STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 3 — April 15, 2021

Published under the authority of The Hon. Randy Weekes Speaker

Legislative Assembly of Saskatchewan

Twenty-Ninth Legislature

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STANDING COMMITTEE ON HUMAN SERVICES

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Mr. Muhammad Fiaz
Regina Pasqua

Mr. Derek Meyers
Regina Walsh Acres

Mr. Hugh Nerlien
Kelvington-Wadena

Ms. Alana Ross
Prince Albert Northcote

[The committee met at 17:00.]

The Chair: — Well good evening, colleagues and officials. We are here to continue our information going forward on the Standing Committee on Human Services. I believe Ms. Mowat is substituting in for Meara Conway today. We have members Muhammad Fiaz, Ryan Domotor, Derek Meyers, Hugh Nerlien, and Alana Ross.

Colleagues, I'd like to table the following document: HUS 6-29, Ministry of Health: Responses to questions raised at the April 14th, 2021 meeting.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — This afternoon we are on the consideration of estimates. We will again be considering the estimates and supplementary estimates no. 2 for the Ministry of Health. We will begin our consideration of vote 32, Health, central management and services, subvote (HE01).

Ministers Merriman and Hindley are here again with their officials. Ministers, if you would like to introduce your officials and any initial comments that you have before we begin today.

Hon. Mr. Merriman: — Thank you very much, Mr. Chair. I'll just introduce again Max Hendricks. I just want to get on the record thanking Max very much for what he's been doing ongoing with COVID and within Health, but especially with these very challenging times. As you can imagine, Health is a massive file with many areas. And we have one point of contact into the ministry. Where we usually have our ADMs [assistant deputy minister], we have Max. And he did an excellent job last night so I just wanted to thank him for that. And my chief of staff, Morgan Bradshaw, is also here as well, Mr. Chair.

The Chair: — Thank you. Mr. Hindley, do you have . . .

Hon. Mr. Hindley: — Sure. Thank you, Mr. Chair. And I also want to extend my gratitude to Max for joining us here tonight. As well in the room, my chief of staff, David Keogan, and helping us out virtually on the Webex: Denise Macza, Mark Wyatt, Billie-Jo Morrissette, and Rebecca Carter. We thank them for their assistance.

The Chair: — Thanks very much. And members, we will attempt to have a break around 7 p.m. tonight, similar to what we did yesterday. And without any further ado, Ms. Mowat, the floor is yours.

Ms. Mowat: — Thank you, Mr. Chair. Good to be back here again so soon. I think I'd like to resume some questions around testing, is sort of where we left off yesterday when my time was up. We were talking about COVID tests, and I do have some additional questions in this area.

And we had asked some questions of the minister in the Committee of Finance in December in supplementary estimates. And one of the tables we were able to receive on December 21st in follow-up to that conversation was how many tests remained unprocessed at the end of each day. What we saw at this time, it was a one-week period of time, so it was between December 1st and December 9th, and at that point there was quite a significant backlog of testing, which makes our test positivity rates, it calls them into question. And of course, you know, we want to know that we're able to process those tests as quickly as possible.

So I know, like for example, on December 9th we had 3,864 tests pending or in progress at the end of that day. There were a couple of days that week where it was not applicable, but most of them had over 1,000. So I'm just wondering if we can get an update on what those numbers have looked like for this past week.

Hon. Mr. Merriman: — Thank you. Yes, I just did double-check, and we have had ebb and flow with our testing. But as I mentioned the other day, we still have a lot of capacity within the provincial system to be able to do testing, as well as we have our point-of-care testing that we also have, that has been distributed out through the schools, through the hospitals, through long-term care facilities and personal care homes.

There are tests that, at the end of the day, that haven't been run through the system, and there's a few reasons as to why that happens. One is if we do a . . . We do them in runs, so in batches so to speak. So if we do a batch from 6 till 10 p.m. and run a batch on all those tested like that, that would be the last one of the day. If anything comes in after that, then those tests wouldn't be processed that day, and they would be carried over into the next day and they would be tested at that point in time.

The other thing about the testing is we're pulling tests from all over the province. And obviously, we've got some geography, and it could have anything to do with weather, the tests not getting shipped out at that specific time. But we do have them all coming in. So there are a wide variety of reasons why the testing does fluctuate, but at the end of the week there is no tests that are pending. So those accumulate throughout the week, and then by Saturday there are no tests that are pending. So there's an ebb and flow to it. But looking back, there's no real information that . . . or nothing that says that the tests aren't done at the end of the week.

Ms. Mowat: — Thank you. Certainly the reason we're raising this question is that we've had folks that work directly with these tests, who have raised these concerns with us in terms of backlogs that have existed, just based on capacity pressures. So you know, what you're describing around a 6 to 10 p.m. window and this sort of thing, certainly makes sense. But what we were hearing about specifically, and what I believe was happening at the time in December, was that there were significant strains on test processing.

So I wonder if you can speak to that. But also if you can provide just a day-by-day breakdown of the past week. So it's great to know that by Saturday it was dealt with, but what was Friday, Thursday, etc.

Hon. Mr. Merriman: — Thanks. I was just informed that we have hired 67 positions as of January to increase our testing capacity within the system. And also, I just want to make it clear

that there are no tests pending for multiple days. Anything that was tested on Tuesday that didn't meet the cut-off time will be done on Wednesday and completed at that point in time. If you're looking for numbers for tests that didn't make the cut-off, there is 1,687 yesterday; 2,194 the day before that, that would be Tuesday; and 1,683 on Monday.

Ms. Mowat: — Okay, thank you. In terms of rapid tests, this is something that we have been talking about quite a bit. I know there have been some challenges in terms of who can administer rapid tests. How many tests have we received and how many have been utilized at this point?

Hon. Mr. Merriman: — We received approximately about 700,000 rapid test kits from the federal allocation. We distributed them to long-term care homes, personal care homes, shelters, detox facilities, group homes, and schools. And the tests will also be available for ambulance, fire, police, and participating pharmacies, as well as dental offices. The total point-of-care tests that we have used approximately, not including the last day or so, would be 55,545.

Ms. Mowat: — So that would be the number of tests that have been administered but not the number of tests that have been distributed out to those organizations? I'm assuming those are likely different numbers with . . .

[17:15]

Hon. Mr. Merriman: — Yes. Yes, they would be different numbers. We provided 100,000 for the school system. And I'll double-check and I'll get it for my next answer for what we have left available. We do have an inventory because we need to replenish some of the ones that are being used at the hospital for sure, and some of the long-term care facilities.

Ms. Mowat: — Thank you. In terms of administering these tests, I know there have been some noted challenges with how to administer them and having to have someone trained. Are some of these tests being administered with internal resources? Or can you speak to what that looks like?

Hon. Mr. Merriman: — Just for clarification, you're asking for what's the training required or who's doing it?

Ms. Mowat: — Both.

Hon. Mr. Merriman: — Thanks. On your question of who can do it, it is any health care professional can be trained for this, to be able to do this. There is a training video . . . like the SHA [Saskatchewan Health Authority] has a Webex training video that a health care professional could watch and be certified to be able to do this. The Panbio ones are the ones that are the easiest, that almost a layman could be trained on that specifically to be able to administer that. But we also do have third party that we are engaging to assist in some of the areas like the schools and some other areas.

Ms. Mowat: — Would that be the RFP [request for proposal] that is out for the end of April, or are there other folks that are currently working on that administration right now?

Hon. Mr. Merriman: — The RFP was designed that if there was . . . It didn't have to wait until it closed, as I mentioned the other day. If there was a qualified person that could do that, then we would instantly engage them in getting out to the area where they can be doing the tests. So we have from what I've been told, two that have "prequalified" and that are going to be engaging right away. And if there are more that come along, we'll engage them that meet the qualifications right away.

Ms. Mowat: — Thank you. When we're talking about rapid testing, we know that timeliness is essential to control of the spread of COVID-19. But there have been many criticisms of the fact that these were in the government's possession for . . . have been in the government's possession for months now. And really it seems only now is it being figured out how to utilize them.

I wonder, is there a plan for getting the rest of these tests out rapidly? It's weird to use the word "rapidly" in this case, but you know, if we're talking about 55,000 out of 700,000 there are still a significant amount of these tests available. So how do you picture them being used in the future, and which sectors do you think will make the best use of them?

Hon. Mr. Merriman: — Just a couple of comments. One is we did distribute them right away into our long-term care. We did have them moving out there. But because our health care professionals were very busy with the provincial capacity testing, we thought it was more important to focus in on that versus the other side of the testing which is the rapid testing. Because even if you get a rapid test positive, that still has to be verified by the provincial lab. It's not foolproof. It just basically gives you a very quick indication of whether you have COVID or whether you test positive or negative. Once that positive test comes along, you have to go and redo the test at the provincial lab anyways.

So we decided to focus our energy on the provincial lab and complement that with these testings. But as I've indicated before, our provincial lab capacity has been very busy at times, where we have done multiple, you know, 5,000 tests a day. I think, just looking at probably the top side of things, it would be maybe around 4,700 tests a day since December, would probably be our peak. So we wanted to make sure that the best testing system that we had was staffed with the most proper, trained people. And we wanted to make sure that if there were rapid testing out there that we had them in the right place for the right people.

But this was something that the federal government sent out to us, and we'd had many calls to the federal government saying that the rapid tests are great, but what we need is vaccines. And instead of vaccines arriving later on in December, we got tests arriving, which are important but not as important as vaccines.

Ms. Mowat: — Do we have the numbers of rapid tests that have been administered within long-term care and also within schools?

[17:30]

Hon. Mr. Merriman: — To answer your question, we have approximately, again this is a moving number, 445,000 that have been sent out: 100,000 of those have been to education, and the remainder have been split at the . . . where I said before, the long-term care, personal care homes, shelters, detox, etc. Approximately 32,500 have been used in long-term care. And

since the education program just started, we don't have updated numbers on that, but we're trying to get it because it's pretty specific.

Ms. Mowat: — Thank you. Yes, I was wondering. I know it can't be many in education yet, but there's obviously some. So I appreciate that.

