STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 30 – April 10, 2014

Legislative Assembly of Saskatchewan

Twenty-Seventh Legislature

STANDING COMMITTEE ON HUMAN SERVICES

Mr. Delbert Kirsch, Chair
Batoche

Mr. David Forbes, Deputy Chair
Saskatoon Centre

Mr. Mark Docherty
Regina Coronation Park

Mr. Greg Lawrence
Moose Jaw Wakamow

Mr. Paul Merriman
Saskatoon Sutherland

Ms. Laura Ross
Regina Qu'Appelle Valley

Ms. Nadine Wilson
Saskatchewan Rivers

Published under the authority of The Hon. Dan D'Autremont, Speaker

[The committee met at 14:00.]

The Chair: — Good afternoon, ladies and gentlemen. Welcome to the Standing Committee on Human Services. My name is Delbert Kirsch and I am Chair of the Human Services Committee. With us today is Mr. Mark Docherty, Mr. Greg Lawrence, Mr. Russ Marchuk, Mr. Warren Steinley, Mr. Jim Reiter, and Ms. Danielle Chartier and Mr. John Nilson.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — This afternoon we will be considering the estimates for the Ministry of Health. We now begin our consideration of vote 32, Health, subvote (HE01). Minister Duncan and Minister Weekes are here with their officials. Ministers, please introduce your officials and make your opening comments.

Hon. Mr. Duncan: — Thank you very much, Mr. Chair, and members of the committee, for the opportunity to speak about the Ministry of Health's budget for the 2014-15 fiscal year.

As you can see, there are a number of officials with Minister Weekes and I. I won't introduce all of them at this point, but I do want to take a few moments to introduce some of the senior leadership from within the ministry. So to my right is Max Hendricks, the deputy minister of Health. Behind Minister Weekes and I is Sharon Lee Smith, the assistant deputy minister; Mark Wyatt, acting assistant deputy minister; and Tracey Smith, acting assistant deputy minister. And as I said, we're joined by a number of officials that'll be able to help us answer some questions. If they do come to the mike, we'll just have them introduce themselves, if they haven't already been introduced. And we are looking forward to taking questions from members this afternoon.

Before we start, with the committee's indulgence I'd like to take a few moments to highlight the key investments that we're making this year to improve health care for the people of Saskatchewan.

This year our budget theme is steady growth. Our government has been tasked with continuing to meet the needs of Saskatchewan people. We are doing so at a time that our province is experiencing record growth. In health care this certainly presents certain challenges as we strive to ensure care needs are met. Strong population growth means increasing demand for health care services. Historically governments across Canada of all stripes have struggled with how to control health care costs. It's why we as a government have placed such a focus on our quality improvement efforts.

I will elaborate on that shortly, but let me say at the outset, the Ministry of Health's budget supports our patient-first philosophy through improved quality and safety, expanded access to services, and shorter wait times. And we're doing this while controlling spending.

This fiscal year the Government of Saskatchewan will invest just under $5 billion in health care, a figure that represents approximately 42 per cent of the provincial budget. This is a significant amount, to be sure. It's the most the Government of Saskatchewan has ever invested in health care and it represents a 3 per cent or $144 million increase over last year's budget.

We continue to focus on using resources responsibly in priority areas that will make the greatest difference in improving quality of life for Saskatchewan people. We're investing in services and facilities to improve seniors' care. We're supporting rural physician recruitment and more collaborative emergency centres. We're funding key capital projects and surgical services. We'll also support government commitments like providing funds to reduce emergency department wait times and improved patient flow.

We'll develop new pilot projects on house calls for seniors with complex needs, and the development of the hot-spotting concept.

The budget focuses on initiatives that increase access to health services and allow us to work smarter and more efficiently. Of Health's $144 million budget growth, 128.2 million or 2.7 per cent can be attributed to cost growth in base programs, including health sector salary increases, drug and medical cost growth, and program utilization changes. 43.7 million or point nine per cent is a result of population growth, new initiatives, programs, and service enhancements. 24.1 million or point five per cent will be put towards capital equipment and facility investments.

At the same time, we continue to ask for the leadership of the Ministry of Health and in the RHAs [regional health authority] and the Saskatchewan Cancer Agency to be careful stewards of these health care dollars. Efficiencies will continue to be found through share of services, attendance management, and reducing costs incurred due to premium and sick time. Of course we will continue to find efficiencies through the continued implementation of lean in the health care system.

I need to make it clear that while we know investing in lean and doing it properly saves money, that's not what lean is truly about. The true focus is on improving quality and safety through better processes and reduced waste. When applied to a health system like ours, it means safer care, a better patient experience, and an improved work environment for providers. As we remove waste from the system, the increased efficiency and dollars saved are actually an added benefit.

Anyone can see that our provincial health care system is large and complex. To apply lean successfully, we know we have to build the internal capacity, infrastructure, and overall cultural organization. This has been done successfully before. Lean is used extensively in health systems to improve processes and efficiency. There is no question government is making a significant investment in embedding lean in our provincial health system. But the amount invested annually over a four-year contract is approximately one-fifth of 1 per cent of our provincial health budget; one-fifth of 1 per cent to reduce waste, to empower providers, and to make the patient experience better and safer. We are confident that it is money

well spent. The investment in lean has already paid off and the proof is in the dozens and dozens of examples of improvements that have occurred, both big and small.

What makes our lean efforts work is that they are driven by those closest to the problem, the patients and the front line. They are the ones taking part in improvement efforts and events, and they are developing the solutions. As a result we see improvements like reduced MRI [magnetic resonance imaging] cancellations in Regina, quicker access to X-rays in Saskatoon, and shorter waits for mental health and addictions services in Five Hills Health Region.

Mistake-proofing projects are helping us to achieve efficient, safer processes that make patient experiences smoother. Eliminating mistakes saves lives. Dozens of these projects have reduced the mistake or defect rate to zero or less than 1 per cent. Not only are these projects reducing the risk of harm and potentially saving lives, they are also saving the system money.

The province's RHAs, which handle much of the day-to-day delivery of health care in the province, will receive a total of $3.25 billion in funding. This is an increase of 107.5 million or 3.4 per cent over last year. Included in that is $38.7 million for paying health care workers and another 41.5 million for inflation on non-salary items.

We've also designated 24 million to help the regional health authorities deal with the pressures that come from a growing population. The province continues to grow and that continues to put pressure on the health system. The range of increases for the RHAs will depend on a variety of factors like collective bargaining agreements and inflationary increases, funding provided for population growth, volume pressures and program expansions, the transfer of existing funding from other program areas to the RHA base for established ongoing programs — for example, the surgical funding — and specific efficiency targets and other reductions.

The budget provides $155 million for the cancer care delivered by the Saskatchewan Cancer Agency. This is an increase of 4.9 million over last year. This is a result of increased drug and medical costs, compensation increases, and increases in hematology programs. Another part of our investment in cancer care is $1.9 million for a new linear accelerator at the Allan Blair Cancer Centre here in Regina.

As members will know, over the past few years our health system has focused on how we can improve access to quality health services. Obviously a major example of this was the four-year Saskatchewan surgical initiative which dramatically improved waiting times for surgeries after a specialist referral.

We inherited the longest wait times in the country. Now 80 per cent of patients in the province are offered a surgical date within three months of seeing a specialist. As of January 31st, 2014, five regions had zero patients waiting more than six months. Saskatoon and Regina Qu'Appelle have made strong progress, but encountered challenges that meant that they did not fully achieve the target by March 31st. But we do expect Saskatoon to meet the target this fall and Regina Qu'Appelle by March of 2015.

In this year's budget we're investing $60.5 million in surgical services to sustain our gains and support achievement of the three-month wait time target in Regina and Saskatoon. The majority of this funding will cover the cost of surgeries. However, investment will continue in health system quality and safety improvement initiatives.

With the surgical initiative wrapping up, we are turning our focus to some other areas that we see significant room for improvement. We're investing $4 million towards efforts that will help achieve government's goal that by March 31st, 2017, no patient will wait for care in the emergency department. That money will be put toward a number of areas.

One of those is a partnership with police and crisis teams to help respond better and earlier to individual's and families' mental health issues through improved assessment, triage, and intervention. This will help eliminate inappropriate visits to the emergency department.

We're also investing in ways to reduce the number of patients coming to emergency rooms with less urgent and non-urgent needs. This will include initiatives to connect patients without a family doctor to community primary health care teams. Other areas of investment include acute care flow and data and reporting infrastructure.

Another initiative to help relieve pressure on emergency departments is a pair of pilot projects of a concept known as hot-spotting. We're providing $1.4 million in new funding to these pilot programs in Regina and Saskatoon. The goal is to identify and assist high-cost, high-use patients who are repeatedly hospitalized and show up in emergency departments. The initiative will connect patients who are not well served by the current system with appropriate services.

We know these patients exist and this an area worth investing in. We've seen numbers that show that 1 per cent of patients account for 21 per cent of all provincial hospital costs, and 5 per cent of patients account for 40 per cent of all provincial hospital costs.

