the question. So yes, we are contracting services at Willowview in Lumsden, and there are 60 beds available — we'll call them services available — 20 of them are in-patient, and 40 of them are intensive out-patient beds that are available. And it comes at a cost of $400,000 a month.

Betty Nippi-Albright: — So of those out-patient or intensive out-patient beds that you have of 40,000 . . . So how many individuals with complex needs completed that treatment? And how much did it cost per month? And how did you evaluate how successful the out-patient treatment was?

[18:45]

James Turner: — Good evening, I'm James Turner, assistant deputy minister. So since we started the out-patient program in the fall, the average daily census was about 20 to 30 people in the out-patient-only program.

Since we were able to open the in-patient and the out-patient blended programs, the average daily census for the in-patient program has been almost full capacity, so 19 to 20 people per day in the program, and the out-patient program in the 8 to 10 people range since the in-patient has been opened.

It's probably too early to say what the success factors are. I think we would probably want a year worth of regular operations before we could actually do a proper evaluation of the program.

Betty Nippi-Albright: — Okay. Just to clarify that. So you're saying 20 people per day, etc. But back in January we were told there was two people for out-patient. There were people that were not receiving the out-patient. Like do you have a report that you could submit on the quarterly reports of the stats in terms of how many people were admitted, I'll say, on an out-patient basis and how many of them succeeded or dropped out? And how many . . . Were we still paying for people that haven't been, whether discharged from the out-patient services? Is that something you could provide?

James Turner: — So there would be some phase transition from when the facility went from 60 out-patient occupancy to 20 in-patient and then out-patient occupancy as well. So that happened on January the 23rd, where that switch happened where there was actually 20 beds for in-patient.

And so during that phase transition there would have been less people in the out-patient program while they stabilized the in-patient program, and then that would have just gradually grown to the 8 to 10 sort of average daily census for the out-patient program. So there was a natural transition for them not admitting people into the out-patient program — as many of them into the out-patient program — while they were standing up the in-patient program. So I think that probably answers the question around the period of transition in January.

I think it's probably a little too early for us to get an annual report from the provider in terms of the actual admissions, and so I don't have a table or a report right now in terms of the admissions. We would likely get that on a regular basis, quarterly or annually, from the provider after it's been stabilized and the facility's operating as it would normally operate. And just maybe on the normal operations, I think we are in the last phases of rectifying the problems in the facility — or the provider is in the last phases of rectifying. The building inspectors have been out this week. I think we are probably weeks away from getting the permit to actually open 60 in-patient beds in the facility.

Betty Nippi-Albright: — So just to clarify, so help us understand that. So you were talking about average 28 people were receiving out-patient treatment before you went into 20 in-patients. So that looks about, is about 14,285 per month on an out-patient basis. For out-patient. Is that the best use of taxpayers' dollars to pay 14,285 for out-patient while you're waiting for the facility to open up to take in-patients? Just a yes or no would be fine.

Hon. Lori Carr: — So I think it's important to talk about the services that we're actually providing the people of Saskatchewan and the expectations. We have a problem with illicit drugs across the province. We're seeing in the city of Saskatoon right now the issues that are happening there.

So we're focused on having services open and available for the individuals of Saskatchewan. And the program that we're talking about here at Willowview — especially you're talking about the out-patient services right now that are being provided — when I say they're intensive, I'm not just using that word lightly. The

intensive treatments include group therapy, one-on-one therapy, psychosocial education, cognitive behavioural therapy, relapse prevention, evidence-based practices such as breathwork and holistic approaches, family and cultural support including Indigenous cultural healing practices, and support tailored for LGBT2S+ [lesbian, gay, bisexual, transgender, two-spirit, plus] community. There are outdoor activities. We have expert staff of clinical counsellors, medical professionals, and mental health and addictions support workers.

We go into the community. We pick up these individuals. We feed them for the entire day. We take them to the facility. They have all of these intensive supports, and then their travel back home at the end of the day. And then they actually have available to them, they can call individuals in the evening if they feel they need some support. So there are those reach-out counsellors that they can actually call.

So I think it's important when we're talking about addiction services to understand that they do come at a cost. And that cost, I don't know. What dollar amount would you put on it? It is important for these services to be available for these individuals, especially with what is happening in our province with illicit drugs.

Betty Nippi-Albright: — Thank you for that. I used to be an addictions counsellor, so I know what it takes. And certainly, you know, I think about the out-patient. It certainly isn't at $14,000 per person or per month.

But just wanted to get back to what was funded. Like I know as funders there's always a requirement to do reporting from the organizations that we fund, and often there is a request to do quarterly reports, not an annual report. We want to know how they're doing quarterly. And we would like to find out when you received the quarterly reports from Willowview, and also the numbers that were . . . the people that were treated, and the people that were still on the . . . that haven't been discharged.

[19:00]

So we want to know if you're able to provide . . . And it would be good to be able to provide because, as any responsible government or funder, it's important to ask for quarterly reports. And in there will tell us what the real cost is to help citizens in this province. Is that something that you could provide? And how quickly and soon can that happen?

Chair Weger: — It now being 7:00 p.m., this committee will recess until 7:30.

[The committee recessed from 19:01 until 19:30.]

Chair Weger: — Welcome back, committee members. We will now resume consideration of the estimates and supplementary estimates no. 2 for the Ministry of Health. I will recognize that Mr. Brad Crassweller is now sitting in for Ms. Colleen Young. And I'll recognize the minister.

Hon. Lori Carr: — Thank you, Mr. Chair. And I guess just to pick up where we left off, yes, we do have reporting requirements for people that we . . . And when I say we, I mean the SHA has reporting requirements with the people that we contract with. In the case of Willowview specifically, which is what you were asking about, because it's so early in the contract and the services haven't been set up completely, that regular reporting hasn't started yet. But we will be getting those numbers from them as they get fully operational, and it will be a regular requirement within the contract.

Betty Nippi-Albright: — So when they opened up in May, or whenever the contract was opened up a year ago in 2024, you don't have that reporting?

Hon. Lori Carr: — No.

Betty Nippi-Albright: — No? So they opened up back in May. So just for clarification, there's no quarterly reports from May to . . . in the last quarter. Like what is it. It'll be a year in a couple months. There's no reports for that right now?

Hon. Lori Carr: — Yeah, I mean as you are fully aware, as Willowview was being set up there were some unforeseen circumstances that happened in the set-up procedure. Delays happened before people could get into beds, and so now we're just working on getting that set up 100 per cent.

Betty Nippi-Albright: — Okay. So can you tell me or show me or explain how much of the budget, in this fiscal year budget, how much of this budget's mental health and addictions funding will be paid to Edgewood Health Network in terms of Willowview Recovery Centre, the Regina and Saskatoon complex-needs units, the virtual treatment programs? Like how much of the mental health budget is going towards giving the contract or the dollars to Edgewood Health Network?