In talking about the COVID response, I have some specific questions around surge planning, and you know, how everything has progressed over the past year. Can you speak to the emergency operations centre? I understand that at some point it closed down and then reopened. Can you speak to when it closed and when it stood back up again?

Hon. Mr. Merriman: — What happened, from what I've been told, is that the EOC [emergency operations centre] has evolved into what is now a permanent COVID response unit. So it wasn't closed. It was just changed out to the COVID response unit, which is directly involved with testing, vaccines, contact tracing. All of that now falls under this. So these were more permanent positions that were created.

And we're also working in conjunction with Marlo Pritchard and his group on the SPSA [Saskatchewan Public Safety Agency] on the emergency response for the province side of things. So those calls happen on a daily basis to be able to make sure that everybody is in the know as to what's happening. But the EOC has evolved into the COVID response unit.

Ms. Mowat: — Thank you. In discussing surge capacity last year, there was a great focus on expanding capacity so that we would have 400 ICU [intensive care unit] beds. Given that we are in a situation where many of our intensive care units are already at or over capacity and we're having to divert to other locations, at a time where there's talk of this exponential growth, how many new ICU beds have been built? And you know, certainly acknowledging the fact that that comes with an associated staffing plan.

Hon. Mr. Merriman: — Well as I mentioned before, I think in the fall either in question period, any bed can be an ICU bed if the staff and the equipment is in and around that person. They can easily convert any specific room into an ICU to be able to make sure that that is there.

I would respectfully disagree that our ICU provincial capacity is not on a bypass or we're not there. We have 41 people that are in ICU that are COVID-positive across the province, and that's why we've been so aggressive with our vaccine rollout, to make sure that we can protect that capacity. Sorry, did that answer your question?

Ms. Mowat: — Well I was asking specifically how many new beds have been built. Like I know that a number of places like Regina and Moose Jaw have talked about being over capacity, so they've had to expand the number of beds.

So I'm just curious about what that looks like. Is there still a plan? The ministry said, you know, in their own documents there was a plan to get up to 400 ICU beds if needed. Is there still the capacity to do that?

Hon. Mr. Merriman: — Thanks. The numbers I received is, we have 79 beds that we could use with a surge capacity of 32. We have an additional 63 that we would be able to do in hospital before we even got to our field hospital capacity.

Ms. Mowat: — Thank you. Can we get more details around the change in reporting around hospitalization and ICU numbers in Regina? So I think initially the numbers that were being reported for hospitalized individuals and intensive care individuals didn't include those surge intensive-care beds. Was this always the case and how long was the data inaccurate for?

Mr. Hendricks: — Max Hendricks, deputy minister. So the change that was made in terms of adding those surge beds in was made, I don't remember the exact date, but a couple of weeks ago. That would have been the case. The only time that would have really affected our numbers is while we were in surge in Regina. So dating back, the last time that it possibly could have affected the numbers is when we had higher ICU numbers back in January, so earlier January. But between January and just recently, kind of March, it wouldn't have impacted the numbers at all.

Ms. Mowat: — Thank you. In terms of hospitalization numbers, I know that daily numbers are coming out, and then certainly whenever there's a press conference we hear the daily numbers. What are the cumulative numbers of hospitalizations? I know at the beginning of the pandemic the cumulative numbers were being reported. I believe they were being reported cumulatively at the beginning, but we haven't heard what those have been recently, both for hospitalizations and for ICU numbers over time.

Hon. Mr. Merriman: — So just a clarification question: you're just asking since what time to what time?

Ms. Mowat: — Since the beginning of the pandemic. Since the first case of COVID-19.

Hon. Mr. Merriman: — So from March . . .

Ms. Mowat: — So probably March 12th or something like that. I don't remember the exact day. It probably goes without saying, I'm talking about just specifically the COVID hospitalizations and COVID ICU.

[17:45]

Hon. Mr. Merriman: — Since the beginning of the pandemic there have been 1,525 hospitalizations and 330 total ICU admissions.

Ms. Mowat: — Thank you. Is there a reason these aren't being reported out with the daily updates?

Hon. Mr. Merriman: — Not to my knowledge.

Ms. Mowat: — Were they being reported out at some point? I believe they were being reported out at the beginning. And it's not just my memory, but were they being reported out at some point? And if so, what changed?

Hon. Mr. Merriman: — I just checked with my deputy minister,

and he doesn't recall it actually being reported out publicly in the beginning of this. It was before my time, but we're having some people look in to see if it is reported publicly. To my knowledge, it hasn't been.

Ms. Mowat: — In terms of presumptive recoveries, if someone who has contracted COVID-19 and then is still in hospital after 10 days but was deemed recovered, is that someone who's included in the counts, like, the daily counts?

Hon. Mr. Merriman: — If they're no longer considered COVID-positive then they would not be included in that. If they come in with COVID, and then they're in for more than 14 days, and they're no longer COVID-positive, then to the best of my knowledge they are not included in that. I'll just double-check.

Just confirming that after 10 days then they're no longer COVID-positive. They would no longer be accounted in the COVID numbers.

Ms. Mowat: — Thank you. And to clarify, when you're saying they're no longer COVID-positive, that is presumptive after 10 days? It's not that they've been tested again at that point in time?

Hon. Mr. Merriman: — Yes. If they come in and they're no longer exhibiting any COVID symptoms but there is something else that they are in the hospital for now, whether that be something, an underlying condition that they extend into hospital, they would be in the hospital for that condition and not necessarily for COVID because they've passed that 10 day.

Ms. Mowat: — In terms of deaths, if someone dies after they were deemed to have been recovered, but they're still in hospital, would that person go toward the data of COVID deaths?

Hon. Mr. Merriman: — As far as I know, each death that could be potentially COVID-positive is investigated. There's pathology done on that to be able to make sure what the actual cause of death was, and that would be up to the coroner to be able to determine that.

Ms. Mowat: — You mentioned field hospitals as well. I've noticed that there has been a bit of deviation around talk of field hospitals as time has went on and we've learned more about the virus. Do you think that field hospitals are still something that are likely to be stood up? Or at this point are we just noticing that more folks are ending up in intensive care, and there's less individuals that have been hospitalized than we were expecting?

Hon. Mr. Merriman: — Well I think when the initial reports came out in March of last year, we were getting our data, as I'd mentioned before, from what was happening in Wuhan. And Italy was the next one that had a very massive outbreak. So the projections that we saw at that point in time, the determination was made to be able to put the field hospitals in play and build the field hospitals and look at what exactly we needed as an overall system, because if we move people into the field hospital, we still have to have the staff in and around that. There's not a field hospital staff that's on reserve. We have everybody very busy right now.

So when we look at moving people to the field hospital, or when we looked at that, what we would do is obviously move the patients that were least impacted by COVID and keep the ones that were severely impacted by COVID. But this was all based on what could have happened, so we prepared for that. Thank God we never got there. We didn't have to inactivate those field hospitals. We still have lots of capacity within our provincial health care system with our ICUs and with our resourcing. But when we see an increase in any hospital in any area, there has to be a subsequent reduction of service somewhere else. It has to be a little bit of a give and take. So if we do a reduction of service, then that gets into bringing more people into the hospital.

But what I've seen over the last little while is that our numbers are starting to somewhat stabilize. They're bouncing around a little bit in the last few days, but our hospitalization seems to have stabilized in the last few days. Our ICU numbers have stabilized in the last few days. So the field hospitals are always there in a contingency on a kind of a worst-case scenario, which we planned for.

And so we'll continue to use our capacity within our system right now before we even get to those field hospitals, but we do have a plan for resources. We do have a plan for the logistics in and around that, and we also have the plan to be able to make sure that we can keep our hospitals functioning to the best of their ability during this time.

Ms. Mowat: — Speaking of that give and take, in the spring, summer there were I think 12 different communities that were affected. This might be a question for Minister Hindley. There were about 12 different communities that were affected by rural emergency department closures. I know a number of folks were quite vocal in reaching out to the opposition and speaking to us and expressing their concern over these closures and what the long-term effects would be.

I think at this time neither . . . and I don't think either of you were the ministers in the portfolio at that time, but certainly maybe your officials can help to guide some of this. You know, why was the decision made that those closures needed to happen at that period in time, I guess, is my first question?

Hon. Mr. Merriman: — To answer the question on why there was reduction in services across certain areas of the province was twofold. One was the cases of COVID. We had to make sure that we had people cross-trained to be able to make sure that just because they were in one specific area . . . And I know Minister Hindley in his area, there was people trained in Herbert, Saskatchewan that were moving into Swift Current and moving into Moose Jaw just to be able to backfill. And the reason that they were backfilling, one, is because hospitalization at the time was increasing. The other side of it is, is we had some outbreaks within the hospital units, so within the staff that were now one nurse or one doctor who might have contacted five or six other people, and one tested positive and they all had to self-isolate and self-monitor.

So it was kind of a double impact that we had to move people around. One, because our hospital capacity was increasing; and two, we had less staff to draw on because people were isolating or they were self-monitoring at the time. And especially if they were working in and around anything close contact with COVID, we were extra cautious to make sure that they weren't spreading anything within the hospital system.

[18:00]

Ms. Mowat: — Thanks. He was looking like he might weigh in, so I was just waiting. In terms of those decisions, you know, only a few weeks later after there was some public pressure on this, many of those communities started reopening again. Can you speak to what happened there?

Hon. Mr. Hindley: — Yes I think it just, and again this is prior to my time as minister, but just knowing what I've seen since November — and I believe I'm correct in stating this — but I think it was just simply a result of the numbers, you know, in terms of what was required in the hospitals. As the minister said at the beginning there, it was to provide, you know, support to redeploy staff into areas where we had some challenges with staff. I know of cases of regional hospitals because of a spike in cases amongst staff, they obviously had trouble filling those shifts, so they redeployed staff from some other communities to help fill those temporarily.