Hot-spotting programs in other jurisdictions such as Ontario have successfully demonstrated that small, innovative clinical teams dedicated to frequent users of health care can achieve real results for these patients. In addition to the patients receiving more appropriate care, the system potentially saves money.

Another initiative that could potentially relieve some pressure on emergency departments is a seniors' house call program. This year's budget invests $800,000 in a seniors' house call pilot program. The goal is to enable some seniors with complex issues to receive house calls from a mobile outreach team. We're going to improve care for seniors by providing more home-based primary health care services to the frail elderly. Accessing primary health services can often be difficult for them. The result is that they end up making more visits to the ER [emergency room] and end up in hospital.

Seniors with complex issues will receive house calls from physicians, nurse practitioners, and other care providers. These pilot projects will take place in a location to be determined later this year, one urban and one rural site. The goal is to provide

better coordinated, optimized care for elderly patients. Ideally this will result in better health outcomes, fewer hospitalizations and emergency department visits, delaying or preventing the need for institutionalized care.

There are other ways that we are supporting seniors in the budget. We're providing 3.7 million in funding for ongoing pressures in 2014-15 and beyond as a part of the Urgent Issues Action Fund. This is in addition to the 10.04 million in one-time funding that was provided last fiscal year. That paid for priorities like the purchase of required equipment, improved nutrition, improved responsiveness to call bells, and training for providers who care for residents with dementia.

This year's budget also provides an additional 2.5 million to expand the Home First/Quick Response home care pilot program to both Saskatoon and Prince Albert Parkland health regions. This is a program that was first piloted in Regina Qu'Appelle. This brings the total annual investment in Home First/Quick Response to 4.5 million among the three regions. The program helps prevent avoidable hospital admissions, facilitates earlier hospital discharge, and provides crisis intervention in the community. Services may include short-term case management, medication management, skin and wound care, mobility aids, and rehabilitation.

We know that seniors want to stay in their homes for as long as possible, so we're helping them do that with innovative initiatives like Home First and seniors' house call. But we also recognize a need for additional long-term care capacity in the province. This year's Ministry of Health budget includes 1.5 million, which is an increase of $750,000, to provide 24 additional beds at Pineview Terrace Lodge in Prince Albert. Pineview Terrace operates 36 beds, but the additional operating fund will bring that total to 60. The new beds will help the region reduce wait time, wait-lists, and better meet the increased demand for care.

And as long as I'm on the topic of long-term care, another area that there is a definite need for additional capacity is in the North. This year's budget provides $500,000 in planning dollars for long-term care in La Ronge. The new long-term care project for La Ronge will be a tremendously important one for the entire North, so we believe it's important to get that one right.

There's also a growing need for additional long-term care capacity in Regina, so the budget contains $1 million in planning dollars towards that. Much like in La Ronge, the money will pay for planning work to move this initiative forward.

Beyond long-term care, the budget also provides $2 million for planning renewal of the Victoria Hospital in Prince Albert. Victoria Hospital is one of the busiest acute care facilities in the province. In addition to serving the third-most populated health region, it also serves a substantial number of patients from the surrounding health regions. And there's no question the hospital is showing its age. It was built in 1969, and the facility has seen incremental growth and various additions over the last 40 years, but it is struggling to meet the current demands. As an example, the obstetrical unit was designed for 1,000 births per year. But currently, care is provided to over 1,500 mothers and babies per year. This work will build on previous planning work completed, taking it to the next level.

[14:15]

So we've talked about planning for future facilities. Our budget also funds a number of facilities that are much more closer to completion. It's very exciting to think that next year at this time we could be discussing the newly opened Moose Jaw hospital. In this year's budget, we are providing $16 million for completion of that facility, the first hospital in Saskatchewan designed according to lean principles. The lean design is expected to provide operational efficiencies of 85 million to $160 million over the next 20 years.

We're also funding other facilities, specifically $27.3 million for five long-term care facilities in Biggar, Kelvington, Kipling, Maple Creek, and Prince Albert. As you will know, these five facilities are a part of the 13 long-term care homes or integrated facilities that the government promised to replace. Also included in this year's capital budget is $8 million for upgrades and repairs to Parkridge Centre in Saskatoon.

Another $23.3 million will go towards life safety and emergency repairs. This funding will pay for maintenance and repairs to improve safety in our health care facilities. Some examples of projects include upgrades or replacements of fire alarm systems, fire protection sprinkler systems, standby generators, and bringing building components up to code. Other infrastructure improvement projects include containment or removal of hazardous material, roof replacements, window replacements, and structural work. Regional health authorities will determine which projects will be undertaken based on their determination of their highest priority.

Since 2007, our government has invested $980 million in health system capital projects — major projects, building improvements, and equipment upgrades — and this year's commitment will push that to over $1 billion.

New facilities and equipment are important, but what really makes the health system work are the hard-working people who deliver care. We're investing in health providers as well. We can see the positive impact of our physician recruitment strategy as overall physician numbers continue to increase. Over 300 more physicians are practising in Saskatchewan today compared to 2007. We've achieved that through effective recruitment and retention efforts, training more doctors here in Saskatchewan, and through our made-in-Saskatchewan physician recruitment program, SIPPA [Saskatchewan international physician practice assessment], which has brought 113 new physicians to Saskatchewan since 2011.

This program is helping to stabilize physician services and reduce disruptions in many communities. It is resulting in greater continuity of care for patients. SIPPA has also addressed a long-standing issue for foreign-trained physicians who had difficulty becoming licensed to practise in Saskatchewan. It ensures that they're assessed with sufficient rigor that Saskatchewan patients receive safe, high-quality care.

Even in light of SIPPA's successes, we know that there's still a need for physicians, especially in rural areas. The 2014-15 budget contains $685,000 in funding, which is an increase of

$435,000 for the rural family physician recruitment incentive. This incentive is available to recent medical graduates who establish a practice in rural Saskatchewan. We believe this will help attract and retain newly graduated family physicians to rural and remote areas. Through this program, grants have already been provided to physicians who have established practices in places like Meadow Lake and La Ronge.

Another way we are dealing with the physician shortage in rural Saskatchewan is through our rural locum program. We are continuing to support a planned 20-physician locum pool that provides temporary physician services to rural communities experiencing service disruptions.

The 2014-15 budget provides $5.2 million in funding, a $2.2 million increase, to complete the implementation of this program. Ensuring that rural communities have access to consistent, stable physician services is one way that the government is strengthening primary health care across Saskatchewan.

We're equally committed to our other health providers in our system, including nurses. Saskatchewan's nursing workforce continues to grow. In 2012 there were over 15,000 nurses calling Saskatchewan home, 2,600 more than in 2007. Our ratio of nurses to population is well above the Canadian average. We continue to be committed to a strong nursing workforce.

Just last week, our government announced a new strategy on recruitment and retention of nurse practitioners. It will help to ensure high-quality primary health services for residents in smaller communities.

The budget also includes $13.1 million, an increase of 3.4 million, to spread other innovative approaches to improve access to primary health care. This will include the development of three additional collaborative emergency centres in Canora, Wakaw, and Spiritwood. The province's first collaborative emergency centre opened in Shaunavon and in Maidstone last year, and we're seeing promising results. Most patients who come during late hours are able to get the treatment they need right there in the community.

You may also recall the eight new primary health care innovation sites that were announced in 2012. They have been implemented with new models of team-based primary health care. These new models provide improved access through extended hours, new chronic disease management approaches, and new roles for providers. For example, we have registered nurse case managers who provide improved coordination and continuity of care by providing advice and support to patients outside of office hours.

Team-based primary health care allows physicians, nurse practitioners, and other providers to work to the top of their scope of practice. It also provides patients with access to better coordinated and expanded care. We will spread these team-based approaches to stabilize and enhance services, especially in rural Saskatchewan.

Our approach to strengthening primary health care reflects the Health ministry's targeted and strategic focus. We look for areas where we can improve services for our residents and then work with the health sector to identify innovative solutions. We test those innovative solutions through pilot projects. If they're successful, we expand them to other locations where they're needed. We've asked the leaders in the health system to keep building on these successes. We believe that we can improve and transform the health system and do it in a sustainable way.

This year's health budget supports the government's plan for steady growth while remaining fiscally responsible. Our budget funds areas that will help us best meet the needs of patients and families. It invests in innovation to help address the pressures that we're seeing in acute and long-term care.

We know that our system will not improve simply by pumping more and more money into it. We need to tackle some of the underlying and ongoing issues to ensure that we are successful in our efforts to improve access quality and safety. We need to have the courage to transform the system in a significant way. We're doing that by empowering providers at the front lines and by involving patient and family representatives to an extent that's never been done before. We're doing this so that we can achieve a system that puts the patients and their families first.

This is a journey of transformation that is still in its early stages, but we're seeing the benefits every day. As Minister of Health, it is so gratifying for me to see every day what is being accomplished by the hard-working people who make up Saskatchewan's health care system. That's why with this budget I'm very excited about the upcoming year. And with that, Mr. Chair and committee members, we would be pleased to take your questions.