Hon. Lori Carr: — So I'll start with the virtual one. This is the contract that we had before this budget year. But in this budget year, we don't actually have it. I'm not sure why we don't have it in a binder, but we will get that number for you tomorrow. So you'll have that number.

For the complex-needs emergency shelter within our budget, it is 6.2 million in the upcoming year. And for Willowview, in the upcoming year it will be 7.6 million.

Betty Nippi-Albright: — Okay. So thank you for that. So I just wanted to kind of go back a little bit from before the break, some of the questions. So based on the numbers that you've provided tonight — and it's all at Willowview — each patient at Willowview is costing $171,000 per year for care. Is that good value for money? Could this money have been put to better use to save lives and get people off substance use harms?

Hon. Lori Carr: — Thank you very much for the question. I think it's important to note with Willowview that there are 60 treatment spaces available in that facility. Especially once it's up and running and we get all of those intensive overnight beds open, it will be that 60 beds. So when I do my math and I figure it out, it actually comes out to 127,000 per year per bed. And it's important also to understand that that isn't just for one individual. There are several individuals that may flow through that individual bed throughout the year and receive treatment.

So I guess when you talk about value for money and having services available for individuals that may be in a time of need, I

think that the services that we're providing and the option for hope that there is a place for them to go so that they can have the opportunity to live a sober life and have the opportunity to move back to their communities and spend time with their family and friends, I think the money that we are investing, whether it be in treatment spaces here at Willowview or virtual spaces somewhere else or mental health supports with a counsellor if they don't actually need that treatment space, I think every dollar that we spend on mental health and addictions is worth it.

[19:45]

Betty Nippi-Albright: — Thank you for that. You know, Willowview was open in May of last year. And certainly all the individuals, the families who lost loved ones since May of last year would have appreciated a bed for their loved ones rather than mourning the loss of their loved ones due to drug overdose.

So I just wanted to come back to . . . I wholeheartedly agree that we need supports out there. We need beds available for individuals and to be ready. So I just want to back up a bit. So Willowview opened its doors in May of last year. And here in January we filed a freedom-of-information release requesting the total cost for Willowview Recovery Centre. However that total cost was redacted, and we're not sure . . . The government said there was a $1.5 million start-up for Willowview, and then last fall there was $800,000 order in council that was put out.

And then today, which is very different than what . . . Today we have the order in council that was signed last week to extend the contract. Oh, sorry, that's a different question. So just getting back to Willowview.

So you're saying that they're given $7.6 million to operate Willowview in this upcoming budget. How could you justify $7.6 million when you only have 20 in-patient recovery beds available, when people that are trying to detox from opiate or crystal meth need in-patient treatment that is monitored by physicians? How could you justify giving Willowview, that is one-quarter operationalized, $7.6 million? And how is that the best value for the citizens in this province?

Hon. Lori Carr: — Thank you. What we have in front of us with Willowview are opportunities for people to get treatment. Was it ideal when we started up? Exactly what we had envisioned? No.

So the number that you asked me for was how much we were paying them in this fiscal year, and that was that $7.6 million. It's important to note that we are pro-rating the money that we're paying them at this current point in time for the services that they're actually providing. So for in-patient and out-patient, it's a different price.

So currently it's the $400,000 a month which you have seen. When they are up and fully functional with those 60 in-patient beds that we talk about, it's $640,000 a month, which will come up to the 7.6 million. But I'm just going to let my assistant deputy minister explain a little bit about the start-up.

James Turner: — Yes, just to clarify that, the facility didn't actually open to accepting clients or patients until October, so not in May. So October was actually when they started accepting patients into the out-patient program. So the May period, or back to the earlier part of 2024, there was a $1.5 million start-up payment paid to EHN to get the facility ready. So this would be fairly normal with any new facility — some equipment, some upgrades, getting staffing ready. So like that's what the $1.5 million would have been to start with.

And then maybe just to also loop back, we did find the number for the virtual spaces, the 42 virtual spaces that predated the services that EHN is providing at Willowview. And that number is about $1.4 million for those virtual spaces that were from the previous year. So that's the third of the contracts that we have with EHN.

Betty Nippi-Albright: — So just getting back to that, so you started in May and you weren't taking patients until October. So you had about 45 staff that were up and running. So how much was that costing the taxpayers?

James Turner: — So just to clarify, there wasn't a May date. So there was a start-up cost paid to EHN to be getting the facility ready to open up, but there was not an opening in May. So I'm not sure what their May date is referring to.

And then they were provided $400,000 through July, August, and September to maintain their staff and get their staff trained and ready to be able to open the facility to the out-patient services in October. So that's when the payments actually started for their services and for them to retain the staff that they had hired to be able to open in October.

Betty Nippi-Albright: — So thank you for clarifying that. But I just want to get back to the $1.5 million start-up fee. So like it doesn't take a rocket scientist to know that when you purchase something or you're investing something you find out if they're up to code, if the building is up to code. Is there problems that are with the building before you put the money in?

So my question is, why would the government give $1.5 million when that building wasn't even up to code in terms of having hard-wired fire system, with problems with sewage, with problems with not having backup generators? Like those are major problems. They're not minor. So I guess why would the province invest $1.5 million on a building that they know will not be operationalized and taking people in?

So I don't understand. Help me understand why you would give $1.5 million to an organization that purchased a building that's not up to code.

James Turner: — So again I'll just go back to the 1.5 million. Start-up costs are normal as part of any new start-up facility and part of this RFSQ [request for supplier qualifications] process. It would be very normal through all of the vendors, whether it's EHN or a different provider. So that's a normal amount paid, but it's not just for the building. It's for all of the start-up costs to payroll, staff, recruiting. It's for a bunch of different things to get the services started.

And so had the building been perfect in April, May, there would have been no further amounts paid by EHN, who actually has the relationship with the landlord for the facility. So when the issues were discovered, the vendor and the landlord are the ones resolving the issue. So we've paid no further money to actually

address the building issues. That's an issue to be resolved between the landlord and the vendor.

Betty Nippi-Albright: — So that's not something you asked? Like what's wrong with the . . . If I'm going to invest in a building that's going to be operationalized, these are major issues. Like do you not think a hard-wired building is not important?

[20:00]

Hon. Lori Carr: — So just to clarify, this is not our building, right? This is a contract that has been negotiated between EHN and the landlord. And obviously when EHN rented it, we procured services from EHN and expected it to be in a certain condition. And as we all know, that's not what happened. But that relationship was between EHN and the landlord to take care of and to fix. And so, as per the conversation that has been happening here already this evening, obviously services were delayed in opening, and we got them up and running as soon as we possibly could.

Doesn't change the contract that we have with EHN. We paid a reduced rate for services being provided and that's our relationship with them. The building, yeah, was EHN and the landlord.