And in the example given, in the case of the Herbert facility, I believe that in that particular case they also used some of those nurses to help out when they were facing some of the challenges with the outbreak in the Hutterite colonies to start with, back in July when there was a substantial outbreak there. Some of those services then as things settled down . . . And in the case of, you know, as an example of a hospital where staff were off self-isolating either because they had, were, you know, COVID-positive or where a close contact, perhaps a spouse, was COVID-positive, once they were in the clear, recovered, they were back on shift and then the nurses that had been covering went back to whichever community they would have been redeployed from.

Ms. Mowat: — Can you speak to the status of those emergency departments? Have they all been reopened now?

Hon. Mr. Hindley: — Sorry about the delay. Just had to check some things here. So the facility in Herbert was one that I had mentioned earlier. It's returned; it was in ALC [alternative level of care] status, then came back. And that was, you know, staff were redeployed, as I mentioned, but then returned back to ALC status in late November. And so there are staff that have been redeployed from the Herbert facility elsewhere in the health care system because of COVID pressures.

There are three other facilities, I'm being told, that remain on ALC status right now, and that's in Broadview, Lanigan, and Wolseley. But those three are due to existing staff shortages, non-COVID-related deployment, you know, redeployment type of situation there.

And I would just, you know, couch that with . . . these are obviously fluid decisions, you know. If as need arises and if there's cases, you know, staff that need to be, positions that need to be filled because of COVID pressures, that that's, you know, that's still part of the plan, to redeploy staff amongst the health care system when it's necessary until we get through this.

Ms. Mowat: — Thank you. We were on a COVID track, but I think I'll deviate slightly now that we've just started talking a little bit about these service disruptions in rural Saskatchewan. We've previously had lists of service disruptions that have existed over time, to get a sense of what that's looked like throughout the calendar days and in what areas. I don't imagine you'll just have that in your pocket at this moment, but I wonder if we can get a list tabled of service disruptions over the last fiscal year here so we can get a sense of what that has looked like. It has been an ongoing concern of residents in rural Saskatchewan.

Hon. Mr. Hindley: — So we'll endeavour to get you the current active service disruptions list.

Ms. Mowat: — Thank you. And just to clarify, I'm looking for by-community. And I think that probably is implicit in what I'm saying, but thank you.

Follow-up question to that. There have been a number of concerns raised in Yorkton about the microbiology lab. We have heard from concerned folks who work in the lab. We've seen some media about this. And it seems to me that there's a bit of a discrepancy between what the workers are being told and what has been put on the record by the Yorkton MLA [Member of the Legislative Assembly]. Is this closure going to happen permanently in the microbiology section of the lab or is it going to remain open?

[18:15]

Hon. Mr. Hindley — On the Yorkton lab microbiology situation, I'm aware of it. As the minister, I've had some letters I think, emails from residents in that area on it as well. The laboratory medicine provincial program in Yorkton has been experiencing some staff shortages for some hard-to-recruit classifications for over a year now. The SHA lab medicine team is actively recruiting across the board to try and fill some of these spots: medical lab techs, CLXTs [combined laboratory and X-ray technologist], and medical lab assistants.

What's happening right now is looking at options to try to ensure that the staff and the delivery of service for both specimen collection and diagnostic testing is supported in Yorkton for the patients of this community and surrounding area. So it's a provincial program that we have within the SHA, lab medicine, but they're able to draw on this whole provincial team to help, you know, fill some of these spots there that are currently vacant to support the Yorkton health system team there. And they're looking at the options here to support diagnostic testing with the microbiology, biochemistry, hematology, and transfusion medicine in the Yorkton area. So that's basically the current status of the situation there in Yorkton with microbiology.

Ms. Mowat: — So in terms of whether it is going to stay open or not, I just didn't catch what the future is. So that's the current update. What is going to happen going forward? Because I understand that they have some folks lined up to fill those vacant positions, that it doesn't seem like staffing is going to be a problem in the future. So what is the go-forward plan?

Hon. Mr. Hindley: — Thank you, Mr. Chair. So the lab in Yorkton is part of a regional hospital, so it's an important part of the health system for that area. Currently, because of the . . . as the member's pointed out there, because of staff shortages, it's impacted the microbiology section of the laboratory, and it's currently supported by microbiology out of Regina. We continue to try to recruit to fill those vacancies. And I've heard as well,

anecdotally, some of the comments that you had put on the record here about, you know, potentially some other staff coming on later in the year. Again, that's anecdotally that I understand, I hear that. But we'll be working to restore microbiology to Yorkton as soon as we can fill those positions there.

Ms. Mowat: — Thank you. I understand it's a regional lab as well and that that work has been diverted to Regina. Is that putting undo pressure on Regina lab staff to manage that caseload? While you're conferring, I guess as a follow-up, so managing caseload but then also . . . I don't know if he's listening to me. I guess I'll wait.

Hon. Mr. Hindley: — Sorry, I didn't catch the second question there but short answer is no, it does not impact Regina. They're able to handle the additional workload with any major impacts.

Ms. Mowat: — Are there additional delays for transporting the samples back and forth? Is it increasing the time it takes for the results to come back?

Mr. Hendricks: — Max Hendricks, deputy minister. So when we did have to transition microbiology to be processed in Regina, it's actually faster in Regina because of the equipment. And the turnaround time in Regina is quicker and so they're able . . . patients are able to get their results faster than actually having them done locally. And so I think, you know, as the minister said, our first goal is to, you know, restore basic core laboratory services in Yorkton, make sure that's all good and everything and that sort of thing, and we'll explore microbiology as resources are available in the future.

Ms. Mowat: — I think that raises more questions than it answers. How is it faster in Regina? Different technology?

Mr. Hendricks: — Technologies, yes. Yes. So they electronically can send the information down to Regina where it can be analyzed by pathologists here and with machines here and, because they have a larger cadre in Regina and different machines, they're able to do it more quickly here.

Ms. Mowat: — Okay. Talking about some of these shortages makes me think about a call that we've made recently talking to many folks within the health sector about challenges with recruiting and retention, and realizing that these are not one-off or isolated incidents and shouldn't be treated as such. And you know, folks in health care have talked to me about the fact that we used to have something similar to a health human resources round table that would bring together folks from the health care sector, also the ministries of Health and Advanced Education, and people, you know, anyone who's impacted across industry so that we can look at having the post-secondary institutions involved as well, so talking not only about recruiting in these positions but making sure that there are trained individuals in those professions, like looking at it as a whole life cycle.

Is this something that's at all being considered when we look at, you know, the number of vacant positions that exist in health care? I think last we looked it was 1,150 positions that have been posted. Is there any desire to come together and put our heads together and figure out what needs to be done here in a big picture?

[18:30]

Hon. Mr. Hindley: — On this issue, and just by a way of just some background, just to speak a little bit to put it in context here, what we have currently and what's been done in terms of staff, just the overall rural recruitment and retention across the province of health care professionals . . . So since 2007 we've added about 4,000 nurses, which is a 32 per cent increase. That includes RNs [registered nurse], registered psychiatric nurses, licensed practical nurses, and nurse practitioners. Nine hundred more licensed physicians, we've talked about that before.

When it comes to minimizing impacts, when the SHA anticipates a disruption due to staffing shortages, they first attempt to try to bring in a short-term replacement. And if the disruption is longer term, the SHA will actively recruit for these positions. And then if the recruitment isn't successful, the SHA considers alternate care models, alternate staffing models, larger centres supporting smaller outlying communities — the hub and spoke model as it's referred to — and that's what's done to try and minimize the impacts.

To try to prevent and avoid future disruptions, what we try to focus on is . . . We have a number of initiatives there, the rural physician locum pool for the SHA, and northern medical services. Recruitment of health care professionals is actively ongoing through a collaboration between communities, Saskdocs, the SHA, and the SIPPA [Saskatchewan international physician practice assessment] program. Just by way of a relatively current update, the fall 2020 SIPPA cohort wrapped up in December with 28 successful physicians. And the SHA continues to work through options for multi-site service models to support many of the small X-ray sites in the province. That's also a challenge in some areas, and as I mentioned before, working with larger community hospitals, trying to support some of the smaller neighbouring communities.

So that's just some of, kind of the statistical, you know, what's been done in the past and where we're at today. In terms of the question about recruitment committees, the Saskatchewan Academic Health Sciences Network exists. It's an interagency body involving the Ministries of Health, Advanced Education, the SHA, the University of Saskatchewan, University of Regina, and Sask Poly is also part of that to collaborate on health science issues, including educational needs, issues related to entry, to practice and scope of practice for key health care occupations. Also they're involved in ensuring a high-quality supply of health care providers for Saskatchewan. So that's the Saskatchewan Academic Health Sciences Network.

We also currently have the advisory council on health human resource priorities, which provides advice on top of health human resource priorities to help with the provincial training and recruitment and retention decisions. Memberships of the advisory council on health human resource priorities includes the ministries of Health, Advanced Education, Immigration and Career Training, the SHA, and the academic institutions.

And then in addition to that, we also have the steering committee on HHR [health human resources] priorities, which reports to the advisory council and helps, leads their research and analysis. Membership of the steering committee on HHR priorities includes the ministries of Health, Advanced Education,

Immigration and Career Training, the SHA, and the academic institutions.

So those are the three main recruitment committees that currently exist in this province that are working to help, again, ensure that we have a quality and a high-quality supply of health care providers across Saskatchewan and to help us manage some of these challenges that exist today and help prevent any that we might, you know, come across in the future as well.

Ms. Mowat: — Thank you. Which of those committees might help with lab staff or care aids, making sure that we have enough of those?

Hon. Mr. Hindley: — I think the question was about which of the committees that I listed there would be responsible for the CCAs [continuing care aid], as an example. It would be the advisory council on health human resource priorities. It would be that committee that provides the advice with respect to, you know, to the hiring, and what would be required in that . . . [inaudible] . . . as I had mentioned before, specific to provincial training and recruitment and retention decisions. Just as an example, you know, the training seats at Sask Poly were expanded from 20 to 32 in the fall of 2016 for the medical lab tech area to address some of the challenges there. And that was a result of some of the collaborative work between the ministries of Health and Advanced Education and Sask Poly as well.