The Chair: — Thank you, Mr. Minister. Mr. Minister, I would ask that you have your staff, the first time they come to the mike, announce their name because we've got quite a few members there and Hansard would need a record of that. With that, I hand the floor over to Ms. Chartier.

Ms. Chartier: — Thank you very much, Mr. Minister, and to all the officials for your time here today. I'd like to start . . . This is my first time as the Health critic in this so I'll have a broad range of questions. I think there'll be some really specific-to-budget questions, but also I'm learning about some of the programs so there might be a little bit of that as well. Obviously you know how broad health is, and so I'm interested in learning some of the details about some of the programs as well.

But I'd like to start with the general theme of mental health, if we could, in particular with respect to the North Battleford hospital and where that is at right now in development. I understand from the budget technical briefing, there was 2 million set aside under SaskBuilds. Yes, if you could just talk a little bit about where you're at with respect to the North Battleford hospital.

Hon. Mr. Duncan: — Thank you, Mr. Chair and Ms. Chartier. Welcome to you, as your first time here as the Health critic.

This has been a very important project for the government, and obviously for the mental health community. We have been working as a ministry with Prairie North Health Region, as well as some other partners including Corrections, because there is

the implication on the existing North Battleford site for what it means for some correctional facility. So they've been doing their work on that side, planning for, you know, what will come after the hospital, the existing hospital, is no longer in operation.

In terms of the planning, so we've been doing . . . We had three rounds of what we called the 3P [production preparation process] planning process, which involves stakeholders, it involves representatives of the family members of residents, it involves front-line staff. I attended the last 3P earlier this year, it would've been in February I believe or, yes, February. So that would've been the third one that really looked at the planning for the support services, so for laundry, food services, those types of services. The other 3Ps which I didn't attend, were late last year. Those were more around the service delivery side.

So the third one was more about the support services. The dollars within . . . So it's not within our budget but within SaskBuilds. Right now we are coming close to, I think, making a decision in terms of the procurement because it was one that had been identified for a possibility of a P3 [public-private partnership] — not to be confused with a 3P, but as a P3 — and so we have all of our information in. I know Corrections has done the same and so, you know, we're doing the evaluation to make a determination of how the procurement will proceed. And then, you know, we'll be making an announcement on that at some point later this spring.

Ms. Chartier: — So the 3Ps, the planning processes, have they been on structure at all then? Like, I know that the 3P process is often used in design of a facility, so I just am trying to gauge, in terms of commitment to the correctional side and the mental health side, is there a firm commitment to put those two together?

Hon. Mr. Duncan: — I'll say on the 3P side, I'll speak more to, you know, what I saw first-hand in February. So that would have been more on the support services, so it did contemplate if the infrastructure of the facility would be required for both the mental health hospital portion as well as the impact that it would have perhaps on having to be able to support a correctional piece to the facility or to a project of that nature. But in terms of the two earlier 3Ps, I believe they were just focused on the supports that we would deliver, that Prairie North Health Region would deliver, based on the footprint of the building that we are thinking about, so in terms of the number of beds and how that would be laid out in an efficient manner.

Ms. Chartier: — And is that footprint . . . Then you're just considering the footprint for the mental health piece then, and not for the corrections facility.

Hon. Mr. Duncan: — So in terms of the work that we've been doing as a ministry with the health region, in terms of the 3P work that's been done, so where it would have an impact on Corrections because a lot of those services are currently provided out of the existing hospital, so dietary and other types of services.

So that would have been a focus of the third 3P in terms of, if there were to be a correctionals component to a new project, how we would still be able to provide those types of shared services, you know, to gain the synergies and the efficiencies of having, you know, a shared laundry, a shared dietary services, those types of things.

So I can speak to that and what the work that we did through a 3P in both the support services as well as what we will be providing in terms of the footprint of the building and the services, you know, the number of beds and so forth. But it wouldn't have included the correctional piece to that. That would be more of Corrections to go into.

[14:30]

Ms. Chartier: — I think what I'm trying to ultimately get at then, in those planning processes are you on a sort of going forward basis? It sounds like this is in fact the approach that you'll take with the hospital and Corrections. And you're doing planning processes, planning that the dietary may serve both. You're doing the planning in such a way that both are being considered. So is it safe to say that that's the direction that . . .

Hon. Mr. Duncan: — I think it's safe to say that that's the approach that we've taken, because that's the . . . It would be similar to the existing arrangement that already is in place. So we already provide those services. There will most likely be some form of correctionals component to it. So we want to make sure what we're building has the capacity to handle that as it currently does right now.

Ms. Chartier: — In terms of the number of beds that you've been planning for, can you give me some sense of that?

Hon. Mr. Duncan: — So the existing, Mr. Chair, the existing Saskatchewan Hospital in North Battleford currently operates with 156 beds, and what will be replacing it will be a facility of 188 beds.

Ms. Chartier: — Okay. Going back to a little bit around timeline here. So the 2 million, obviously the 2 million isn't in your budget but this is something that impacts your ministry. And I'm wondering what that 2 million, when we talk about planning dollars, what will that $2 million be used for.

Hon. Mr. Duncan: — In terms of the timelines, that would be, because it is still under consideration as a potential for a P3, that would be more of a SaskBuilds. They would be the lead on that. But in terms of the $2 million, this will continue the work that we are doing around the planning. So now that we have all the information from the 3Ps, that gives us a really good idea of what, in terms of the 188 beds, what the layout of the facility will be. So that just furthers that work that needs to be done to move the plans to the point where we can actually start construction.

Ms. Chartier: — And you just briefly mentioned timelines there, and the money under SaskBuilds. But what is your expected timeline as the Ministry of Health? What is your goal or aim?

Hon. Mr. Duncan: — Thank you for the question. So initially 2015 was the year that we had initially contemplated for opening the new hospital. Obviously that's going to be pushed

off for a number of reasons. One is putting the process through a lens to see whether or not it made sense from the perspective of doing a P3. So that has certain implications in terms of that timeline.

What we also did do deliberately was, we did want to take some time to determine, knowing that the existing hospital has some implications on the correctional facilities that are on the same grounds, and so, you know, we wanted to make sure that Corrections was also involved in this because it would have implications on their operations. But we also wanted to take some time to see whether or not, you know, it made sense to do a joint project with Corrections. And so we've been working through that process. The timelines really will depend, will be largely determined, you know, based on the procurement method that we do ultimately decide later this spring, whether or not it's a P3 which will then have its own type of timeline that SaskBuilds would be responsible for, or whether we do, as a government, decide on a more traditional procurement.

Ms. Chartier: — If 2015 was your original goal — and obviously you've cited some changes, one of them looking at a P3 model — you must have some sense though as to when you'd like to have this open and operational.

Hon. Mr. Duncan: — Thank you for the question. Obviously depending on the procurement method that government does choose, if it were to be a P3, you know, we would start looking into, you know, 2018-19 fiscal year. You know, that's just a rough guess on my part here, just based on kind of what we know about their timelines.

But the work that we have done I think has allowed us to . . . In the meantime, you know, we've done a lot of work around lean 3P design in a number of facilities, and Moose Jaw is a really good example of that, which will be opening next year. So between that and the work that we've done with Corrections, I think while it will take longer for the facility to be complete than we had first thought, I think, you know, we will have a better product than we would have I think before this process had begun, and one that will be, you know, that we're not just taking it into account today what it is to build that facility but also the operational costs over a number of years, a number of decades.

And you know, I think we've been able to drive a lot of efficiencies in the design of the facility on the mental health side that I think will have a benefit to the patients and families for many years to come, and the providers that do provide care to patients at SHNB [Saskatchewan Hospital North Battleford]. And so I think in the end we'll have a better product.

Ms. Chartier: — When do you expect SaskBuilds . . . I think you said spring but I just want to . . . When do you expect SaskBuilds to give you an evaluation? And how are they evaluating that? You must have some sense.

Hon. Mr. Duncan: — Well you know, I would probably just perhaps refer you to the SaskBuilds estimates when they come up to the minister. He'd have a very much better idea than that.

Ms. Chartier: — Again just double-checking on timeline with respect to SaskBuilds though, when you are expecting to hear back from them?

Hon. Mr. Duncan: — It'll be based on kind of the latest information that we have. Working through this process it'll, you know, it'll be later this spring. But it won't be . . . You know, it'll be short. It'll be, you know, relatively soon we'll hear something.

Ms. Chartier: — Is there a contingency plan if SaskBuilds says this isn't a good model for a P3?

Hon. Mr. Duncan: — Well first of all there would be, there's a number of things that we still need to continue. So the 3P gives us, so that gives us, you know, what the design will look like, you know, essentially what the design will look like. That still needs to go to an architect to do plans and blueprints and so forth. And so you know, that work would continue through this year. You know, that would take us through this year. If it were not to be done through a P3, we still need to do that work regardless.

Ms. Chartier: — So SaskBuilds is determining whether or not it is a good model for a P3 and what kind of P3? So they're looking at sort of whether it should be a P3, and then how all of that would play out as a P3?