Betty Nippi-Albright: — Thank you for that. So let's just go back to the pro-rated rate that you give the EHN. So they're being paid . . . So you pro-rated what you're giving EHN. So you're paying out 63 per cent of the contracted price for 33 per cent of the occupancy. Help me understand that discrepancy.

Hon. Lori Carr: — So with Willowview we have 60 spaces available, and that's what we're paying for is 60 spaces. I believe what you're figuring is not based on 60 spaces. You're using different numbers to get that. And so our contract is that they have 60 spaces available. And as we've already talked about, the whole goal is at the end of the day is getting to that full 60 spaces in-patient.

Right now it's 20 in-patient, 40 intensive out-patient, and we are paying that pro-rated rate because of that. But at all times those 60 spaces are available to us whether they be out-patient or in-patient.

Betty Nippi-Albright: — Thank you. But just to go back to that, you're paying for a service thinking that you're going to get 60 in-patients and then midway or in the beginning had to change course on that.

So my question is, at what point was the government made aware of the extensive problems in this building that delayed the opening of the 60 in-patients? When or were you ever notified?

Hon. Lori Carr: — So I'm just going to go back just a little bit to the 60 spaces. The 60 spaces today are available to us — 20 in-patient and 40 out-patient. And those costs that we're paying them . . . If they were all full today, they need to have the staffing available. They need to have the facility available. They need to have the buses to run back and forth for those out-patient beds. So that is what we are paying for is 60 spaces with that $400,000, in the form that they are today. And they need to be prepared for all 60 to be full, so they have to staff up accordingly because that's what we've asked them to do within the contract.

And we found out about the deficiencies in the building in early June.

Betty Nippi-Albright: — Thank you. So of the 20 in-patients and the 40 out-patients that you have, how many referrals for out-of-province treatments have been made by EHN? And how much is it costing the government for these out-of-province treatment referrals?

Hon. Lori Carr: — Thank you for your question again. I mean as far as we know these are all Saskatchewan residents. That is the goal of this is to serve Saskatchewan residents, and that is what I am aware of.

Betty Nippi-Albright: — Thank you. Thank you for that. So of those, you know, the people that have been treated, are you able to provide, since when you started taking patients in October, whether it's intensive out-patient programming or when you were able to bring them in in January . . . Do you have the numbers of how many people have been treated, how many people have completed the programming, how many people dropped out of the programming? And also have you done a cost-benefit analysis of the effectiveness of the intense out-patient treatment?

[20:15]

James Turner: — So I think, like we've said before, we don't have those numbers of treated, completed, or dropped out since October. We can endeavour to get that as part of the regular reporting, but we probably won't have it for tomorrow.

And whether we've done a cost-benefit analysis of the out-patient, I think the program developed by EHN is actually based on a lot of best practice. Like they're not the only ones providing intensive out-patient programming in Canada, or probably even in the world.

They are a fairly well-respected provider of most of these types of services using pretty well-established cognitive behavioural therapy, dialectic behavioural therapy. So they're using pretty well-established protocols. So there is value in this type of programming. And so I think that's probably what we would say with respect to a cost-benefit analysis of that program.

Betty Nippi-Albright: — Thank you. It would actually be also interesting how many organizations that provide treatment, that have treatment facilities here in Saskatchewan . . . and also the mental health and addictions professionals to see what their thoughts are because they are in the province. And if you could provide those stats, and I'm hoping that this could be done within the month or so.

And also if you could also include in whatever you provide to us in terms of stats, how many — if any, if any — people were referred by Edgewood Health Network for out-of-province treatment. If you could provide those stats, that would be very helpful.

But my next question is going to be on . . . I just want to turn it

over, kind of switch it over to the complex-needs units that is operated both in Regina and Saskatoon. And you gave a number here that the complex-needs units in Regina and Saskatoon that for this fiscal year, is 6.2 million that they will be provided. However I've got the order council here document that states last week the extension for the two years and it's actually 9.653 . . . anyway over $9.6 million.

Help me understand why the difference in numbers — 9.6 in an order council for this fiscal year and the next year, and the 6.2 million that was referred to this evening.

Hon. Lori Carr: — I think when I answered my question I said that within our budget it was that 6.2 million. It is a cost-sharing program with the Ministry of Justice, and so they actually pay the remainder of that amount that you see in the order in council.

Betty Nippi-Albright: — Thank you for clarifying that.

Hon. Lori Carr: — Oh, Corrections and Policing. I'm corrected here.

Betty Nippi-Albright: — Yes, yes. Thank you, thank you.

Hon. Lori Carr: — The Ministry of Corrections and Policing. I just want to make sure that we get the right ministry here.

Betty Nippi-Albright: — Perfect, perfect. So I want to go back into some of the stats for the complex-needs unit. And I'll just say Regina for example. So they've received about 9.6 million to operate the two facilities. So July 30th of last year to January 19th of this year, there were 376 individuals that used the complex-needs unit. And these are the monthly admissions. And we know that an individual can use that facility up to 20 times a month, right.

So when I look at the money for the two facilities, it works out to 533,333 for the two facilities for the month. So if you break that down to each facility, you're looking at 266,666. So that works about 8,769 per day, and the average number of people that are being helped is less than 2.2 on average from July to January.

So you're looking at about $4,000 per interaction. How do you justify that as being beneficial to individuals and also the taxpayers in this province?

Hon. Lori Carr: — Okay, so you were asking around our complex-needs emergency shelters and the numbers and the services that we're providing there. So I'm just going to go through a little bit of information to start off with here.

So the Regina facility is located at the Manor on the grounds of the Regina Pioneer Village campus. The Saskatoon facility is located at the former SLGA [Saskatchewan Liquor and Gaming Authority] building. The Ministry of SaskBuilds and Procurement is working on making the Saskatoon location a permanent site to ensure the facility can operate at that location beyond November of 2025. EHN Prairies Incorporated has been contracted by the Ministries of Health and Corrections, Policing and Public Safety to provide the health and security services at the complex-needs emergency shelters.

The complex-needs emergency shelters aim to seamlessly coordinate with other services including community health services, social services, community-based organizations, and existing shelters. This integration is designed to provide comprehensive support as a part of a continuous care network for individuals.

Complex-needs and emergency shelters provide an alternate safe and secure location for individuals who are intoxicated and exhibiting behaviour that presents a danger to themselves or a danger or disturbance to the public. Complex-needs emergency shelters will better support individuals in crisis and enhance community safety. They are health-based bases with dedicated on-site health care and security personnel that provide another option to the current method of holding intoxicated individuals in police cells. People will be required by law to remain in the shelter for up to 24 hours or unless deemed safe for early discharge.

Every province in Canada has some form of legislation that allows peace officers to take people into custody who are intoxicated in a public space. In Saskatchewan, section 52 of SOPA [*The Summary Offences Procedure Act*] has been used for years by police and is well-established practice.