Ms. Mowat: — Thank you. While we're talking about staffing and staffing levels, is it possible to get a breakdown of SHA employees for the number of full-time equivalents, out-of-scope, and in-scope? And could we get it for each fiscal year since 2016-2017?

Hon. Mr. Merriman: — Thanks. Usually we focus just kind of on this budget's numbers. So we can probably get you this. The other stuff would probably be available in public accounts. But usually we try to maintain the talks in and around the current fiscal budget estimates.

Ms. Mowat: — I think that in order for us to get a sense of staffing and whether we have adequate staff in this upcoming budget, when we're talking about the big picture of recruiting here, I think it's appropriate for us to go back like at least to the last fiscal year. I've regularly asked questions in these committees and gotten, you know, for the past five years, comparative data.

Mr. Hendricks: — Max Hendricks, deputy minister. So you had asked for paid FTEs [full-time equivalent], will that work? And for in-scope paid FTEs I'll start it at '16-17. And this is SHA and affiliates, so 29,703; 29,839; 30,051; 30,694. Out-of-scope we have 2,940; 2,869; 2,925; and 3,022.

Ms. Mowat: — Thank you. For the same time period could we get a breakdown of the FTEs that are full-time, part-time, and casual?

Mr. Hendricks: — Let me look and see if we can find it.

Ms. Mowat: — It might be easier to take all of . . .

Mr. Hendricks: — I'm sorry, Ms. Mowat, I don't have that with me. That would be something we'd have to provide afterwards.

Ms. Mowat: — Thank you. Is that something that could be provided back to the committee at the next sitting of Human Services?

Mr. Hendricks: — Yes, I'd just have to see if it's a special run or something that they've got to do, and I don't know when the next sitting will be. But we'll endeavour to get it to you quickly.

Ms. Mowat: — Neither do we. Thank you. Would appreciate that.

In terms of the temporary wage supplement, we talked about this yesterday that it was administered through the Ministry of Finance. But did the Ministry of Health give any input in terms of who would receive the wage top-up, and which groups would not receive that 56 million that went to health care providers?

[18:45]

Hon. Mr. Merriman: — I'm pretty sure the program you're referring to is actually a federal program that was administered by us and it had criteria from the federal government. The program was set up, to the best of my knowledge, because there was individuals that could be receiving more money by going on CERB [Canada emergency response benefit] than actually maintaining their employment. So that $2,000 . . . And I think they had an issue, well I know they had an issue in Quebec on this where there were people walking away from their positions and collecting CERB.

So the federal program was there to be able to top up to $2,500, so anybody that was earning that wage would be able to get that top-up. As far as Health is concerned, we provide information to Finance on how many people that could potentially impact, but not the decision. It was not based on a position is my understanding; it was based on a wage, and it was the federal government's criteria.

Ms. Mowat: — Okay, that's fair. I think that there were discrepancies though between provinces in what was being offered. And we were certainly hearing from a lot of folks on the front lines of health care saying, you know, I'm doing the exact same job as John or Jack and just because I'm in a different department, I don't qualify. And I know that my colleague, Mr. Wotherspoon, wrote to the Finance minister about these concerns in the summertime. So I'm not clear on where the criteria broke down and sort of whose feet that lays at and whether there was any role in the Ministry of Health for that.

Hon. Mr. Merriman: — That was, from my understanding, was a federal program. If there was discrepancies between provinces, I'm not aware of that. Because Health didn't administer the program, it's probably best that maybe Mr. Wotherspoon take it to the Finance minister to be able to discuss.

Ms. Mowat: — Thank you. I'll take a note of that. In talking about the COVID response, I did raise the issue of this study that was done by an infectious disease specialist from the University of Toronto suggesting that the number of people that have died from COVID-19 in Saskatchewan could possibly be hundreds higher than what our official record indicates. I'm wondering

what actions the ministry is taking now that it has this information. Or was it aware of this information already?

Hon. Mr. Merriman: — I remember this got brought up in question period and I did read the article. What the article was extrapolating was over a few years, the last few years, how many people had passed away in that amount of time on average in Saskatchewan, and then took that into the pandemic and said that there is people that haven't been reported that could have died from COVID — not that did die from COVID, that could. So there was a couple of an assumptions in there in that article. So I did read it.

As far as we're concerned, we're reporting things, the SHA is reporting things as accurate on people that are sick with COVID and people that have passed from COVID. And this is verified by pathology and by the coroner if need be to go down that path. But in that article there was two assumptions made from that person at the U of T [University of Toronto], I believe it was, across the whole country, not based on anything other than pure statistical information over a five-year average and moving that into a pandemic which our province has never seen before. So there was a couple of assumptions made in that article. And I'm not discrediting it, but I'm just saying I'm comfortable with the numbers that we have versus some statistical hypothetical.

Ms. Mowat: — Is the ministry trying to look into this at all and determine what the cause is of these excess deaths that have been identified?

Hon. Mr. Merriman: — To answer the question, unfortunately when anybody passes in Saskatchewan, and this does happen, each doctor that is in charge of that particular patient assigns a cause of death. That's done by the doctor at that point in time. If it's COVID related, then there might be some further investigations to be able to see, you know, exactly if it was caused by COVID. But the doctor assigns that death when somebody passes.

And like I said, it's a hypothetical and a statistical assumption that this is somehow related to COVID. I'm pretty confident with the doctors being able to assign the right cause of death to the right individual. And if it is COVID related, I'm confident that they'll be able to do that as well too. So this is the decision that the doctor makes on who has passed from COVID, certainly not the ministry.

Ms. Mowat: — I understand that. I think it's jarring information, so it's worth taking a look if there is any way to have a review of it. That's all I'm suggesting here.

Hon. Mr. Merriman: — So I'm not sure what I'm understanding. Would you like us to review doctors assigning cause of death? Is that what you're suggesting?

Ms. Mowat: — Like not on an individual basis, but I think it's worth looking at places where COVID hasn't been detected. I think that's the question at hand here. And there's always assumptions about . . . We don't have to continue on this line. But there's always assumptions about COVID that exists in community that we don't know about, right? And this has been something that Dr. Shahab has referred to often. You know, our COVID numbers are simply the numbers of folks that have been tested. So if there could be something else explaining an excess number of deaths, I think it's worth taking a look. And that's my perspective on it. I understand you disagree with that.

Hon. Mr. Merriman: — Well no, I'm just not sure. We would have to go back again and look at every doctor's reason for . . . like a certificate of death to make sure. I mean all the doctors in our province are well aware of the COVID situation, well aware of what the symptoms of COVID are, and what are the potential outcomes. And if somebody passes from COVID or thought that was passing from COVID, I'm sure the doctors did their due diligence in being able to check those boxes off. Because that is a very important part of the process of the medical care, to make sure that that is done accurately, and I'm confident that it has been.

Ms. Mowat: — Are there any hospitals that are currently being used for COVID purposes only?

Hon. Mr. Merriman: — Not to my knowledge.

Ms. Mowat: — When we talk about COVID rates, I know there's been a lot of value coming from studies through University of Saskatchewan researchers who have been able to predict COVID rates using wastewater samples. It's my understanding that the province isn't working with these folks to make sure that they're funded or expanding funding. I wonder if you can provide some information on that.

Hon. Mr. Merriman: — In talking to Dr. Shahab, and this has come out at a couple of his media avails that he's been . . . And I don't know a lot about this but just listening to him and learning what he had to say, this is one of many tools that Dr. Shahab — and there has been consultation with this group — one of many tools that Dr. Shahab uses to be able to make a lot of his recommendations to us as government and as to myself as Minister of Health: the numbers in the hospital, the modelling, the wastewater, ICUs, trends across the country, variants of concern that are out there, new variants of concern that come on board. No decision is made in isolation. These are all taken into consideration when Dr. Shahab looks at what he needs to provide us with a recommendation.

And I appreciate that there's a ton of work that goes behind the scenes with Dr. Shahab and his team of medical health officers to be able to bring all of that information in and boil it down to layman's terms so we can understand it as politicians, and work with Dr. Shahab and his team to make decisions on what we need to do as far as recommendations, vaccine rollout programs, and also some suggestions on what we need to be able to do with our hospitals and the organization of that.

[19:00]

Ms. Mowat: — That concludes my time with the committee this evening. I want to thank the ministers and officials and also committee members and staff for their time this evening. And I will see everyone again as we keep going through this process. But I understand that my colleague, Mr. Love, has some questions that he would like to ask at this point in time. And maybe there's a break as well.

The Chair: — Thank you very much, Ms. Mowat, for your questioning both yesterday and today. Much appreciated. Colleagues, committee members, we'll take a short break, as close to five minutes as possible, and resume at that time. Thank you.

[The committee recessed for a period of time.]

The Chair: — All right, committee members, we'll resume questioning. Matt Love is now in the committee and is substituting for Meara Conway. Mr. Love, the floor is yours.

Mr. Love: — Thank you, Mr. Chair. I just want to start and just get a chance to set the record straight, to make sure that my understanding is correct on some of the numbers that we discussed yesterday and again today in the Assembly.

So to the minister: my understanding is 185 vacant positions, 108 promised in this year's budget split between long-term care and home care, for a total of 293. So close to the 300 positions promised in the campaign. And I know that there's some confusion about what that campaign promise was, whether that was, you know, backfilling or new positions or in addition to the vacant ones. So I just want to give the minister a chance to clear that up for me. And also, I guess, just a more direct question: would that indicate that it's the goal of this government to hire 293 new staff, full-time permanent equivalents, this year?

Hon. Mr. Hindley: — So just with respect to the continuing care aids question, so the 185 vacant positions, we need to remember that that was a point in time, a number from last September, so not current numbers, but that's what we had available last night at committee.

The 185 are fully funded positions from previous budget years. So it's our intention and we're trying to attempt to fill all of those vacancies, any vacancies we have in health care as soon as they arise. So we're trying to fill those 185 fully funded positions of continuing care aids that already exist, but in addition to that, over and above that, is the election commitment for 300 continuing care aids.