Mr. Hendricks: — Max Hendricks, deputy minister. One of the things that SaskBuilds is doing right now is they're looking at the value of money of a P3 project in comparison to what would be a traditional build or integrated project delivery, which we're doing in Moose Jaw right now. So their assessment of that value for money is a comparison of those different models. So were they to determine that the value of money did not warrant a P3 project, yes, we would revert to a more traditional build.

Ms. Chartier: — Okay. Thank you for that. Still thinking about mental health here and addictions, you're in the middle of a mental health and addictions review. I wouldn't say in the middle. I'd say closer to the end of finalizing that. Can you give me some sense on timelines when the commissioner will be reporting back?

Hon. Mr. Duncan: — Ms. Chartier, I think that that is a . . . I think a good way to put it, that the commissioner has been doing a lot of work but we are getting closer to the end of that process.

The bulk of the consultation phase is wrapped up. There is still a little bit more that she's doing, particularly with members of the steering committee. To date we've received, so on the online portion of the consultation, 3,081 responses. The commissioner's met with over 135 stakeholder groups as well as focus groups and individual meetings with individuals in 18 communities across the province. I would expect . . . I'm looking forward to the commissioner's recommendations, and I'm expecting them this fall.

Ms. Chartier: — Okay, this fall. I know that in previous conversations with her, I had understood that she'd be reporting this spring. Has there been something along the way that has changed that?

Hon. Mr. Duncan: — Yes. Initially the commissioner, when she first started, believed that the work would be complete by June. I think just the amount of feedback that she was receiving and the requests from people to meet with her, she felt that June was not going to be adequate enough time to finish the consultations. So that's why we're expecting it this fall.

Ms. Chartier: — Okay, thank you. Sorry to do this to . . . One quick question, going back to the provincial hospital. The $2 million that's in SaskBuilds then, if SaskBuilds decides not, that the P3 wasn't a valuable way to pursue it, will the $2 million come back into Health?

Hon. Mr. Duncan: — That's our expectation.

Ms. Chartier: — Okay. Thank you. Sorry to . . .

Hon. Mr. Duncan: — No, that's fine.

Ms. Chartier: — With respect to the work that the commissioner's been doing, I'm looking, as the new critic I've gone back through plans, previous year's plans, and in the '12-13-14 plan, under the actions it says, "continued planning on community residential supports for individuals with complex and severe mental health needs."

And I know that I've found a paper online which . . . and I actually don't have a date for that, but that was called *Charting a New Course*. Actually I've got it here, sorry. My writing isn't always so great. *Charting a New Course for Mental Health's Most Vulnerable*, and it was in conjunction with the health region, the Prairie North Regional Health Authority. So you're in the middle of this review, and there'd clearly been a great deal of work done already on determining what some of the needs in mental health are. And so I'm wondering in light of the review, what's gone on with the planning for those community residential supports?

[14:45]

Hon. Mr. Duncan: — At this time there hasn't been a decision made on if and how to proceed with those types of supports. Our focus at this point has been the work around the redevelopment of the Saskatchewan Hospital at North Battleford as well as the commissioner's work.

You know, I wouldn't want to, you know, speak to what the commissioner is going to recommend because I don't know. But I think that just in terms of the things that we've been hearing back from her, in terms of her feedback, that support in the community has ranked pretty high. And so we haven't at this point made a decision to move forward with that recommendation of Prairie North.

Ms. Chartier: — Has that work been on hold then? Like just a year ago, part of the plan was continuing work on that, and then last May it was I believe you announced the review. But I'm wondering if that work just halted then?

Mr. Hendricks: — No, the work hasn't halted on the idea of the community residential supports. Obviously, you know, hand-in-hand with the redevelopment of the SHNB, there was the idea of having additional community supports for patients with mental health needs so they could be transitioned back into the community. That continues to be something that is front and centre for us and something that is front and centre for the commissioner.

So I think we'll wait till the fall when she delivers her recommendations. And we're hoping to see, you know, some recommendations that deal with the spectrum of mental health disorders in the province and how we can best meet the needs of our clients provincially. And so we're looking for a more fulsome report from her on how to deal with these challenges.

Ms. Chartier: — With respect to the *Charting a New Course*, when was that written? And it wasn't just Prairie North, it actually said it was a joint paper between the ministry and the health region.

Hon. Mr. Duncan: — We're just having a bit of a discussion about when it was. It was prior to the . . . yes, around 2011, but we don't have an exact date on it.

Ms. Chartier: — It just seems to me that . . . And obviously I think that the consultation process is incredibly important and it might sound counterintuitive to say that work should continue while you've got a consultation process. But you did some really good work with some really strong recommendations on a couple of different kinds of residential care models for people who are transitioning out of a tertiary hospital like North Battleford.

So I have some concerns that that work . . . There is a huge gap, as you know, in those services for people who leave a place, either an acute facility or a place like North Battleford.

Hon. Mr. Duncan: — No, and the point is well taken, Ms. Chartier, and I really appreciate your comments. And I think that this is something obviously that we haven't lost sight of. We just are not in a position at this point to approve with a plan to move forward on that. We've put a lot of focus on Saskatchewan Hospital at North Battleford, which I don't think anybody would deny that it is a major priority for the province in terms of a provincial hospital that is 101 years old, which parts of if were deemed not inhabitable, unfit for human habitation back well over a decade ago. So that's taken a lot of, I think, a lot of the focus for the work that we're doing around mental health and addictions.

As well, I think, is admittedly needing a plan for the province in terms of mental health and addictions, so an action plan. So that's where our focus has been. I think there's been a lot of good work on those files, particularly the work of the commissioner and Saskatchewan Hospital at North Battleford.

I think there's also some really good work that's been done by our regional health authorities to, you know, try to cut some of the wait times that we know that people are waiting for mental health services in the province. But in terms of the specific question, the community supports, you know, it's certainly something that we haven't lost sight of.

Ms. Chartier: — Has there been a time in your time — I guess you've been Health minister now for two years, just about two years — that it's come before cabinet to discuss residential care

spaces? And perhaps not just in your time because you've been in cabinet for longer than the two years.

Hon. Mr. Duncan: — Thank you, Ms. Chartier, for the question. And yes, it has been almost two years. A lot of the grey hair has shown up in that time. Certainly it's been a topic of discussion amongst the ministry as we've been putting in place a number of different plans around mental health and addictions. As I said, we haven't lost sight of it.

You know, I would just say with respect to the cabinet agenda over the last two years, I just won't, I won't comment on that.

Ms. Chartier: — Thank you. Another question. Actually, I'm sorry, I'm going to jump back and forth here. My apologies. Still on mental health, but in terms of getting a handle on the amount of money that has been committed thus far, spent on planning for the Saskatchewan Hospital, can you give me a sense of that, and a timeline?

And I really don't mean to keep going back and forth. I really don't mean to keep going back and forth between questions.

Hon. Mr. Duncan: — So the Saskatchewan Hospital at North Battleford, the redevelopment plan, to date we have spent just under $1.3 million in planning.

Ms. Chartier: — And as of what timeline do you count that as?

Hon. Mr. Duncan: — That would include up to the 3P work that would have taken place to the end of this fiscal year, to the end of the fiscal year that just ended.

Ms. Chartier: — 2013-2014.

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — And starting when though? That $1.3 million investment, starting when?

Hon. Mr. Duncan: — That's just in the last fiscal year.

Ms. Chartier: — Okay. Because there was some previous money spent on planning, was there not? And the indication in that charting the course document actually says that there was, going back . . .

Hon. Mr. Duncan: — Ms. Chartier, if we could, we'll take some time to provide that information. Some of that does go back prior to 2011 and previous to that even. We just don't have that at our hands right now, but we will commit to get that to you.

Ms. Chartier: — That would be great. I'm just looking for a full picture of how much to date, over both administrations, how much has been spent on planning for the North Battleford facility.

Hon. Mr. Duncan: — Yes, absolutely.

Ms. Chartier: — Okay. Going back to residential care spaces, how many residential care spaces are there currently across the health regions right now?

Hon. Mr. Duncan: — Ms. Chartier, so in terms of residential services, there are 802 beds. Those are located in the mental health approved homes. There are 28 beds that are designated within the adult group homes across the province. And there's an apartment program and there are 373 beds in that program. So that's — just doing some really quick math — 1,203.

Ms. Chartier: — And have you crunched any numbers on optimal number of beds? I know in the charting the course document, they made some very specific recommendations. So we've got 1,203 currently. Do we know what we need?

Hon. Mr. Duncan: — I think it's fair to say, Ms. Chartier, that we would still be in some of the discussion within the ministry, within the ministry and particularly Prairie North that has a lot of expertise in this area.

The charting the course document that you speak to about the 120 beds, you know, that would still be . . . In any of those discussions, that would still be the number, you know, that we would be working off of. You know, I think if and when we get to a point where we start to have some I think more intensive discussions about moving in that type of direction, we'd certainly want to be in a position to confirm what that need would be. But certainly that would be, you know, where we're at today.