As of March 23rd, 2025, 1,503 individuals have been admitted to the complex-needs emergency shelters — 941 in Saskatoon and 562 in Regina. Almost all patients accepted transportation to services and supports. Each complex-needs emergency shelter provides up to 15 individuals in crisis with a safe place to stabilize while being monitored for up to 24 hours for the negative effects of drugs or alcohol. These individuals are also connected to services such as addictions treatment, housing, and income supports.

Health staff provide basic health services in the 24-hour support environment. Security services are provided 24-7. Individuals will have access to health services which will include basic health assessments, detox withdrawal support, wound care, navigation to mental health and addiction supports, and other wraparound services. Medication is administered with client consent as required to adequately manage symptoms.

A discharge plan is developed with the individual. It includes two components: connection to other service providers and a transportation plan. Transportation is provided by the service provider. If all efforts to gain consent to transportation are exhausted, individuals will be transported to the appropriate place, whether that be police services or a hospital, depending on their circumstances. Some individuals who are not eligible for discharge per SOPA requirements may be appropriately transferred to a police service or a hospital for additional support.

And so I think it's clear to see that these facilities in each location have those 15 beds. And whether they're completely full or they're not completely full, once again, it's important that the police service especially know that those services, those 15 beds, are available. So they have to be staffed up to the proper complement that if they were full, they would be serviced properly. And so the cost of the individuals working there, the fixed costs of the buildings, all of those need to be taken into consideration. And once again, we're contracting for those 15 spaces to be available if we need them.

And it's also important to note that these individuals, unlike sometimes, they're arrested because they're out on the street and they're put in the cells. And one of the things that I read from some of the comments that the individuals that have spent time in these facilities is they find them a much better option, because when they go to police cells, it's very agitating for them. They get even more worked up than they were when they went into the cells because it's not a very welcoming environment.

[20:30]

But when they go into these complex-needs emergency shelters they actually can have a warm shower; they have a warm place to sleep; they get a warm meal. They have people who are engaging with them that are truly trying to connect them with those services when they do get out on that next day. And as I already noted, the majority of people do get connected to some sort of services.

And I think another important thing to note about these complex-needs emergency shelters is we're diverting people that may go to the emergency room, which maybe isn't necessarily the right place for them. So we're freeing up space in our emergency departments for people to be able to access those services for emergencies, and these individuals are getting treated in a location that is really focused on trying to find them a path to recovery.

Betty Nippi-Albright: — Thank you. I would absolutely love to hear who those individuals are that are finding it very successful. I've had many people that spoke to me and reached out to our offices to say this is a drunk tank and they might as well be in the jail cell rather than getting what they're . . . That's what they've been telling me and emailing us. So I would love to meet those individuals that are finding the warmth and the help.

And also I really wouldn't mind getting the stats on that, of how many people that have received that care and where they are in the system, whether they've been referred to an addictions . . . or if they're receiving counselling. I would like to see that to demonstrate that is the best use of our public dollars.

And if you have those . . . And I'm assuming, with all the wonderful stories of people getting the help that they're getting, that there should be some kind of reporting to show that. So if you could present that, that would be wonderful. That would be really good. So then that way I'm not on you guys, right?

So if you could provide it, that would be really good to demonstrate and show how many people were served, how many people were successful in receiving the treatment or services that they need, and how many referrals were made to different various organizations to help them to stop substance use or to limit that. So that would be good.

Anyway, I'm going to move on to how much of this budget . . . Besides the money that is going to Edgewood Health Network to operate Willowview and the complex-needs units, how much of this budget is being allocated to current in-patient treatment centres across the province that you fund to help them to continue building their capacity to help more people suffering from substance use harms?

Hon. Lori Carr: — Okay, so within the upcoming budget, taking out the EHN portion, for addictions services we are spending an additional $122 million.

Betty Nippi-Albright: — Thank you for that. So community organizations, as we all know, many of the community organizations, grassroots organizations offer many good programming, and one of them is mental health supports and services.

And some of the supports and services may be support groups for families that are left behind after suicide. They may be support programs for families that have had loved ones die from drug overdose, or they may be parental support groups, parent support groups, or peer support groups and even sharing circles.

So these programs help people make meaningful connections through peer support. How much of the mental health and addictions budget is allocated to help these organizations further their capacity in continuing the work of helping folks maintain or establish good mental health and well-being?

Hon. Lori Carr: — Can I just ask a clarifying question? So you talked about mental health supports and services, and then you talked about peer supports. So are you just looking for all of the mental health supports and services?

Betty Nippi-Albright: — Yeah.

Hon. Lori Carr: — Inclusive of peer supports?

Betty Nippi-Albright: — Inclusive of all of that.

Hon. Lori Carr: — Okay, thank you. So we don't have that number right at our fingertips right now. We have some people looking it up to see if we can come up with a number this evening, but if not we will get that number for you.

Betty Nippi-Albright: — Thank you. Thank you so much. Thank you. Where is my next question? So how much . . . and maybe if you don't have this next question, if you could provide it when you get that information and have it available for me. So how much of the budget is designated to recovery homes or supportive living after an individual completes in-patient treatment?

[20:45]

Hon. Lori Carr: — So just because of the nature of the way the contracts are set up with the different providers, we don't have the breakdown right with us. But they seem to think they should be able to get it within the next day or two for you, so yes.

Betty Nippi-Albright: — Thank you for that. Thank you. So I'm just going to move, just to have a question for . . . How do I say this? In the North is very vast. And we've had high rates of suicide in the North. We have families, children, adults, youth, seniors suffering from lack of good mental health support.

And we also have a challenge of recruiting mental health and addictions professionals in the North, and we also have high rates of substance use harms in the North as well. So it's all over the province, but I'm looking more into the North.

How much of this addictions, mental health and addictions budget is going towards ensuring that the people in the North are given an opportunity to access good mental health and addictions supports, and how much in this budget is being allocated to recruit and retain mental health and addictions professionals?

Hon. Lori Carr: — Thank you very much for the question. I guess just really high level as we develop our mental health and addictions budget, all of the services that are being thought of and being provided, some of them have a very culturally sensitive component within them. But you know, James is just going to give you a few specific examples here in a minute of some of the services that target the North.

But all of the services that we develop, no matter where they are in the province, are available no matter where you live. You know, someone from the South may access a service further north, or someone from the North may come down south and access services in Estevan. And I've seen that happen.

So I'm just going to turn it over to James to give you a few little examples here.

Betty Nippi-Albright: — I just, because of time, just for time's sake, is that something you can provide for me tomorrow with those? That would be really good. And I want to table three questions that you hopefully can answer. And I want to ask one question while I have my last question.