So the funding in this year's budget is for the first 108 continuing care aids, and again that's separate from the 185, above and beyond that. And then the remaining positions, as part of that 300, will be filled and hired as quickly as we can in future budget years.

Mr. Love: — Thank you, Minister. So I just want to ask, and I'm going to qualify my question here in just a little bit. The 108 in this budget year — and I understand we're going to focus on that here tonight — my question is, will those be permanent full-time positions?

And the background of my question here is that one of the concerns that I'm hearing lots of, that I want to make sure that you're aware of, is the casualization of the labour force, that we have a lot of folks working in long-term care who are not employed full-time. They're part-time, maybe casual, sometimes temporary. I've looked at many of these positions that are posted and lots of them do indicate that they're temporary. They're maybe, you know, relief positions. They're maybe 0.75.

[19:15]

And I certainly haven't had the time go and look at all 185 and do a breakdown, but you know, in my opinion I think that this has some vulnerabilities to it. And I think we've seen that during the pandemic.

And I just want you to consider, what does it mean for somebody who has a 0.5 job as a continuing care aide in the province? Likely it means that to afford life, they have to work a second or maybe a third job. A lot of these folks are coming from other jobs to their jobs in a long-term care facility. During a pandemic, that's a dangerous recipe.

Now by no means am I blaming these people They're trying to pay the bills, serve their communities, and you know, we all agree on this matter. There's no point going into who supports front-line workers. I think we're together on that one, Minister.

But my question that I want to come back to is, are you committing that these 108 new positions will all be permanent full-time positions? And perhaps further to that, as you continue down the road to fulfilling that election commitment of 300, will those also be permanent full-time positions?

Hon. Mr. Hindley: — I'll just start here, and then I'll ask Max to jump in with some additional details. But the commitment is for 300 FTEs. So 108 FTEs is what's budgeted for this year, and then the remaining 192 are FTEs as well.

Mr. Hendricks: — So for many years . . . I just want to provide some context here. For many years we've been doing work across the health sector on regularization of the workforce. And that actually is targeted at having more positions identified and filled as full-time positions.

The challenge and the reality that we face is that some people in different stages of their life who work in the health care sector don't want full-time work. They want part-time work. Others have liked the flexibility associated with casual work. So they can pick and choose their days, fill in shifts where they like doing that.

We did a pilot with SUN [Saskatchewan Union of Nurses] a few years ago around regularization, and it does yield a lot of benefits. It yields predictability for us. It actually does lower our costs in the longer term. Obviously people get more familiar with the ward, that sort of thing. And it would address some of the issues related to split shifts in long-term care homes and that sort of thing.

But the reality is, is in the past when we've tried to fill full-time positions, we've had difficulties. Whereas casual, part-time, we have had some better success.

So we still endeavour, and we will continue to do more work to have full-time positions where they can. But we'll always have some casual because we need to be able to move our workforce as, you know, there are pressures in certain areas, that sort of thing.

So there will always be some of that, and part-time so that we can accommodate changing family conditions for workers, that sort

of thing. But the goal is to move the yardstick more to a regular, full-time workforce as time goes on.

Mr. Love: — So I mean, it certainly sounds like there's a lot of challenges in meeting these vacant, you know, these vacant positions and meeting the commitments of this government. Would you consider committing to more of a round-table approach with other partners in health care to strategize and move forward to make sure that you're able to meet these commitments?

Hon. Mr. Hindley: — Sorry just had to find information here. Just to reiterate, this is a . . . The member's colleague had a similar question, an angle question earlier on this evening, so I'm just going to just refer to that in terms of what's done for recruitment and retention here.

You know, we've added a number of nurses in the province, a number of more licensed physicians as well. We've talked about some of the work that we do, you know, in rural areas to help deal with disruptions that would occur because of staffing shortages, those sorts of things. You know, 700 more staff in long-term care that are working now since 2007, and continuing to build upon those numbers which is why we've made the commitments we have in the election here to hire 300 more CCAs in this province.

With respect to the recruitment committees, we have three right now. The Saskatchewan Academic Health Sciences Network, which is the inter-agency body involving the Ministries of Heath, Advanced Education, and the Sask Health Authority, University of Saskatchewan, the U of R [University of Regina] as well. Sask Poly is also part of that. And they collaborate on health science issues including educational needs, issues related to entry to practice and scope of practice for key health care occupations, and then also ensuring a high-quality supply of health care providers across the province.

Secondly, there is the steering committee on health human resource priorities, the steering committee which reports to the advisory council and leads the research and analysis.

And that's the other component, which is the actual advisory council on health human resource priorities, which provides advice on top of the health human resource priorities to help with provincial training, recruitment, and retention decisions as well. And that also involves the ministries of Health, Advanced Education, and Immigration and Career Training as well, along with the SHA and academic institutions as well.

So those are, you know, the recruitment committees that we have in place that work each and every day trying to, you know, not only address some of the challenges that we currently face with respect to staffing and recruitment and retention issues in all parts of the province, but also try to gauge, you know, where we need to go in the future with some of these things.

Mr. Love: — You know, I'll probably have a lot of comment on that that I'll reserve for now. I'm curious for the 90 care aids designated in this budget. Has the SHA already designated facilities for those? Do you know where they're going? And just a follow-up to that, if any of these, you know, which is a government decision that are going . . . Are any of them designated for Extendicare facilities? And if so, will Extendicare be paying to increase their staffing levels?

[19:30]

Hon. Mr. Hindley: — So to the member's question, I just remind the member that all long-term care is publicly funded in Saskatchewan regardless of who owns the facility. There's a preliminary list of where the first tranche of CCAs would be allocated to.

There's a number of communities here on this list across the province: Moose Jaw, Gull Lake, Assiniboia, Estevan, Moose Jaw again, Middle Lake, Wynyard, Kelvington, Ituna, Wolseley, Broadview, Gainsborough, Elrose, Eston, Craik, Dinsmore, Kyle, Leader, Shaunavon, Maple Creek, some in Regina, some in Saskatoon, Duck Lake, Cudworth, Arborfield, Carrot River, Melfort, Porcupine Plain, Cut Knife, Edam, St. Walburg, Macklin, Wilkie, Unity.

Again that's the preliminary list. And some of those are going to Extendicare as well.

Mr. Love: — Can you commit to providing a written answer of which communities and which facilities are on the preliminary list to receive the first tranche of CCAs?

Hon. Mr. Hindley: — Yes, we can provide that list.

Mr. Love: — Excellent. Thank you. I want to continue just with some questions here about the relationship and the arrangement with Extendicare Canada and their operations in Saskatchewan as they relate to this budget.

I think I just want to preface that with the answer tabled to this committee. I see that there are 649 beds in private, for-profit facilities, as we understand them, and that in those 649 beds we had 44 fatalities. In comparison, SHA-owned and -operated facilities fared much better: 5,608 beds with only 31 fatalities thus far during the pandemic, a stark difference. I know there's great public interest to inquire as to the discrepancy.

And one of the things that I hear is that lots of folks, when they're looking for a facility and they examine what's available either for themselves, their partners, their loved ones, a lot of folks don't really consider the difference. Yes, I think that there's maybe a lack of public education out there. Even the difference between a personal care home or a special care home, lots of folks see them as kind of all being in the same basket, but of course here we know that not to be true. Even within special care homes, you know, the evidence shows a huge discrepancy between them in the outcomes for the residents.

So with that in mind, Minister, could you detail for me what is the financial arrangement with Extendicare as far as addressing capital investments that are consistently outlined in CEO [chief executive officer] tour reports? So in other words, whose job is it and was it to fix problems like HVAC [heating, ventilating, and air conditioning] and four-bed wards?

Hon. Mr. Hindley: — Thank you, Mr. Chair. To the member's questions, like I said, I would start with, you know, recognizing of course that the member's asking about or talking about the

number of beds that are in private, for-profit facilities versus SHA-run. And you know, there's faith-based organizations as well, of course, that do very good work providing long-term care in this province.

But you know, I would start with — because I think the member's probably alluding to this just in terms of what happened at Parkside earlier this past winter with respect to the outbreak there — and note that, as I have before, that that was a very serious situation that happened in that facility. And the deaths that occurred there were indeed tragic and should not have happened.

And that's why we took the steps we did a number of months ago. Some of them I've detailed to the committee earlier tonight and yesterday with respect to cohorting and PPE [personal protective equipment] use and making sure we're working with staff and with these facilities to make sure that they're doing everything possible to provide a very high level of care to the residents, but also making sure that they're safe from COVID-19.

You know, in the case of Extendicare, they are a private facility and it would be incumbent on them to make sure they're keeping up with maintenance and those sorts of things and to provide and to protect, you know, the safety and maintain the safety of that environment for their residents. I'm just speculating here, but I suspect because they're a publicly traded company there's probably a number of points of the contract that are probably confidential, so I'm not going to mention that. But you know, it's important to note that Extendicare has a long history in this province. All of their facilities, the Extendicare facilities, opened in between the years of 1963 to 1972. So they've been operating in this province for quite some time.

When we had the situation at Parkside, there was a co-management agreement that was put in place with the SHA, and that was in place until the 15th of February. The outbreak was declared over on January 21st.

And in terms of some of the support that was provided to Parkside during that situation, we had occupational health specialists supporting PPE fit testing and education at Parkside. We had SHA managers supporting daily rounds and regular physician support as well. We had daily point-of-care testing, retesting of staff and residents, and as well of course a review of and provision of PPE and infection control protocols as well.

[19:45]

And then just finally, there's been some questions about the four-bed-room concern with respect to that particular facility. And we're actively working with the SHA to determine how we can best and quickly move away from four-bed-room model.

It's my understanding that at least that the four-bed wards are relatively uncommon in Saskatchewan's long-term care facilities. And that, at least it's my understanding that since 2007 there's been no new long-term care facilities at least that's been built under this government, with double or triple or quadruple rooms, excluding of course couple and separate entrance joining suites.

And then just finally, as a result of all this, you know, the members of the committee would know that we've — in, I think, it was February — wrote to the Ombudsman asking for her investigation. And so that is under way right now, and I fully anticipate it will be a very thorough and detailed investigation as to what happened with respect to Extendicare.