[15:00]

Ms. Chartier: — Okay. So in addition, at this point in time, an additional 120 beds, different kinds of supports, between the step-down and other residential.

Hon. Mr. Duncan: — Yes, I think that that's fair to say. I think we're also challenged too, while it's not in a community or residential type of setting, but you know, I think we're always challenged to ensure that we are utilizing the beds that we do already have within the system. And so we know that.

You know, there's a number of communities that would have designated mental health beds within facilities that perhaps aren't always at capacity. While it's not, you know, in a residential community type of setting, there still would be those types of services, you know, that we would have available that may not be always used.

Ms. Chartier: — Okay. I just want to go back to this. I actually had some questions from people in the community who work in the area of mental health or live in the area of mental health. And I'm asking this question because it's coming from people who've asked me to ask this.

There were some people who understand that there was in fact a decision before cabinet on residential care spaces, and quite some time ago; like prior to the launch of the mental health review. And the comment or question that I've had is, where did it go? Great that we're having a mental health review, but there is a pressing need right now, and why couldn't this have continued to be developed?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Ms. Chartier. You know, again, you know, I won't discuss agendas or decisions of cabinet.

But you know, I will say that in the time that I have been the minister, for nearly two years now, you know, I've indicated publicly, I've indicated I think in the House, I think I've indicated to you that mental health and addictions is one of the areas that personally is a priority for me. I think we've been really, you know, we've been really pressed to move forward as a government on the Saskatchewan Hospital in North Battleford and the replacement of that facility.

As well, you know, one of my priorities was to announce and appoint a commissioner to actually produce a plan for the province, you know. I think you know and I think you would agree that, you know, Saskatchewan in the mental health and addictions community, you know, has been singled out by the Mental Health Commission of Canada and others as not . . . I think one of the only provinces, if not the only province yet without a plan, a provincial plan. So I think that's important work and I, you know, I think the commissioner's going to provide us some direction and some recommendations that will speak to some gaps that we do have within the system right now.

But in terms of the residential support, you know, I guess my answer to that is that we have not yet approved a direction on that. It is something that we are following closely though. You know, we want to obviously move forward with SHNB replacement with getting the additional beds over and above what the existing facility does have and as well wait for the commissioner's recommendations. But certainly we haven't lost sight of that report or that the recommendations for that had been made previously for residential support, but at this point we just, we haven't moved forward on that.

Ms. Chartier: — Did cabinet reject the move on residential care spaces?

Hon. Mr. Duncan: — Again I really can't get into cabinet discussions or even, you know, whether or not a topic would've been on the agenda except to say that we as a ministry know that this is an area that, you know, that the Prairie North Health Region and the ministry have been working on and have identified that there is a need; that, you know, I would expect, while not knowing what the commissioner is going to recommend, I would expect that her recommendations will say something about community support.

But at this point we . . . I've been able to move forward to this point on Saskatchewan Hospital, to the point that we are now, as well as appointing a commissioner for the province and some other work that's been done that I . . . You know, unfortunately it probably doesn't get enough attention in terms of reducing wait times for mental health services, knowing that we still have more work to do, you know, but I would just, in terms of the residential question, you know, I would just leave it at, you know, that we haven't made any decisions on it yet.

Ms. Chartier: — Thank you. Just back to the previous question about the North Battleford hospital. I'm just looking at a news release from October 18th, 2011. So I know you said you're compiling some numbers in terms of what has been committed thus far to the North Battleford hospital. But in this particular news release it says the province is providing $8 million immediately so Prairie North Health Region can begin work on the detailed planning. So I'm wondering if that $8 million was provided and what happened to that.

Hon. Mr. Duncan: — We're just going to confirm those numbers. But the deputy, the officials, are reasonably confident that the first 5 of that 8 had gone immediately, and then whether or not . . . We just need to confirm the other 3, whether or not the dollars that we spoke about, the 1.32 million, includes that or if that's over and above. So we'll need to confirm that. But it was, we know, we're pretty certain that, you know, the first 5 of that 8 did go immediately for planning.

Ms. Chartier: — Okay. So yes, just again, if I could get the full, what's been committed over time by the Government of Saskatchewan to the hospital planning. And that would be great.

We'll move off of mental health here for a little bit, if that's okay. I just have to . . . Another bigger project would be the children's hospital. So I'd like to talk about that for a couple of minutes, if we could. So just generally, I know we hear lots in the media about it and a little bit in the House, but could you let me know a little bit about where you're at and what the facility is going to offer and to how many people?

Hon. Mr. Duncan: — Sorry, Ms. Chartier. Just give us one second. We're going to get to the right page here.

Thank you, Mr. Chair, Ms. Chartier. So just to give committee members just by way of background, so the initial scope that was approved included a 152-bed facility, 56 maternal and 96 pediatric. The services that were planned for this facility include antepartum, inpatient pediatric, labour and delivery, pediatric ambulatory services, fetal assessment unit, maternal ambulatory services, postpartum, adult and children emergency services — so the emergency room at Royal University, it'll actually be, the new emergency room will be in the new facility for both adult and children — neonatal intensive care, pediatric surgical suite, and the pediatric intensive care.

So in 2009 when the project was approved and announced, it was announced at a $200 million project. Those dollars went immediately to the Saskatoon Health Region where they've been earning interest on those dollars to approximately $13 million. So at that time $213 million would have been available for the project.

So we went through some cost estimates after the initial design. That's when we came to a position where the dollars that were already announced at 213, the design exceeded that. So at that point, based on some of the early work that we'd been doing in lean, the region spent about seven months revising the program needs through a lean 3P process. This resulted in a new design concept that significantly reduced the space and the capital cost.

So the outcome of the 3P event was a reduction of about 15.6 per cent in the overall space. That brought us down to $229.9 million less $1.4 million that the foundation had agreed to fund.

So at that time when that work was done, and this would have been . . . So this would have been I think early when I became the minister or around that time, the shortfall at that point was $15.5 million. So in July of 2012 we announced the new design for the facility. As well at that point we announced the $15.5

million, bringing our commitment to 228, I believe is the number, 228. I think members will know at some point last year there started to become concerns that were raised about, you know, whether or not it was, the design, the scope was big enough for the needs and for the services that were contemplated to be provided, not only at the children's hospital, but already being provided with pediatric services at RUH [Royal University Hospital].

So we've taken a bit of a step back. There was some work done over the last number of months to I guess re-evaluate a number of assumptions including, you know, the population growth projected for the province. So that work is ongoing and, you know, we'll be announcing I think later this spring the results of that and the recommendations that'll come out of that.

Ms. Chartier: — So you don't have at the moment right now . . . So the initial scope you said was 152 beds, but you don't have the new number yet?

Hon. Mr. Duncan: — Not at this point. Not ready to announce, no.

Ms. Chartier: — Not ready to announce. I understand and, well a couple of things here. So after the 3P project, it's now going to be a joint emergency room. Is that correct?

Hon. Mr. Duncan: — No, it was always going to be. Basically the first . . . I'm trying to think of the schematics of the facility, but the first floor of the facility will be the co-located emergency department for both pediatrics and adult. So that will move out of RUH and will be located in that space.

Ms. Chartier: — Am I correct in, going back here in thinking about what some of those who were advocating for a children's hospital, one of their wishes, one of their desires was in fact to have a separate emergency room?

Hon. Mr. Duncan: — So the design team that's been working on the children's hospital project, they're of the belief that the two need to be co-located, that that was the, I guess, the appropriate way to proceed, you know, based on a number of factors. And so it won't be separated out. It'll be co-located in the same area.

[15:15]

Ms. Chartier: — So the architects have made that decision. But am I correct in, when people are advocating for a children's hospital, one of the things that they were talking about was a separate emergency room?

Hon. Mr. Duncan: — I'll maybe have the deputy speak to that. That, I think, probably predates my time as minister, so I wouldn't have been that familiar with the discussions prior to when the original scope would have been approved. So Mr. Hendricks will answer.

Mr. Hendricks — Yes. So right now there is a pediatric emergency at RUH and it's co-located with the emergency room as well. When the design team . . . and then just in terms of service . . . [inaudible] . . . looked at this, a pediatric emergency in a facility of our province's size doesn't operate entirely independently from a full-scale adult emergency room. So having them co-located still made sense, and yet having the pediatric emergency proximate to the children's hospital made sense for high acuity patients or emergency patients requiring surgery, whatever.

It also did provide a bit of an opportunity in terms of RUH and redevelopment. As you know, the RUH emergency room is not particularly well designed. It's an older design. It's very busy; it's very crowded. And so it did present an opportunity. There will be a noticeable separation between the two in the sense that you won't have drift between the two emergency rooms. So it will appear as separate ERs.

Ms. Chartier: — In all this work that's being done — and again this will take me back to mental health — one of the things that I've heard is a huge challenge is, when you go to RUH and you are suicidal or in the middle of a psychosis, sitting in a brightly lit emergency room is a huge problem. I'm wondering if in any of this planning where you're talking about co-locating or rebuilding, moving the emergency room and putting it in the children's hospital, has there been any thought to the challenges the people who will be admitted to the Dubé Centre face in sitting in an emergency room?