But the three questions I want to table is, how much of the mental health budget is going towards youth mental health? The second question is, there's a shortage of child psychologists and spaces available for youth struggling with mental health. How much of this budget is designated to recruiting more child psychologists?

My third question I'm going to table is, there are only 15 schools with a mental health capacity building program, while there are 27 school divisions. How much of the mental health funding is going towards expanding this program to more schools, and how will this budget alleviate the pressure on schools that do not have this program available to them? And kind of an attachment to that question is, how will this budget account for similar programs in rural schools? So that will be tabled.

But my question hopefully you can answer is, you know, in the hospital, when youth are in the hospital with mental health, suffering from mental health issues, there's a wraparound process in the hospitals. But once they leave the hospitals, that wraparound supports in the community often doesn't exist. So how much of the budget is being allocated for youth mental health supports for a continuum of care in the community, not in the hospital?

[21:00]

James Turner: — All right, just to answer your question about sort of that middle tier or wraparound between the hospital and the community. So there is $2.01 million in this year's budget for four youth mental health group homes in the Ministry of Health budget, and there's also 2.01 in the Ministry of Social Services budget to jointly fund those four mental health youth homes — Saskatoon, Regina, and P.A. [Prince Albert]. There's two of them in Saskatoon with Egadz.

Betty Nippi-Albright: — Okay, yeah. No, I was thinking about those individuals that are not in the homes. But I don't know what to say, just individual, like children, children and youth that are needing those services. But if you can clarify that and present it because I'm cutting into my colleague's time.

Hon. Lori Carr: — I can probably clarify.

Betty Nippi-Albright: — Oh, thank you.

Hon. Lori Carr: — So you had said the individuals, the youth that are getting out of the hospital and they're looking for a place to go. These homes would be the place for them to go.

Betty Nippi-Albright: — I was actually talking about the ones that have loved ones that advocate, help them, and they're in a mental health crisis and are in the hospital. And they return back to their home, to their house. Those are the questions. But if you can provide that, that would be wonderful.

And I just want to say thank you so much for taking the time to answer my questions. And I already took one minute of my colleague's time, so thank you so much. Have yourselves a good evening. Thank you.

Keith Jorgenson: — Thank you very much, everyone, in advance. I want to thank everyone opposite for coming here tonight to help me better understand the seniors and long-term care budget. And in particular I wanted to thank Minister Carr and — I don't see him right now — Minister Cockrill for their dedication to the province and being here late. And I'll apologize in advance. I'm a kind of early-to-rise, early-to-bed person, so if I seem a bit sleepy, again I apologize in advance.

Most of the questions that I'm going to be asking are kind of more qualitative rather than . . . qualitative. So I'm going to try and ask these somewhat rapid-fire because I have quite a few to go through. And if there's items, pieces of information that will take longer to find the answers to, I'm quite happy to have them tabled and provided to me tomorrow or in a week or whenever the amount of time is required.

So I have a number of questions I wanted to ask about alternative-level-of-care beds. So the first question that I have is, how many — and in particular I'm interested in alternative-level-of-care beds that are not in SHA-controlled facilities — so this would be facilities that are contracted to provide alternative-level-of-care beds.

So first of all I was wondering how many alternative-level-of-care beds are being provided to the SHA at private facilities. So yeah, how many alternative-level-of-care beds are currently provided by private facilities to the SHA?

Hon. Lori Carr: — Thank you very much for the question. So you asked how many alternative-level-of-care beds are not run by the SHA and being provided by other providers. All level-of-care beds are at the SHA.

Keith Jorgenson: — Okay, apologize. I didn't bring the entire list, but there certainly are historically, in the last couple years, there's a large number of for-profit entities such as Diamond House that have contracts like — have to pull out my notes —

that have been contracted to provide alternative level of care. And actually as well in last year's estimates there is a specific mention of an amount of money that's being spent on these beds. It works out to around $8,000 per bed per month.

Hon. Lori Carr: — Maybe it's a definition in the way we're . . . Maybe we're not talking the same thing here.

Keith Jorgenson: — Yeah, so again my understanding is there are beds that are being contracted at a rate of between 7,500 and $8,000 a month to personal care homes to provide people who are sort of stuck in acute care who don't require acute care as an outflow point for those patients.

I can ask another question. I can find the reference in last year's budget estimate questions. Okay. So maybe let's come back to that in a second.

So in the budget it mentions an increase . . . Sorry. I would like to talk about . . . I have a few questions to ask about inspections of facilities. So it mentioned increasing the rate of inspections that occur at personal care homes. So currently from my understanding is there are two people that are employed in Saskatoon, and a third person has been recently hired that performs inspections of personal care homes.

So I just wanted to confirm how many full-time equivalents will be performing inspections in Saskatoon and Regina for personal care homes, and is there a plan . . . Currently from my information the median inspection interval for personal care homes is three and a half years. Will the minister commit to having all personal care homes inspected in 2025 as is required by provincial legislation?

[21:15]

Hon. Lori Carr: — Okay, well thank you for the question. You had thrown out some numbers that you thought there were two inspectors in Saskatoon and a third person in Regina, I'm assuming is what you mean. But what we have is, we have three inspectors in Saskatoon. We have two inspectors in Regina. And we are adding an additional inspector this year. And so as of last week, all homes have been inspected as per our regulations within the past two years. So what the regulations say is that the homes are to be inspected every year. If there are no issues flagged with the facility, then they can go on a two-year schedule. All of our facilities are within that two-year schedule.

Now that doesn't mean that if there is a complaint of some sort that falls within our legislation that we won't go in and do an inspection at that point in time. So if there's a complaint we will go in and have a look.

Keith Jorgenson: — Okay. I'm going to come back to that in a second, the inspection interval but . . . So I guess this is like a yes-or-no question, and I do have 27 questions I'm hoping to ask. You know, hope springs eternal. Will you commit to having all personal care homes inspected in 2025?

Hon. Lori Carr: — I think what I just said was all care homes are already in . . . within the legislation have been inspected and up to date. And so we will continue with our cycle.

Keith Jorgenson: — And I have some information. I'll come back to that, because my data certainly paints a starkly different picture. But we'll come back to that in a second.

So in line with the inspections and assessments, so provincial regulation requires that all individuals entering a personal care home be assessed independently. Since 2017 no one entering personal care homes not from like . . . Anyone who's entering a personal care home in Saskatoon who was not in acute care beforehand has not been assessed independently by CPAS [client patient access services].

Is there money allocated in this budget to ensure that all seniors who are entering long-term care in Saskatoon and other areas are assessed independently for their needs as per government regulations?

Hon. Lori Carr: — Okay.

Keith Jorgenson: — Thank you, Minister Carr.

Hon. Lori Carr: — You're welcome. So within this year's budget we're actually adding a million dollars to build capacity for assessors. Of course when an individual goes into a personal care home, they do an assessment of that individual, and they need to determine the level of care that that individual needs to receive. And of course if the level of care is too heavy, then they shouldn't be accepting that individual at that point in time.