And we are co-operating fully with the Ombudsman and her office and look forward to the release of her report, the findings that she comes up with, and any recommendations that may come as a result of the Ombudsman's investigation.

Mr. Love: — Yes, I think it's fair to say that many people are anticipating that report from the Provincial Ombudsman. And in fact I have several questions related to previous reports that I'll be happy to get into later, later tonight or at our next meeting.

I just want to be clear here though, Minister. So you are saying that from the perspective of the province and the SHA, that it is the duty of Extendicare to pay for regular maintenance, including those noted in previous CEO tour reports as posing a risk to the residents? For example, the HVAC improvements that were noted in previous CEO tour reports as posing a risk, that that responsibility falls on Extendicare. Is that correct?

Hon. Mr. Hindley: — Mr. Chair, they do receive some funding from the SHA is my understanding, capital funding that allows for Extendicare to do, you know, some of the necessary upgrades. But yes, they have received some additional assistance from the SHA. And I think Max might have a bit more details just in terms of how that works.

Mr. Hendricks: — So they do participate in our evaluation of our facilities. And in the past, we provide what we call life safety and emergency funding for maintenance to Extendicare. Having said that, Extendicare does, as the minister said, provide corporate money to support their capital costs too. I think I would need to actually refer to the agreement. They have purchased the buildings. They own the buildings. We pay them to provide care in those buildings to those seniors.

And so, you know, by letter of contract are we obligated to pay, to provide any funding to them? Probably not, but I would need to refer to the contract. I think we also need to keep in mind we can focus on facilities, but I think we should await the Ombudsman's report to see what some of the issues are here because I don't want to jump to conclusions right away on what all of the issues might be.

Mr. Love: — Okay, fair enough. So you've indicated that, you know, as we knew that Extendicare owns these facilities, they're responsible for these facilities. Some funding comes from the SHA and then there's follow-up inspections to see if they're engaging in upkeep and maintenance in these facilities to provide the care that they're contracted to provide.

But how many requests have come in for replacement facilities from Extendicare? Could you update the committee on when these requests for new facilities have been received and what is the status of those requests? Are there any requests for new facilities under active consideration?

Hon. Mr. Hindley: — Thank you, Mr. Chair. It's my understanding that Extendicare has submitted proposals in the

past to the government. I don't know when exactly or how many proposals. I don't have that information in front of me. I would point out that it's well within Extendicare's right to build a facility on their own whenever they wish, obviously. But yes, it's the short answer to the member's question. Not sure if Max might have some additional comments as well perhaps on the history of that.

Mr. Hendricks: — Yes, over the years we've been approached a few times by Extendicare about their capital facilities in Regina and their interest in rebuilding them. You know, I think the simple answer to the question is that, you know, it's not to say that they wouldn't be on our consideration list, but there are other facilities that were maybe ahead of them: you know, most notably, I think Pioneer Village, that sort of thing.

But you know, I think one of the things that we have to be mindful of is they're coming to government with a proposal, and I don't want to discuss the details. I'm not at liberty to discuss the details of the proposal. But an interesting discussion when you know, kind of the public participation in a private sector build, you know. So there's some issues there.

And I think that going forward, you know, we're looking at the Regina plan overall for long-term care and how we can most effectively provide quality, safe, and adequate care here. And so that's our goal, and that's what we're looking to do with some of the improvements we're making.

Mr. Love: — Okay. You know, certainly I think that there is lots of confusion here over, you know, things that have taken place in the last year and who's responsible and what can be done to improve the situation moving forward. And I think that some of the confusion over who bears responsibility for, you know, what's happened at Parkside and Preston and other Extendicare facilities that have had outbreaks that these . . . The relationship is a bit murky as far as what I'm hearing is that Extendicare should have been, you know, keeping up on maintenance on things like their ventilation systems. But the four beds to a room is a situation that even in the report from the CEO tours it appears as though Extendicare wanted to move away from that, that they wanted to move towards eliminating four-bed rooms.

So I guess just a simple question: like, why not? Why hasn't this happened? Why did it take, you know, 44 deaths in Extendicare facilities to start to see some motion away from this practice that went against, you know, federal COVID guidelines for long-term care. Why not find ways to move away from that?

[20:00]

Hon. Mr. Hindley: — Thank you, Mr. Chair. I guess, a couple things. You know, I've touched on the Ombudsman's investigation earlier tonight in committee and the importance of that investigation to try to help to determine why there was such a discrepancy between what happened at Extendicare as in comparison to SHA or affiliate-run facilities in the province.

And we're not going to prejudge, I guess, the Ombudsman's report and what her determination is based on, you know, any and all the factors that may have been part of this. And again, we'll await the Ombudsman's report into this and her investigation and her findings with respect to what happened at Parkside Extendicare.

You know, I guess I would say as well that what we're focused on here tonight, right now this is on what we're doing in this budget year. The estimates are for this budget year, and we're working with Extendicare today on the four-bed issue.

You know, I've said that they are relatively uncommon, these four-bed-room facilities in long-term care homes. Again there's been no new facilities, it's my understanding, since 2007 that have been built with double, triple, or quadruple rooms, excluding couple and separate entrance adjoining suites. But that's not something that, you know, that has happened under this government.

You know, Extendicare has been around since the 1960s, 1970s. And that's when those four-bed-room facilities were built back in the first place. And that's what we're moving away from. We're trying to build the long-term bed capacity in this province. You know, we've made a number of significant investments into staffing, and I've talked about those earlier this evening, but also into facility replacement and not just in this city but across the province.

You know, there's more funding in this year's budgets and these estimates for development of a La Ronge long-term care facility. There's more funding in this year's budget and estimates for the Grenfell long-term care facility replacement project. Those are important projects in those communities, and a couple of new ones that were announced this budget as well for the future new facilities in Watson and Estevan.

Those are important new facilities to, you know, replace aging facilities in this province and replace beds. It's been significant investments into long-term care over the last number of years, and new long-term care facilities. And Meadow Lake's another one I should mention there as well.

But we're trying to build a capacity as best we can. And then finally in Regina, as the deputy minister said and I've mentioned before too, there's additional funding in this year's budget to help expand the scope of what is it that needs to be done in this city, in the capital city of Regina, where we have had . . . You know, members will be aware of the work that has been done so far on the replacement of Regina Pioneer Village. But there's an additional half-million dollars in this budget to expand the scope of that, to look at all the beds that are required in Regina, and what the future looks like for long-term care here in the capital city.

Mr. Love: — Okay so, you know, back to this budget then, Minister. And again I'm trying to just understand this, this relationship with Extendicare so we understand who's calling the shots and who makes decisions. So you indicated that Extendicare facilities are some of those that are designated for the 90 new care aids in long-term care. And you said that, you know, that they receive public funding, which they absolutely do. And I think that we could debate for a long time whether or not, you know, tax dollars are well spent at for-profit facilities and what the indicators are to prove whether that's the best way to spend our tax dollars.

But what it looks like here is that the province is deciding in the

budget commitment — you know, roughly $6 million for the new care aids — deciding to place those at Extendicare. Now is that the province deciding or the SHA deciding you need to increase your staffing levels and we're going to put money in our budget to pay for that? Or is that Extendicare deciding that they need to increase their staffing levels and asking the SHA to pay for that? Or is it an increase in the subsidy, you know, the continuing care subsidy given to Extendicare to afford to hire more staff?

Does my question make sense? In other words, who is paying for the whatever small number it is, might only be a couple positions, but who is paying for those positions that you indicated are for Extendicare facilities?

Hon. Mr. Hindley: — Sure. Thank you, Mr. Chair. What the commitment in the campaign was for the 300 new continuing care aids, the way it's broken down is that there is one new care aid for every 50 residents of long-term care. So that's regardless of whether it's an SHA-run facility or an Extendicare-run facility or a facility run by an affiliate. And not all of the Extendicare facilities are receiving new care aids as part of the first tranche of 90. It's spread out across the board amongst a number of different long-term care facilities in the province, but in order to do it equitably again between whether it's Extendicare or an affiliate-run facility or SHA run, the formula that's used is one new care aid for every 50 residents of long-term care. That's how the numbers break down.

Mr. Love: — Okay, I'm not sure that that really answered my question. It was related to who was paying for the ones designated for Extendicare, if that was at their request? I'm just trying to find out what this relationship is. Who is making decisions as far as their staffing levels? And I think this is a fair question. If an answer comes to mind, I will be eager to hear it.

I would like to move on and just ask a few questions here, and this will be about this year's budget, Minister. But I'm just going to start with the preamble and just mention that in last year's budget, the government put aside funds for what they call the innovative community-care project in the Regina area, essentially to take residents who were being housed at Regina Pioneer Village while their replacement facility is being designed and built and planned for. And I know that takes time. But essentially what happened was two private personal care homes were successful applicants in that, and that was Brightwater and Emmanuel Villa. And essentially what this is doing is it's kind of funnelling individuals who are in long-term care into a personal care home, and also funnelling payment for that through, you know, continuing-care subsidy agreements for individuals who are in a house there.

So I guess, my question for you is if you can please update the committee on that situation. How many residents who were previously housed at Pioneer Village are now living at Brightwater Senior Living in Regina? And can you explain the financial arrangement between the province, Brightwater, and the residents and their families? My understanding is that the residents and their families, or power of attorney, are paying and then are reimbursed, you know, a certain amount for their loved one's care at Brightwater.

[20:15]

Hon. Mr. Hindley: — Thanks, Mr. Chair, and thanks to the member for the question. I thought I had the numbers here but I don't. So we'll, just in terms of the current numbers there, so we'll endeavour to get those to you here, to the member. Max, I think, wanted to speak just to what the background of the situation is there and just kind of the arrangements and those sorts of details.

Mr. Hendricks: — So this arrangement was developed as an approach to help address some of the needs of reduced capacity at Regina Pioneer Village due to the infrastructure challenges over the next two or three years. So we did an RFP as you know and there were two successful proponents. There was Emmanuel Villa Personal Care Home which has 40 beds in Emerald Park, and Brightwater Senior Living which contracted for 60 beds, for a total of 100.