Mr. Hendricks: — So I think one of the clearer benefits of doing the 3P design, the way that we've undertaken it is that we have involved the patients and the providers in the design of the facility. So the children's hospital and Moose Jaw have been the first two hospitals that have had patients at every step of the design process. So inasmuch as patients provide that by advice and they look at the flow, you know, they look at the flow into the emergency room, that sort of thing. So I think you're going to see some changing trends in the way our ERs look.

But also with our ER wait times initiative, you know, in terms of how patients . . . You know, the idea is to get patients out of the ER — it's the least comfortable place for somebody that's sick to be — and into a room where they can begin receiving treatment and care. So we're going to see a number of changes on that front.

Ms. Chartier: — I'm just wondering specifically if that piece around mental health has been brought into the discussion, if you're aware of that at all.

Mr. Hendricks: — So the answer is yes. We've been looking at not only just mental health patients but other categories of patients where direct admission to the ER would be appropriate and in line with our specific conditions.

Ms. Chartier: — Thank you for that. What are the timelines with respect to the children's hospital?

Hon. Mr. Duncan: — So there has been a little bit of work just in terms of preparing the site, some early works that have been done. Once we can move forward with addressing some of the concerns around whether or not the facility was the proper size — and that will be shortly — from there, you know, the tender can be awarded and construction can begin. We anticipate later this summer that construction will begin.

Ms. Chartier: — So construction later this summer. And yes, I

know that some of the preparation work on the site has been challenging for RUH itself too. But so later this summer construction would begin, and when is your expected timeline for completion?

Hon. Mr. Duncan: — We anticipate, based on some of the . . . Now a lot of this will depend on the milestones that'll need to be hit during the construction process, but based on the timelines at this point we'd be looking at summer, fall of 2017.

Ms. Chartier: — Thank you. Just going back to that population challenge, I understand that there was a report done last summer by the Hay Group that in fact said that the 152 beds was not enough. I haven't seen the report for myself, and I've done a freedom of information request and haven't got that back yet. But I wonder if you could speak to what the population projections . . . what the 152 beds currently is based on and what this report told you.

Mr. Hendricks: — So last year the region brought in the Hay Group to look at the population projections and whether the planning assumptions for the hospital were consistent with expected growth in the province. Our analysis of the projected growth and the requirements of the hospital has been based on our own population projections, but we have validated those against the Hay Group's work to make sure that we're consistent with those. So you know, they haven't formed the basis, but certainly we've looked at them.

Ms. Chartier: — Okay. So the 152 beds, what population projection is that based on?

Hon. Mr. Duncan: — So those population projections that would have been used to determine those numbers, those would have gone back to 2009. That would have been when those population projections would have been, when they would have been used. So that was around when we first announced the hospital and also the anticipated footprint of the hospital.

Ms. Chartier: — And what were you looking at in terms of population projection, like the numbers? So you've got 152, a total of 152 beds — 56 maternal and 96 peds beds. What population is that based on?

Mr. Hendricks: — So the current estimates are based on the 2009 forecast.

Ms. Chartier: — What was the forecast is what I'm asking.

Mr. Hendricks: — It's more complicated than that in the sense that we're looking at very specific data with respect to the age of the population. Because it is a maternal-fetal hospital, obviously it's impacted by, you know, the number of mothers that you have in the hospital delivering. And we've seen our deliveries significantly increase, particularly because the growth in Saskatoon has been within that age strata.

And so also other factors that enter into that are the acuity of the patients, that sort of thing. Changes in Regina in terms of pediatric intensive care have affected and caused us to look at the numbers again. So there are a number of factors that are playing in this. It's not just population.

Ms. Chartier: — And that is the reality that our population, the number of women we have in those childbearing years has gone up. And I don't have them in front of me but the *Sask Trends Monitor* Doug Elliott has crunched some of those numbers. And those are obviously increasing and have increased substantially since 2009. I know, like we've got 73,000 children under the age of five, I think, right now in Saskatchewan, or thereabouts. So your numbers, did they match up? You said you've done your own analysis. How different was your analysis from the Hay analysis?

Hon. Mr. Duncan: — Yes, thank you for the question, Ms. Chartier. You know, certainly this had really come to our attention last year, particularly through last summer and last fall, that there were some concerns about, you know, whether or not the scope of the project that had already been approved was going to be adequate enough to serve the population not only of, really of today or whenever the doors opened, but also looking down the road 10 and 20 years out to ensure that, you know, that it was going to be of an adequate size.

So you know, I would just say that those assumptions . . . I'll maybe back up and say this, that in 2009, even with those assumptions and those projections that the deputy minister has talked about, they did certainly forecast a growing population into the future.

I think what we've seen in that time, particularly what you've identified within women within childbearing years as well as, you know, I think significant population growth over the last number of years, we'll certainly be releasing those assumptions when we do announce, you know, what our decision has been around that question about whether or not the size is adequate enough. So I think that, you know, at that time we'll have more information. We can certainly share those assumptions with you when that happens.

Ms. Chartier: — Could you save me another FOI [freedom of information] and table the Hay Group document?

Hon. Mr. Duncan: — I would say if you want to save an FOI, you know, wait a couple of weeks, and we'd certainly provide that information.

Ms. Chartier: — So what we can expect, within the next couple of weeks you'll be announcing whether or not the children's hospital will have to be amended in size?

Hon. Mr. Duncan: — Yes, that's correct.

Ms. Chartier: — Again just with respect . . . Did the Hay Group tell you something very different than your own provincial analysis was doing?

Hon. Mr. Duncan: — Well no, I think it's more of a question of, you know, whether or not the . . . I think what . . . not to say that I have the Hay Group just off the top of my head or have had that information because that was Saskatoon Health Region's report that they'd done. But I think it's fair to say that while both 2009 and the work that's been done in the last number of months around projections, both indicate that the population was expected to grow. I think that, you know, our earlier numbers were maybe a little, frankly, conservative in

terms of the growth that we would see over the next number of years and decades.

Ms. Chartier: — So maybe just help me out with process here and what's developed over the last few months then. So in the summer, you would have had the projections from the Hay Group and some concern flagged. Has there been work . . . Obviously you'll be announcing something in a couple of weeks. But clearly if you want to start construction this summer, the decisions will already have been made on whether or not that was the right number of beds or not.

Hon. Mr. Duncan: — Yes, so just, you know, just as a way of some background, so what we did do last fall was as the drawings for the plans that had been approved, as we were progressing, we essentially stopped the plans at about 90 per cent. So that gave us an opportunity for, you know, the steering group for the children's hospital to go back and do some work around whether or not it was going to be the right size.

So essentially what needs to happen is . . . It's my understanding the RFQs [request for quotation] have already gone out and closed. What we really need to do is make a decision, a final decision on what the scope will be. Then the drawings will either complete at 100 per cent of what they were already anticipating or make an adjustment for a different type of size. And then the tender can go out and be awarded later this spring.

[15:30]

Ms. Chartier: — So there wouldn't have to be . . . As you said, 90 per cent of it's been done. It wouldn't be a huge reconfiguration?

Hon. Mr. Duncan: — No. No, I think it would be, you know, if a decision was made to amend the size of the children's hospital, we certainly would not be going back to the drawing boards in terms of the design. I think we're at a position where, you know, we've stopped the drawings before they were completed, and we could make an amendment at that point.

Ms. Chartier: — In terms of . . . I've been told that the building is very different than it started out. It's very unusual. It's ended up being a very long building. It's changed shape from how it originally started. I'm just curious about some of that.

Hon. Mr. Duncan: — Yes. So I may have an official talk a little bit about this because it would be prior to my time as minister. But you know, so what I would think would happen is when government first made an announcement back in 2009 or 2010 . . . [inaudible interjection] . . . Well I'll go to the recent history, if Mr. Nilson is okay with that.

So you essentially have, you know, when any project is announced and you have a set number of beds that you are going to build, there are I think in any project some preliminary ideas of what the facility would look like through the 3P process. That's where we really, you know, looked at what the design would be in terms of the flow of the patients and providers and medicine and the seven flows of medicine. And from there the design, the indicative design comes out of that process.

So you know, there were a number of things that families and parents and patients and providers wanted to ensure. They wanted to ensure that if it possible, that patient rooms had access to outside light. And so that, you know, has some . . . That results in a particular design. So I don't have it in front of me but, you know, if I were to explain it right now, it would be, the upper levels would be a triangular type of shape overtop of the first level which would be more of a rectangular type of shape. But that's . . . Pretty close on that?

A Member: — Pretty close.

Hon. Mr. Duncan: — Yes, pretty close on that. And that's through the 3P process. That's really where the design really comes to life. And I think it is a good process because you're providing an opportunity for families and patients and parents and providers to really design the indicative design, and then you turn that over to an architect. And the architect, through the process that we use, the architect has to keep to that design. Now they are responsible for ensuring that, you know, all the intricate details of a building, the water and everything else, you know, that that can be accomplished within that design.