Once they're in a personal care home, as the individual gets older and their care needs change, then they can be assessed again so that they can move on to a level of care such as a long-term care facility which can actually take care of those needs.

Keith Jorgenson: — Okay. So I don't know if you want to, for expediency, if you wanted to provide me this follow-up question with regards to, you know, CPAS and assessment tomorrow, that would be fine. But I'm just curious how many people . . . Like and I apologize. I know CPAS is a Saskatoon term, and I know in Regina there's a slightly different acronym that's used for those people that provide the interface, kind of, between, you know, long-term care, acute care, and the community.

I'm just curious how many FTEs there are of people who work with CPAS. And has that changed historically over time as we've had capacity issues? Is it possible to, when . . . [inaudible interjection] . . . Oh, yeah. I'm just thinking. You don't have to give that to me tonight because I . . .

Hon. Lori Carr: — We're going to have the individuals in the background work out and see if we can figure out that number. And we will move on to your next question then.

Keith Jorgenson: — Yeah, I wanted to come back to the assessment of personal care homes. Sorry, I didn't have this open because I didn't . . . So according to my sort of quick mental math, there were 137 personal care homes that have gone longer than two years without inspection.

Because I don't want to run out the clock just reading out the names of these facilities, I'll just read out, you know, a few of them. Warm 'n' Cozy, two years, two months; Warm 'n' Cozy, two years, two months; Warm 'n' Cozy, two years, four months;

Weldon cooper, three years, two months; Westminster, two years, two months; Westhill Manor, two years, six months. Again, I could go through all 137 that went longer than two years without being inspected.

And so the reason why I'm asking this is we've had one person who's come in last week in question period who died in a facility that hadn't been inspected in almost four years. So I'm just wanting to . . . I'm not wanting to dwell on the past in estimates. I think maybe that's a more effective thing to do in question period. What we're wanting to do is be forward focused and say like, okay, this is clearly broken. If we have 137 facilities that have gone longer than two years without an inspection, how do we make that not 137? How do we make that zero?

So I guess my question again is, when can we expect that that number be brought back to what it should be, which is zero? Will all these homes get inspected this year?

You can see the Excel spreadsheet if you'd like. I'm happy to provide it to you.

Hon. Lori Carr: — So thank you for the question. And I guess you mentioned Warm 'n' Cozy was one of the facilities that you believe is in arrears. I had mentioned earlier in my previous answer that everything is up to date as of March of this year, and Warm 'n' Cozy was actually inspected in March of this year, so just earlier this month. So I'm not sure when you pulled your data, but it has been inspected and we are up to date. And our goal is to stay up to date. As we said, we were adding extra inspectors.

Keith Jorgenson: — Warm 'n' Cozy has multiple facilities and so it is possible, if you sort of pick one of the facilities listed . . . again I'm not going to waste our time going through all 137. Like anyone who wants can go to the public website and start clicking and opening the various inspections and see that the interval is . . . it's been more than two years. So all I ask — I do want to move on because I have other questions that I want to ask — is that those facilities be brought up to inspection. And in particular, the facility where the gentleman died at was inspected a few days after the gentleman passed away, which is great, but probably would have been better a few days before.

So I'm going to go back to alternative level of care. So this is from the Human Services . . .

Hon. Lori Carr: — Could I just address that though? I mean, and if you're going to ask a question about inspections and if then you want a commitment that they're going to be done according to our regulations, I think, you know . . . You just said, "I can go on the website and I can look and I can see." Then I would suggest you go on the website and you look and you see. And you will see that they are all up to date.

And so that is the information. This was just printed off last week from the officials, not a list that I generated. And yeah, as far as the facility that you're talking about, it was inspected in 2021 and then a complaint was received and it was inspected in 2023 and then again in 2024, and most recently in March of 2025.

Now I am told that we haven't been in the practice of actually putting those complaint-driven inspections in, but it is something that we have started doing. And so moving forward, you will see the regular inspections and then you will see the monitoring inspections that are happening. And so that'll be full transparency that will be happening moving forward.

Keith Jorgenson: — So all anyone wants is not to say, like, oh I got you. We want to know that the system is going to be fixed and is going to be better. And so, like there are intervals that you see when you go through that data; you see gaps of three or four years. So if it's happened that those facilities that have been mentioned, inspected, that's awesome. They were finally inspected. So hopefully they continue to be inspected on a regular basis.

So going to the Human Services Committee of April 10th, 2024, there's an exchange that mentions where Mr. Love asks about 12 alternative-level-of-care beds at Brightwater. And then — I'm going to butcher the person's name — a Mr. Havervold responds about those beds. There are a list of places that I understand that have alternative-level-of-care beds that are private entities: Diamond House, Kensington Gentle Care, Beacon House, Warm 'n' Cozy.

So all I'm trying to understand is, who are providing these services to SHA? How many beds are being provided to SHA for people who are leaving acute care and have whatever issues that don't allow them to go directly into a personal care home, and so on and so forth? So I want to know . . . And again, if this requires some research to make sure we're talking about the same . . . we're using the same wording, you know, how many facilities are contracted to perform these services? How many beds? And I'm interested in the budget for this year and the actual from the previous year for these alternative-level-of-care beds that are being provided in our larger centres.

Hon. Lori Carr: — Now that you've clarified some of the facilities, I think we probably should be able to get an answer for you. So just give us a couple minutes.

Okay, so it is a little bit of a definition issue, but we're going to be talking about the same thing here. So what these beds are that you're talking about are transitional or convalescent beds, is what we're talking about when we talk about the facilities that you listed.

And so we actually have 75 beds located in the personal care homes, utilizing the Saskatoon community action plan. We have 21 beds in Kensington. We have 24 beds in Diamond House. We have 30 beds at Warm 'n' Cozy. And we no longer have any beds at Brightwater or Beacon House. Those were just temporary services that we had at that point in time.

And so last year the approximate budget was 5.12 million, and this year the budget will be 6.4 million.

Keith Jorgenson: — Okay, thank you. Thank you. Okay, I wanted to move on and I wanted to get a better understanding of staffing ratios at long-term care facilities. So I don't know how readily available information is. Is information readily available about budget or FTEs by facility? Like how difficult is that to get?

Hon. Lori Carr: — I guess I would need to know what your

question is.

Keith Jorgenson: — Okay, fair enough. So I'm curious about, and maybe I'll table part of this, but could you tell me just . . . I'll pick a couple of facilities that I'm familiar with and I have toured. So if we were to go to, say, Central Haven in Saskatoon, Sherbrooke in Saskatoon, Pioneer Lodge in Lloydminster, and then Pioneer Village here in Regina, how readily available is the information about what the total budgets for these facilities are, how many people reside within them, and the FTEs of care aides that work within them? Is that something that's is best to sort of be tabled, then you kind of get it back to me when you are able? Or is that kind of readily available?