In the case of the residents, if they move from Pioneer Village or another long-term care facility in Regina, the SHA reimburses the residents for their full cost of care there. There's no change in the fees for the resident and so there's no change financially for them.

And then, you know, in terms of the contracts with these organizations, they're all required to meet all the core standards for long-term care as described in guidelines that we have described for our other long-term care homes. And the SHA's put a process into place to, like a support structure for residents and their families, to access services or with any concerns that they have in place. So I think thus far we're feeling that the arrangements are meeting our needs in the near term.

Mr. Love: — Are these facilities inspected?

Hon. Mr. Hindley: — So the short answer is yes. Both homes are required to meet core standards of the long-term care services as per the accountability agreement that we have with them as well as a requirement under *The Personal Care Homes Act*. Through their approach to delivering, or I should say, though their approach to delivering these services may be unique, these standards are the same as those followed by special care homes and are defined in the accountability agreement that Emmanuel Villa and Brightwater have signed with the SHA. Quality and safety will be monitored and evaluated in accordance with current standards that apply to all special care homes. My deputy minister tells us that we have gone out and checked both locations on several occasions. And it's my understanding that inspection results are posted online as well for people to be able to view.

Mr. Love: — Could you maybe update me? I believe that in the last budget year there was roughly $2.3 million allocated for the 100 beds that you described in this innovative community-care pilot project. Can you tell me, has that number stayed the same? Has it increased, decreased? Assuming that this arrangement is continuing in this budget year, could you give me an update on that number and also could you give me any indication of how that number broken down for 100 beds compares to other facilities, you know, on a per-bed basis, what that kind of funding looks like compared to, say, a bed in a SHA-owned and -operated home?

Hon. Mr. Hindley: — So the member is correct — 2.3 was the

amount last year — and it's about the same amount, 2.3 million this year in this budget as well. And, just further to the detailed question about the dollars-per-bed comparison, I think Max has a bit of an explanation of how that works and why.

Mr. Hendricks: — So this part is part of the RFP evaluation process. One of the things that we're required to do is compare those costs against our best estimate of what a public delivery of the same service would be. It's actually required under the CUPE [Canadian Union of Public Employees] collective agreement, which is the predominant union in Regina. And so that was done as it is with all types of contracts like this, and it was shown to be cost effective. But I don't have the number and, in fact, I could probably give you an idea of what the public costs are, but I don't know that I necessarily . . . I'd have to check whether their bids can be released. Again, whether that's proprietary or not.

Mr. Love: — Yes, and I understand that, you know, comparing beds to beds is challenging. It's different levels of acuity and needs, hours of care, all these types of things, I know. But I think on the kind of macro scale we could possibly get a sense of, you know, this investment of public dollars here.

Just kind of continuing on, thinking about this pilot project as a way to relieve some of the pressure in the short term for the low number of beds in Regina compared to other regions, as we discussed yesterday. You know, certainly Regina is well below Saskatoon in terms of the number of beds that do exist here for, you know, similar populations.

I'm curious. You know, it's been a while since the tender for Pioneer Village was issued. And I'm curious. What's the latest update as far as where we're at with that? You indicated, Minister, that there's additional funds in this year's budget as we continue moving forward.

[20:30]

Can you comment at all on what's on the table for getting that facility built: where we're at, how many staff and residents you may be preparing for, assuming that some of the money in estimates is also going to be, you know, put into planning for those things in terms of staff and residents? But I'm also wondering about, like, the level of care that you're prepared to house in that facility, assuming that that's something that's being considered if you're looking at, you know, alternate levels of care in Pioneer Village. As we know, there's a need for that in the Regina area.

Yes, I guess, just overall can you give me an update on where we're at and what's on the table at this point for getting that facility accomplished to increase the beds in the Regina area?

Hon. Mr. Hindley: — So when the funding was committed, the $500,000 was committed in this year's budget to the expanded scope of the replacement project, essentially what happened is we cancelled the RFP for the Regina Pioneer Village replacement project because the determination was made that we wanted to expand, you know, the overall scope of what needs to be done in Regina. So that's kind of a current status update.

It will take a little bit of time here, you know, to get this new or expanded process up and running and through its paces here. But that being said, noting that, you know, we need to make sure that it moves in an expedient fashion, to make sure that there's not a lot of time that's spent on this. We want to make sure that we do it quickly but that it also is done right.

And you know, I think I would point to how some of the other long-term care facility projects that have been completed in the province in previous budget years, how they're different than how projects were done decades ago. And we've kind of spoken a little bit tonight about the four-bed-room model that previously existed. And that was the way they built things back in the '60s and '70s, and obviously isn't the case anymore.

And I'm not sure if the member has been into any of the newer long-term care facilities, if he had a chance to visit any of them. I've had a chance to be in a few of them just to see them. And they're all a little unique, right, and innovative in terms of what they offer.

The one that's most familiar to me is in my home community in Swift Current, The Meadows, which is based on one of those sort of mini house model types of layouts and is very highly regarded by both the staff and particularly the residents in terms of the more home-like atmosphere it provides. Anyway less of an institutional type of design and allows for a better quality of life, I would argue, I think, for the residents, which is what they all want and they all deserve too.

So anyway, just kind of a bit of an answer around making sure that with the replacement of the Regina beds that we do the same sort of thing — look at what's been done in the past, look at what the needs are going into the future for the requirement of beds for seniors and older adults in this city. And of course the surrounding area probably supports a little bit of that as well. It wouldn't just be the city of Regina.

But anyway, just making sure that we do move the process along quickly but making sure we consider all the factors and make sure that we get it right.

Mr. Love: — You know, Minister, I do appreciate your comments. And you know, I haven't been in a long-term care facility in the last year, but the last time I was, it was with my students and we visited St. Ann's long-term care home at Christmastime. Spent some time with the seniors there, and incredibly valuable. And you know, just a really valuable thing to do with my grade 9 students. So that's going back a couple of years, two years ago I guess.

Just for clarity here though, if you could just spell out for me, exactly what is the half million dollars for in this year's budget? It sounds like we're kind of going back to square one, starting again, re-evaluating what is needed. But if you could explain what will the half million dollars do? What are you expecting it to do in these estimates? And also if you could give me a target for the number of beds, the number of staff that you're anticipating for the new facility, if and when it's built.

Hon. Mr. Hindley: — So just in terms of some additional information with regards to the Regina beds replacement project. So the work that's been done already is part of the Regina Pioneer Village RFP. That would not be wasted work. We would take whatever information that we've gleaned thus far in that process

up to this point in time, to use that as part of, you know, part of the process going forward.

The 500 million . . . sorry 500,000 — let's get that number correct — $500,000 committed in this year's budget is specifically for the planning, as I said, to expand the scope and just take a much broader look at this. But again, building on the work that's already been done to this point in time, just based on the RPV [Regina Pioneer Village] project. So that work is not for naught. It'll be utilized as well.

We're of course scoping a new plan, you know, right now. We'll be working with SaskBuilds. SaskBuilds has an involvement in this just as they do on some other health care projects, the urgent care centres which I think we've talked about before, perhaps not in these estimates but in some other forums about that. So SaskBuilds is involved in this project as well.

And with respect to the question about number of beds and staffing. So the operational and capital portions of it are separate from each other, of course. So you know, what we're working on now, that will be determined along with SaskBuilds as part of this process. So that will determine . . . Not the staffing. That'll be something to be determined once, you know, the size and scope of the building, what it looks like, what's included. That will help inform the decisions on staffing.

But in terms of beds, we don't have any numbers in mind right now. That's what the 500,000 is for this year, to help and try to inform the decision as to how big would that long-term care facility be. And so that'll be something that's part of the process and will help inform the number of beds that we feel are required to adequately serve and provide service to the seniors of Regina.

Mr. Love: — Okay. You know, I'm kind of surprised that there is no even kind of ballpark figures. And you know, the money that's already been put into this, you say, is going to continue moving forward. But you know, so be it. Just trying to get kind of a sense of the size of the project that this government is investing in at this point.

[20:45]

But let's move on and talk about the dollars in this budget designated for the La Ronge long-term care facility. And I'm just again curious, what are the anticipated deliverables for these dollars, and when are we looking at shovels in the ground?

Hon. Mr. Hindley: — Sorry, that was La Ronge?

Mr. Love: — Yes.

Hon. Mr. Hindley: — Okay. So the La Ronge long-term care facility, that's an important project up in that part of the province, and I know it's an important project for the member up there, the member for Cumberland. He's been advocating for that for quite some time, and it is an important project for the government, for the people of La Ronge and area there.

So here's the status update on La Ronge. This budget year, the member will know that we've included an investment of $7.6 million in the budget for the La Ronge long-term care facility. So that brings us to a total investment of 12.3 million since 2019. The new facility will be an 80-bed facility. It will have 70 long-term care beds, 10 respite care beds, space for an adult day program. It will also replace, you know, the current 14 permanent residents and two-respite-bed facility adjoined to the La Ronge Health Centre.

In terms of the current project status, the development work and land acquisition is under way, I'm told. There's an existing . . . What we have in La Ronge right now is an existing 16-bed facility which is, as members might know, is the only long-term care facility in La Ronge and is experiencing some pressures due to population growth in the area. So this is definitely a needed facility in that area.

The actual proposed project site, which is adjacent to the La Ronge hospital, is owned by the town of La Ronge. And as specific to the question I said before or the point I made before about land acquisition, there's working on some negotiations there and are in preliminary stages. That needs to happen before any construction can occur. But in terms of the actual timeline, this is the current status right now. It's in the design phase, and the decision on the construction methodology will be made this spring. Geotechnical investigation on the adjacent site was completed just last month, March 2021.

And you know, pending the land acquisition and the detailed design progress and the selection of, you know, the type of construction delivery method on this particular project, we're anticipating that the construction could begin as early as late this year — late 2021, early 2022. That's kind of the ballpark that we're given right now. And target completion for the new facility in La Ronge is late 2023, probably stretching into 2024. But that's as of the current state of the La Ronge long-term care facility project; that's where it stands as of today.