But it's really a different way of doing things rather than just announcing, as we had in the past, you know, the number of beds and the total amount of dollars, and then giving that to an architect and say, you know, design us a facility. This is really designed by the people that are going to use it.

Ms. Chartier: — I'm curious again. I'm not harping here, but going back to feedback in that 3P process on the emergency room. And obviously not everybody in a collaborative process gets their way. Consensus is all about everybody getting a bit of something. But I'm just curious what families or users of the facility had to say about the shared emergency room.

Hon. Mr. Duncan: — Yes. I'll maybe just begin on that and the officials can maybe confer a little bit in terms of what actually came out in the 3Ps. I was certainly there at the announcing of the final indicative design. You know, I think it's fair to say that when you're using a collaborative process like this, where in this case I think there was three rounds of 3Ps, and so, you know, you're dealing with, I think in the one case, the final 3P that I . . . for the report-out that I would have been at, there would have been well over 100 people that would have been involved. So you know, you're going through various ideas from individuals. You know, I'll maybe have the deputy minister talk about what that process actually looks like. In the 3Ps that I've been at, the report-outs . . . So if it's a five-day process, they oftentimes refer to Wednesday as wailing Wednesday because that's when your ideas, you know, some of them don't get through to the final round.

So it's, you know, it's really a lot of give and take in terms of what people's expectations are and what is the final result. But it really is designed by the people that will use it, both on the provider side and the patient side. But I'll maybe have the deputy minister talk a little bit more about the process.

Mr. Hendricks: — So just to add to I think the point I made earlier, the emergency rooms are not . . . There is a physical

barrier between the two. They are in the same building, but it would not have made sense to have them actually in different buildings because co-located with the emergency rooms, you have diagnostics. They need to be close to MRI, CT [computerized tomography], that sort of thing. And so having them physically separate would not have been in the best interests of providing care to either the adult patients or the pediatric patients. So a decision was made. I don't think many hospitals that have a pediatric emergency would find them, you know, hugely apart in terms of proximity. So a decision was made, but there won't be commingling of the patients. There will be a wall, so to speak, up between the two.

Ms. Chartier: — I'm just curious about the feedback from families. I understand that there's rationale for things, but I'm just curious about feedback from users who participated in the 3Ps.

Mr. Hendricks: — Yes, and that's one of the nice things again about the 3P is that people may come in with, you know, their own ideas at the beginning or preconceptions of what things should look like, and through the 3P oftentimes in discussions with other patients and with providers and stuff, they understand the reasons why things are done in a certain way, or they have input into changing them, quite frankly. So you know, through the 3P process, obviously those two are still proximate to each other.

Ms. Chartier: — Okay. If in the next few weeks when we hear the report-out about the children's hospital . . . So the financial commitment right now is 228 million. Obviously that 152 beds isn't going to go down. Is there the commitment from the government to support an additional number of beds?

Hon. Mr. Duncan: — At this point I wouldn't be able to confirm whether that would be the case.

Ms. Chartier: — Could you add more beds and keep the cost at 228 million? Or who would have to pick up the . . . Like where would that additional money . . .

Hon. Mr. Duncan: — Well no, I think it's fair to say that . . . So the Children's Hospital Foundation, you know, they have stepped up in a major way to do the fundraising around equipment and that portion of it. But if there were to be additional space, additional beds added, I mean certainly it's a provincial-funded hospital. It would be provincially funded.

Ms. Chartier: — Thank you for that. I may come back here at some point. But if we could, I'd like to talk a little bit about home care.

Okay, so these are going to be some pretty basic questions here, again just in my learning about some of the different programs. My first question is, what is the difference between home care, home care that we've had in this province, and the Home First/Quick Response pilot, and now the extension of the pilot? So what's the difference between home care and the Home First/Quick Response?

Hon. Mr. Duncan: — Thank you for the question. And appreciate the opportunity to talk about a very exciting program that we're seeing launched in the three communities: well at least the extension in Regina Qu'Appelle, which was funded last year as well; and now we've rolled it out into Saskatoon and Prince Albert.

So essentially Home First/Quick Response would be a subset of home care. The difference would be . . . And each of the pilots would have their own variation on it. But Home First/Quick Response is really to provide some support to facilitate transition back home for individuals. So this may be people that are coming, seniors or other people that may be coming into the emergency room who may have some episodic care that is going to require some intensive supports in a shorter amount of time rather than . . . So that's kind of the difference between that and home care, which is essentially for those individuals that are now clients of the program either for a short amount of time or perhaps this is going to be a part of, you know, a longer part of their life to have some support back into their home. So this is really that intervention to either keep them out of the emergency room or transition them back home quicker.

Ms. Chartier: — I'm not really seeing the nuanced difference here. So I just am trying to . . . Help me out here.

Mr. Hendricks: — So with your home care programs obviously based on assessment, you're referred to home care and assessed and a certain level of need is determined. That takes a period of time, and to go through the referral process. What we found is that a lot of seniors were showing up in our emergency rooms with immediate needs. And with a lack of other supports, what we saw happening was they were being admitted into our acute care facilities because there was no other way of caring for them.

Home First provides that immediate crisis intervention so that they actually are able to return to their homes with the appropriate support. So we are quite excited about it because it is one of the elements not only of our ED [emergency department] waits project trying to reduce the load on our ERs but also our acute care flow, because one of our challenges in acute care is that we have people waiting for home care, that sort of thing, that are blocking beds.

So this provides a different level of response. It allows seniors to get back to their . . . or others, for that matter to get back to their homes as quickly as possible and have those supports in place. It is not in some ways different than home care. It's just a quicker, more immediate intervention.

Ms. Chartier: — So the services are the same, but it's just the point of intervention is different then. Okay. Can you tell me a little bit about how home care across the health regions is funded generally, and the amount of money?

Hon. Mr. Duncan: — The dollars that are provided to the health regions for home care, that would be a part of the global budgets that we provide to the regional health authorities. But we can estimate what each of the regional health authorities would spend on home care.

So as a whole we estimate that in this budget they'll spend approximately $177 million on home care. There is also some dollars of course through the Home First/Quick Response, the $4.5 million that are going to those three health regions. That

would be outside of the 177 million. As well as through the surgical initiative, there had been some dollars put in in previous years of the surgical initiative to enhance some of the home care, to be able to transition people back to home after their surgery had taken place. And so there is approximately $3 million that has now been annualized through the surgical initiative that is transferred into their base budgets, into the global budgets for the regional health authorities.

[15:45]

Ms. Chartier: — And that's over and above the 177 million?

Hon. Mr. Duncan: — Yes, that's correct.

Ms. Chartier: — Okay. So the $180 million, not including the new pilot projects, is not targeted then. So health regions have the opportunity . . . They look at their global budget and decide how much home care they can or can't offer?

Hon. Mr. Duncan: — Yes, that would be correct. So the 177 million, that's our estimate based on, you know, what they would have spent in prior years and what we expect that they'll be spending on home care this year. The $4.5 million is targeted, so that must be spent on that program. And that doesn't include the fees that home care recipients, the clients, would pay of their own. And so that's almost an additional $7 million that would go towards paying for home care.

Ms. Chartier: — Okay. Looking in last year's plan for 2013-2014, where you first announced the Home First/Quick Response, it was, in the pilot region, increase home care utilization and clients by 5 per cent per year. Was that specific to this particular program — that goal, the increase home care utilization and clients by 5 per cent? Was that specific to Home First?

Hon. Mr. Duncan: — Yes, that was the goal for those regions that had dollars for the pilot programs.

Ms. Chartier: — And last year it was just RQHR [Regina Qu'Appelle Health Region]?

Hon. Mr. Duncan: — Yes, last year it was, if I'm correct on this. So in the '13-14 budget, Regina Qu'Appelle was I think the only one that was funded. And then it was in mid-year that we also announced Saskatoon and Prince Albert.

Ms. Chartier: — So that goal of increasing home care utilization and clients by 5 per cent per year, where are you in meeting that goal?

Hon. Mr. Duncan: — So because Regina Qu'Appelle, that would have been the only health region that would have been announced last budget, and so by the time the program actually got up and running which, you know, was kind of getting into the summer months, on an annualized basis it would be about 5 per cent but because it was basically a half year that they actually had the program operating, it was about two and a half per cent. But we expect that on an annualized basis that yes, it would be 5 per cent.

Ms. Chartier: — Okay. Are you aware or not if any health region has — and I want to talk about RQHR in a moment, but I'm wondering across other health regions — any concerns around home care being raised and the lack of access to home care?

Hon. Mr. Duncan: — From the ministry's perspective, nothing major has been flagged by the health regions. So yes, nothing that's come forward.

Ms. Chartier: — Okay. With respect to RQHR, I know that I've had calls from a few different people, from both people who work in providing home care and clients actually. I had one client who got meds seven days a week — and it was a mental health issue and was very important that this individual got their meds — and at one point was scaled back to two days and then, after some advocacy, not on my part but someone else's part, had that restored.