Hon. Lori Carr: — Can you just repeat the second one? You said Central Haven in Saskatoon.

Keith Jorgenson: — Yeah, I apologize. My apologies. It's Central Haven in Saskatoon, Sherbrooke in Saskatoon, Pioneer Lodge in Lloydminster, and Pioneer Village in Regina.

Hon. Lori Carr: — Okay, I will see how available that is.

Keith Jorgenson: — If it's hard to find then tomorrow or the next day is fine.

[21:45]

Hon. Lori Carr: — So you are correct. We don't have all of that information with us here tonight, but my ADM [assistant deputy minister] has committed to getting the numbers that you asked for, best efforts, over the next few days.

Keith Jorgenson: — Yeah, that's fine. Thank you. And I don't know if this is asking for too much, but on the website I think it says there's 157 long-term care facilities. So I don't know how extensive, if it's in a dashboard or something like that. It would be interesting for me to sort of know the numbers from one facility to the next. However expansive you can make that of the list of the facilities, both affiliate and non-affiliate, just to sort of understand the cost associated with each, that would be fabulous.

Are you able to tell me, in terms of continuing care aides, how many FTEs currently work in the long-term care system? My understanding is that there was 5,089, give or take, according to last year's Human Services Committee. Now do you have a number for 2024?

Hon. Lori Carr: — I'm sorry. Did you say there were 5,000 in 1989?

Keith Jorgenson: — No, sorry. I must be mumbling. I apologize, Minister Carr. According to the Human Services panel, it says that there was 5,089 in 2023, and I think a slightly smaller number the year before. So I'm just curious. Yeah, 5,054 in '23. So I'm just curious how many there are in the current year.

Hon. Lori Carr: — Okay. The question was how many CCAs [continuing care aide] are working in long-term care. And you said 5,089 were in '24. And you're correct. That's exactly what my chart says. And the updated number for '23-24 is 5,221.

Keith Jorgenson: — Okay, thank you very much. Okay. I wanted to move on and talk about wait-lists. And so my first question is . . . Again I don't know. Some of this may be knowable and some of this might not be tracked. I guess tell me what information you're able to ascertain. I'm curious about how many people are in acute care that don't require acute care.

And I don't know if it's possible to break it down by sort of category or reason as to why people are there. So there are elderly people obviously requiring long-term care, people that aren't elderly that require long-term care who, in theory, don't qualify for the personal home benefit because of their age, and then patients that end up in acute care because of issues associated with homelessness and addictions. And I'm just wondering if there's a global number on a given time on average of how many people we have in acute care through the province that don't require acute care, and then if there's any breakdown. Thank you.

Andrew Will: — Hello. I'm Andrew Will, CEO of the Saskatchewan Health Authority. And while officials are looking to see if they have that data, I thought I'd maybe just describe a little bit about what alternate level of care is. And actually your question pretty accurately described what alternate level of care is. It's a patient that's in hospital that's been designated by a physician as no longer needing acute care level of service, and those needs could be met in an alternate care setting. So that could be . . . In some cases it might be long-term care. It could be convalescent care. In some cases it might even be a discharge to home with certain supports around that patient.

I'll also say that, you know, throughout the province in some of our rural community hospitals it's not uncommon to be able to provide convalescent care appropriately in those facilities. Where there's more pressure for us to manage flow of alternate-level-of-care patients is in our tertiary hospitals where, you know, we have capacity challenges. And obviously, you know, we want to transition people into the most appropriate care setting that we possibly can as well.

So anyway I just thought I'd provide that sort of explanation. So earlier when you were asking about ALC [alternative level of care] beds, it could describe a lot of different types of options for patients. Thank you.

Hon. Lori Carr: — So we're just waiting on a number, but you can carry on.

Keith Jorgenson: — Okay. Yes. Yeah, just for the case of expediency if it's okay?

Hon. Lori Carr: — Yeah, for sure.

Keith Jorgenson: — I shall carry on while they're looking for the figures. I wanted to ask a second about day support programs for seniors that sort of step between the community and long-term care. I'm just wondering if we know how many day support program places that we have currently, and what the wait-lists are.

I also hear complaints from people that those day support programs are not available in rural communities. And again I'm perhaps mistaken about that. I might be unaware of some of those. But I'm just wondering if those day support programs are sort of geographically spaced through the province.

Hon. Lori Carr: — Okay, so with our day programs, which you were asking about, we don't have access to wait-lists. The programs are provided throughout the province at varying facilities. You know, one community may, one community may not have that program, so it's not something that we are able to track. I'm sorry.

Keith Jorgenson: — No, that's fine. Okay, while I'm waiting for the math on the other thing, I'm just curious if you could provide me with sort of a global number and if there is any sort of breakdown in terms of the total wait-list for long-term care.

The other thing, and I don't know if this is something that's tracked, but certainly anecdotally I hear, both from when I've toured facilities that even SHA officials have kind of acknowledged that there is an increase in the level of complexity. You know, we I think all became familiar with the term "classroom complexity." I'd say long-term care complexity, that the needs of a person in long-term care are vastly different now than they were 20 years ago.

And I'm wondering if there's any sort of way that the health region tracks that or quantifies that to say that, you know, on average we've gone from level X to level Y. Sorry, does that make sense?

Hon. Lori Carr: — Yes, it does.

Keith Jorgenson: — Thank you.

Hon. Lori Carr: — So just while we're looking for the last question, we've got a follow-up with the number of acute care you were asking for.

Andrew Will: — So this is for the Saskatoon hospitals as of today, just to give a bit of an example. So today at RUH [Royal University Hospital], we have 58 patients that are designated ALC; at St. Paul's, it's 48; and Saskatoon City Hospital, it's 5.

Keith Jorgenson: — And you don't have a breakdown for the province as a whole?

Andrew Will: — I don't have that.

Keith Jorgenson: — Would you be able to, you know, when — like not tonight because we only got like 20-some, 23 minutes left — just when you have an opportunity over the next little while?

And the other thing again I'm curious about, is there any . . . I think in terms of sort of being, you know, proactive in trying to sort of solve some of those issues that we see in terms of congestion in our acute care spaces. There's people that are there for very, very different reasons. So somebody who may have been involved in street activity and was addicted to drugs is obviously totally different than, you know, a 90-year-old person who may be frail. And is there any sort of tracking of like what those certain needs are, so we sort of can plan out for where these people, you know, what facilities are appropriate for them to go to?