Mr. Love: — Okay. Thanks, Minister. Will you be expecting the municipality of La Ronge to contribute any funds to the cost of the project?

Hon. Mr. Hindley: — Sorry, just had to confer with officials there. The policy's currently under consideration with government right now in terms of whether a local share will be required or not for this project.

Mr. Love: — So you know, I guess is there any reason to treat this any differently than the hospital in Prince Albert, as a, you know, the hospital that I . . . My understanding is that the government sees this as a hospital that serves the entire northern half of the province and folks from all different geographic regions that are served through that hospital. Is there any reason to see this new facility for long-term care in La Ronge any differently than your perspective on the Prince Albert hospital?

Hon. Mr. Hindley: — Thanks, Mr. Chair. We're reviewing it for both projects, so both . . . currently looking at that for both La Ronge and the Prince Albert hospital project. So no decisions have been made at this point.

Mr. Love: — Okay, fair enough. I'm wondering if we can just get back into some numbers, and specifically I'd just like to ask some questions about long-term care wait times. And I'm wondering if you are able to access the data or if you keep this type of data. I believe that you do. I'm told that this is something

you might have, like, snapshot twice a year of long-term care wait times in each of the regions that you've listed for me where you keep track of beds. So Athabasca, North-East, Northwest, Regina, Saskatoon, South East, Southwest. Can you provide me even the last two to three years of wait times for those regions for long-term care?

[21:00]

Hon. Mr. Hindley: — Thank you, Mr. Chair. Before we answer the question about wait times for long-term care, I need to just make a correction on my last answer about a local share for Prince Albert. One hundred per cent will be paid for by the government to that capital cost, so just to clarify that for the record here. So my apologies.

And with respect to wait times for long-term care, I think Max has got some fairly recent statistics that he could probably provide to the committee here this evening.

Mr. Hendricks: — Yes, so what I think I'd like to do, just because there's a lot of numbers and because they go by regional health authority up until March of 2020, and then after that we went to service areas, so maybe I'll just give you . . . Do you want the RHAs [regional health authority] for a year? Or do you want the provincial totals for a few years, maybe? I don't know.

Mr. Love: — That's a good question. I imagine there would be a lot of numbers to write down here. If it's easier to table an answer to this question, I'm certainly open to that if you're willing to do that.

Mr. Hendricks: — It's probably easier to table it. So for the average wait time by service area that we have from 2007-08 to September 2020 . . . That's a big average, but it's 14 days in the Northeast; in the Northwest, 144 days; nine days in the Southeast; three days in the Southwest; Regina, 15 days; and Saskatoon, 31 days.

Mr. Love: — Okay. That's interesting. And are you able to table the more detailed answers? It sounds like you were interested in doing that, going back into the last couple years.

Mr. Hendricks: — Yes. We're able to table the average wait times by regional health authority going back several years, yes.

Mr. Love: — Thank you. I appreciate that. And thanks to the minister for correcting that previous answer about the Prince Albert hospital. You know, I want to maybe spend the last 10 minutes or so here just asking a few questions to the Minister for Seniors just about, you know, kind of getting outside of long-term care and even personal care homes and talking just a little bit about the situation with independent living or, you know, retirement living. I know there's a lot of different classifications there.

But I'm just curious if you can point me . . . And actually, you know, I'll just see if I can preface this just a little bit. You know, as critic for Seniors, I hear from lots of people. And again, like the public education out there on the different levels of options for communal living for seniors that ranges from homes that provide services not unlike a hotel to services right up to long-term care, you know. And a lot of folks call me or call my office, email, share their stories, and they need help kind of figuring out where they fit in and what legislation there is to protect them and make sure that they're safe and their loved ones are safe.

So when we think about, you know, independent living facilities, I've got a lot of concerns about this coming my way. And it's challenging to hear because there's not a lot of recourse for these folks. So I guess my question for you, Minister, is what legislation exists to protect seniors living in independent living facilities, retirement homes. What type of legislation is there to protect them from, you know, from any type of predatory . . . whether it's financial actions or whatever it is, in these types of facilities?

Hon. Mr. Hindley: — So in response to the member's question . . . And I've, you know, heard some of these concerns before, a number of concerns raised by seniors and older adults' groups in the province. I've had a chance to meet with the Saskatchewan Seniors Mechanism, and I think I've got a meeting coming up next week with the council on aging. And then just of course through regular correspondence and people that I represent back home, and I'm sure the member represents as well, hears somewhat similar queries and concerns and questions about these sorts of things just in terms of what's, you know, available for them.

It's not funded, you know, independent living facilities, that sort of a thing. You know, those types of seniors' homes aren't funded by the ministry, so there's not really any direct oversight, I guess is the best way to put it. You know, there's existing legislation under, for example, through the Ministry of Justice, you know, *The Consumer Protection Act*, things like that. Of course there's always the ombudsman's offices as well that can take enquiries and look into complaints from anyone, including seniors as well. You know, in the case of where a senior may be renting a property, of course that would fall under *The Residential Tenancies Act*. So there's that option as well.

But some of this, I think, would probably better fall under the Ministry of Justice in terms of what's, you know, currently available for legislation in these sorts of areas that the member is asking about.

Mr. Love: — Yes, so I think that we're mostly on the same page here, but I'll just maybe make one correction, if I may. I don't believe that there's any provincial oversight of any kind, certainly coming from the SHA or from the Minister of Health in any way, of these independent living facilities. [Inaudible] . . . that you're correct. *The Residential Tenancies Act* and consumer protections may be in place, but as far as contacting the Ombudsman, I have had people reach out to me who did contact the Ombudsman and were told that she had no jurisdiction to investigate or to have anything to say about what goes on in those facilities.

And here's my concerns, and to be fair, I'm not sure that this is something that other provinces have an Act or legislation on either. It doesn't prevent us from being a leader here. And I'll tell you one of the stories that I heard was from somebody whose mother was in independent living. You know, and they move in before they have a higher level of care that's needed. You know, they move in for the independence and then, under the guise of

aging in place, their monthly costs go up, their level of care or their needs goes up, and before you know it, they're paying about $8,000, $9,000 a month.

They didn't want to move. But during that time, they never had to see a medical professional. There's no nurse on hand. There's no one to evaluate their increasing needs. What there was an increasing bill every month. They got to the point where this woman fell, and it was during the pandemic. Her daughter wasn't able to get in to see her right away. It was as case numbers were rising. And as it turns out, she stayed in her room for eight days with two broken hips.

And it's terrible to hear these stories and the neglect that went on there, but also, you know, the ongoing exploitation and just the increasing costs for everything was being charged to this woman. I mean they'd spent half a million dollars or so. It was just unbelievable. But when they contacted the SHA, when they contacted the Ombudsman, there was no recourse, no oversight into the situation, no inspections, you know. And so when they contacted my office, you know, it's . . . There's not a lot to say other than, you know, they're not getting the services that they paid for, but they're not yet within provincial jurisdiction of the SHA to really have any oversight to what's going on inside the building.

[21:15]

And so I guess I'm just asking here to conclude, like do you see a need as Minister for Seniors to have a look at this? You know, to perhaps dedicate some money, some funding out of this budget year or next to consider what can be done to protect seniors who are aging in place in situations like this, who really need to be in a facility that does have oversight? That's where they should be, right, and I think that would be the right thing to do. But as is, they're staying there, again with no medical attention and no oversight from the provincial government. Do you care to comment on that at all, Minister?

Hon. Mr. Merriman: — If there's, in your opinion, a miscarriage of justice, can you bring that case forward to us? Like, you say you've got documentation. They contacted your office. Can you bring that to us and we can have a look at it? Or we can forward it on to the Minister of Justice and they might be able to investigate. Do you have that information?

Mr. Love: — You know, I can go back to these individuals. And I asked them if I could share it and then they said no. In fact the individual moved to, you know, a personal care home in a different community outside of Saskatoon. And they describe it as a wonderful experience. And so they have both, you know, a positive and negative as far as like, good ways to do things and bad ways. But the home that they're in now, it's a smaller facility and they're really quite happy, and they didn't want to carry on from there.

The Chair: — All right, committee members, I think we've reached our agreed time of adjournment. I'll ask the ministers if they have any closing comments.

Hon. Mr. Merriman: — Thanks, Mr. Chair. I want to thank certainly my colleague and my friend, Minister Hindley, for I think he took the majority of the questions over the last two days. The committee; I want to thank you, Mr. Chair. Thanks very much to the Legislative Assembly, and Max Hendricks for being the front person for the entire Health. I want to thank the member opposite, a couple of other members that were here, member from Cumberland and member from Saskatoon Fairview. Thank you for their questions and being respectful. And that's all I have, Mr. Chair.

Hon. Mr. Hindley: — Thanks to my colleague, the Minister for Health, for being here to help answer some of these questions here over the last couple of days, and thank you to the committee members that are present here and those that were here or present earlier tonight and tomorrow for your questions.

Thanks, of course, to Max; to the staff, who are virtually attending and supporting us providing some of the detailed answers to some of these questions here tonight; to our chiefs of staff, Morgan Bradshaw and David Keogan, and all of the staff in our offices; and of course, the staff in the room here tonight for helping manage through this. Probably better things to do on a Thursday night, but it'll get you ready for bedtime, I guess. So thanks everyone for your assistance.

The Chair: — Matt, did you want to say something?

Mr. Love: — Yes, thanks to the ministers for engaging and for answering the questions of myself and my colleagues. Thanks to all the committee members who stayed late again tonight. And also thanks to the officials who were here to provide the detailed answers that I think will help us to keep moving forward. And appreciate all the co-operation, and thank you to all committee members again for another long night.

The Chair: — Well thanks very much, colleagues and officials. Eight hours in two days, I think that's a very aggressive schedule by anybody's compilation, so thank you. I would now ask a member to move a motion of adjournment. Mr. Fiaz has moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned until the call of the Chair.

[The committee adjourned at 21:19.]