Andrew Will: — So we don't track this for every hospital in the province but certainly the tertiary facilities, particularly in Saskatoon, we're tracking this. So those same numbers that I gave for today, and it's a little hard to read in this chart on the phone, but basically seven of the ones at RUH are waiting because there's some sort of housing, financial, social issue that they're working through to be able to discharge. It looks like . . . It's tricky to read this. So yeah, 17 look like IV [intravenous] therapy . . .

Keith Jorgenson: — If you want, you could table that when you have an opportunity, sir.

Andrew Will: — I think I should because . . . See there's no heading on this column.

Keith Jorgenson: — Is it okay if you table it? Because I would hate to . . .

Andrew Will: — Sure. So what we'd be able to provide is like a snapshot in time for Saskatoon. How many ALCs we have in each of the three hospitals and the breakdown of what those patients are waiting for.

Keith Jorgenson: — That would be excellent.

Andrew Will: — Super, because this graph I have doesn't have titles on all of the columns.

Keith Jorgenson: — Yeah, no, and I don't want to force you into misspeaking.

Andrew Will: — And . . . [inaudible] . . . give you wrong information.

Keith Jorgenson: — Okay, thank you very much. So I know we're nearing the end of the evening. I only have a couple questions left. So I'm curious in terms . . . I've been to a number of . . .

Hon. Lori Carr: — We have an answer on . . . [inaudible].

Keith Jorgenson: — Oh, fabulous. Sorry, sorry to interrupt.

Hon. Lori Carr: — No, no. So you were asking about the wait-list for long-term care and the increase in the complexity and do we track it and how do we quantify it. I'm just going to turn it over to . . .

Heather Murray: — Hi, Heather Murray, executive director of the continuing care branch, Ministry of Health. So in regards to the wait time question, as of September 2024 the approximate days waiting for a long-term care placement was 29 days. It does vary by location depending on number of beds. We collect it twice a year as a point in time, and so we're just collecting now so we won't have updated data until later.

Keith Jorgenson: — And just by way of clarification, is that 29 days . . . Is that for people who are in acute care waiting for long-term care, or just global for everybody?

Heather Murray: — Global.

Keith Jorgenson: — Okay, thank you.

Heather Murray: — And then in terms of heaviness of care or complexity of care, it's a bit of a tricky explanation so I'll do the best I can.

The new nomenclature is not to use levels of care but to use case mix index and the resource utilization groupings that are derived out of our quarterly assessment in long-term care. So there, an average CMI [case mix index] of 1 basically means it's, you know, basically normal long-term care. And then as you go up, it requires more resources. That's the average.

But there's 44 resource utilization groupings that create that average number and so I can explain . . . Do you want me to explain the different levels? I can tell you, about 62 per cent of residents in long-term care are in that lowest level of category which is reduced physical function. And that has been fairly consistent over the years. There are pockets of heaviness of care, but on average it's stayed around that 60 per cent at reduced physical functioning.

Keith Jorgenson: — Okay. So I think I have two questions left, which should hopefully be about the right amount of time. So there are a number of seniors' facilities that are controlled by the Saskatchewan Housing Authority, and we frequently see complaints when I visit them about maintenance in the buildings. As way of an example . . . Sorry, is that okay to ask a question about this?

Hon. Lori Carr: — This actually falls under the Social Services portfolio. They're in charge of the Saskatchewan Housing Authority and all of the components that go with that. So yeah, we can move on.

Keith Jorgenson: — Okay, fair enough. My apologies. So do we have information in terms of when you talk about respite beds within SHA facilities. And one of, again, the complaints that I've received is that there's a lack of respite beds, but also that many of the respite beds don't allow somebody who's at risk of wander to go there.

[22:15]

So the complaints that I've heard is that somebody who maybe needs kind of a break from care, and if they have a loved one who has dementia, that they can't leave them in a respite bed because they're at risk of wander. So I'm just curious about how many respite beds that we have for long-term care and how many of those will allow or accept somebody who is at risk of wander.

Heather Murray: — So in terms of respite, I'll give . . . The number I have is for temporary care, which is 2,801 beds across the province. And so they wouldn't necessarily all be respite. We would typically refer to them as flex beds because it may be if someone needs some palliative care. It could be respite. They may use it for alternate-level-of-care people to move them out of hospital. But in general it's for temporary supports.

So probably in the past there has been some challenges taking more complex people into the system, but with the new principles and services agreement, particularly in Saskatoon where most of the homes are affiliates, we've really tightened the . . . or the SHA, I should say, has tightened the admissions and having more say on who is admitted or not.

And so, yes, someone with wandering would be a challenge because the flex bed may not be in a secure area, or you may have to staff differently to support that person. But we are moving to having more say in who can go into those affiliates and be managed.

Keith Jorgenson: — So in terms of the number that would accommodate someone at risk of wander, is sort of a work in progress? Okay. I'd like to ask, so of the full-time equivalents that we spoke of earlier, the 5,200-and-some, how many vacant positions do we have within long-term care currently?

Hon. Lori Carr: — Thank you. We don't have a current number here in the binders, but we will get you the most recent point-in-time.

Keith Jorgenson: — Thank you. Thank you, Minister. And I don't know if I have time for one more question. If I do, great.

I did want to sincerely thank everybody here for helping me better understand the file. Also a sincere thank you to Minister Carr and Minister Cockrill for being here so late tonight to help us understand this.

On behalf of my colleague, I was just going to ask if you could provide us with the amount that the government has paid Pine Lodge, I believe it's called, an addictions treatment facility that I believe has approximately 33 beds. What is the annual budget provided to that facility?

And then I will thank everyone for their time sincerely. Thank you, Minister Cockrill. Thank you, Minister Carr.

Hon. Lori Carr: — We found the number.

Keith Jorgenson: — Thank you so much.

Hon. Lori Carr: — And it's $2.4 million.

Keith Jorgenson: — Okay.

Hon. Lori Carr: — And I guess we're just ending up here. We've got just over a minute left, so I just want to thank you and your colleagues very much for spending the evening with us tonight and asking the questions that you asked. I'm sure that some of the committee members learned some new stuff tonight that they weren't aware of before, because of some of this stuff we just don't talk about on a regular basis. But thank you very much. And I'll just turn it over to you for closing comments.

Thank you to all the officials for being here tonight. Lots of you didn't get the opportunity to come up and sit at the table, which I know you all wanted. So maybe tomorrow night.

Keith Jorgenson: — Again, thank you so much, everyone, for being here late tonight. I'm sure that you probably could find more exciting places to be on a Monday night, but I appreciate your dedication to our province.

Chair Weger: — Having reached our agree-upon time for consideration of these estimates, we will adjourn consideration of the estimates and supplementary estimates no. 2 for the Ministry of Health. I will take just a moment to thank the

legislative staff here and committee members, Minister Cockrill, Minister Carr, and all of the ministry staff for being here this evening as well.

This committee stands adjourned until Tuesday, April 1st, 2025 at 5 p.m.

[The committee adjourned at 22:30.]