Another story where a woman who was already an existing home care client . . . She received nursing services and then was to get, had a procedure scheduled and needed some additional supports — some home health aid — and was turned down. So this was an existing home care client already. So we know that there are problems. And you talked about capacity.

But I'm wondering if you can tell me a little bit about what's going on in RQHR.

Hon. Mr. Duncan: — Thank you for the question. Just with respect to the issues at Regina Qu'Appelle Health Region and that we spoke about earlier today, so I think first of all it would be, you know, it's difficult to say when somebody's service is cut back because programs are always reassessing the needs of the individuals. And so it would be hard to put a number on, you know, how many individuals would be put into each category of why their services would be changed because they're always continually reviewing the needs of the people that are in the program or the clients of the program.

So these numbers would be as of I believe last Friday or Monday of this week. Last Friday. So they have created a list for new referrals. As of last Friday, they had 91 new referrals to the home care service. As of last Friday, 80 of the 91 had already been accommodated by home care. And the remaining 11, at that time they said that the remaining 11 remained on the list over the weekend.

What they are doing is that they are recruiting some additional staff, and they have added additional staff at the treatment centre to provide some options for clients. So I think as I said before, you know, they continue to evaluate the situation, depending on whether or not this is maybe just a point in time where there's more demands on the program or whether or not this will, you know, result in maybe making some more longer term adjustments to deal with the clients that they do have. But certainly they are in the process of . . . They have indicated they are in the process of adding additional staff.

Ms. Chartier: — So as of last Friday there were 11 individuals who needed home care who did not get new referrals.

Hon. Mr. Duncan: — Right. So of the 91 new referrals, as of Friday, 11 had still . . . So 80 of the 91 had been accommodated

by home care. I'm not sure from Friday till now the situation with the 11. We'll certainly check with Regina Qu'Appelle as quickly as we can, but that's certainly the latest update that we have from them.

Ms. Chartier: — And is that broken away from people in the Home First program then? So you've got the Home First program and then you've got new referrals into home care.

Hon. Mr. Duncan: — This would be separate from the Home First/Quick Response program. This would be new referrals to the home care program. The other thing I'll say is of the 91, the new referrals or new requests, they have set up a triage program so they are trying to get to . . . It's not necessarily the first come, first served of the 91. It's a triage process based on the needs of the client so they are getting to the more urgent, the more serious ones soon.

Ms. Chartier: — So if you leave Home First then or if you get referred, if you come into an emergency room or are leaving hospital, you'll get home care but if you're in the community possibly you may end up . . . I'm just trying to understand here that . . . So the Home First, the pilot project, you've got this targeted, designated money and so if you get that referral, you'll get your service. But you may, in the community with the home care piece right now, it's being triaged because there's not enough staff.

Hon. Mr. Duncan: — So just to try to answer your question, Ms. Chartier, so it would really depend I guess on . . . For the most part our understanding of these, these would be just, the 91 would be referrals into the program, not necessarily having come through the Home First program.

But I think it's important, while Home First is a subset of home care, I think it's important to recognize that Home First is that intervention particularly in situations that come to the emergency room that aren't necessarily an emergency room. So it may not even require the person to become a home care client. It may just be some, you know, an urgent type of situation that arises that in many cases leads them to the emergency room, may not necessarily mean that they become a home care client. But the Home First program is that short-term intervention to try to keep them out of the hospital, out of the emergency room.

So I don't, you know, I don't know. I'm not sure. Because it would really depend on each individual client's needs and the experience. And I don't think it would . . . I'm just not sure it would be fair to say that clients of Home First/Quick Response would be getting service quicker than home care. That may be the case, but if somebody's showing up in the emergency room at midnight, particularly a senior, they may need Home First/Quick Response. At the end of the day, they may not actually need home care.

So they're getting the service that they need. I'm not sure if I'm maybe explaining that right, but I think it's hard to put, it's hard to separate out the two categories and just kind of put people into one or the other.

Ms. Chartier: — And that's what I'm trying to understand here, too. So those referrals . . . So it could be, with Home First, it could be a more acute situation. Or sometimes people show up in emergency rooms without emergencies but . . . and may not require ongoing home care, but do require a little bit of intervention in their home.

Hon. Mr. Duncan: — So just maybe to illustrate this a little bit, and we're just trying to think of an example. So you know, let's suppose, you know, there may be a senior that's living on their own at home. They may or may not have home care, but let's say in the example that they have home care. Let's say that client perhaps has a catheter. If the catheter, if there's a problem with the catheter and it happens outside of the hours that home care typically is available, really in that case, you know, it may lead them to go to the emergency room.

So it's not an acute episode. It's not something that requires an admission to an acute care bed. It frankly doesn't even in that case probably require a trip to the emergency room. But there's really no service. There may not be a service, or there may be a gap in the service. And so that's kind of the intent of Home First/Quick Response is to provide that intervention without, you know, tying up the resources of the emergency room or an acute care bed when it may not actually be an emergency room.

[16:00]

Ms. Chartier: — Is there, just in that particular example then, is there . . . would the individual have to go to the hospital to then go home and get the support? Or is there a number that they call, or how does that all work?

Hon. Mr. Duncan: — So it would be a range of different types of options, and each of the different programs are set up a little bit different. But in the case of Regina Qu'Appelle, there would be Home First personnel in the emergency room so they could provide that assistance there. They could provide, you know, whatever assistance would be required, or perhaps it would be required back in the home, depending on the situation. So that's kind of the version of the program that Regina has built, where they provide that support in the emergency room to free up the staff of the emergency room for hopefully true emergencies.

Ms. Chartier: — So actually that was going to be one of my other questions. Are they the same? I was going to ask if the Home First staff are in fact the same staff that work for home care.

Hon. Mr. Duncan: — Well they would, now correct me if I'm . . . I'll have an official correct me if I'm wrong, but so they technically are staff of home care, but they were new positions that were advertised and posted for those specific positions.

Ms. Chartier: — Specific to RQHR then, and I'll want to talk a little bit about the other two pilots as well, but specific to RQHR, how big is the staff complement in home care?

Hon. Mr. Duncan: — Regina Qu'Appelle, so within home care in Regina Qu'Appelle, 480, just a touch under 485 full-time equivalent positions.

Ms. Chartier: — Sorry, under what did you say?

Hon. Mr. Duncan: — It's 484.89 full-time positions, but 485

full-time equivalents.

Ms. Chartier: — In home care as of . . .

Hon. Mr. Duncan: — So that's as of 2013-14.

Ms. Chartier: — Can you give me a comparison to the previous couple of years?

Hon. Mr. Duncan: — Sure. So the prior year, it was 481; the year before that, so '11-12, it was 438; 423 the year prior. Sorry, I'll maybe do this a little bit of a different way.

So 2006-07 it was 413; 2007-2008 was 412; '08-09, 407; and then it went up to 423 in '09-10; it stayed the same in '10-11; and went up in '11-12 to 438; and in '12-13 jumped up to 481. So about a 70, I would say just rough estimates about a 70 FTE [full-time equivalent] increase over the last seven years.

Ms. Chartier: — Okay. And with respect to Home First, when it started last year, I'm just wondering about the staffing complement? Are they included in that staffing complement?

Hon. Mr. Duncan: — So within Regina Qu'Appelle's Home First/Quick Response pilot program, there's 5.6 RN [registered nurse] positions. There are 14 continuing care aid positions. Just on that, they've orientated 40 individuals, CCAs [continuing care assistant], to fill those positions. But there are 14, like they represent 14 full-time positions. There's one pharmacy position and there's an assessor coordinator position.

Ms. Chartier: — Okay. And they do completely independent work from the home care folks . . . the nursing staff and the continuing care aids? Like there's no crossover in the RQHR model.

Hon. Mr. Duncan: — Well there may be some crossover in terms of individuals who choose to take some hours on a home care shift and then may fill . . . Like say a CCA may take one of those positions or a portion of that position. You know, I think it's fair to say they're distinct. Home First/Quick Response is a subset of home care, but it's a distinctly funded program.

Ms. Chartier: — And tell me how it works here in Regina then. You were saying the staff is based out of the hospital or hospitals? Like, how does that work?

Hon. Mr. Duncan: — The RN positions would be the ones that you'd find in the emergency room. For the most part, the CCAs would be dispersed throughout the community to provide that transition support back in the home, and the pharmacy position is also in the emergency room.

Ms. Chartier: — Okay, thank you. In terms of the home care, you've given me the home care FTEs over the last several years. How about the number of clients?

Hon. Mr. Duncan: — In terms of home care across . . . So this is a provincial number. We'll try to find the breakdown, but there are just over, as of '12-13 — and we'll see if we have a '13-14 number — but as of '12-13 there were just over 35,000 clients. And that has gone up by about 11 per cent province-wide since 2007-2008.

Ms. Chartier: — Do you have the Regina or RQHR numbers?

Hon. Mr. Duncan: — Not specific to Regina, just the provincial-wide number. But I'll endeavour to get that number.

Ms. Chartier: — Because it's good to have those numbers to compare with the FTEs. Like that's what sort of makes sense.

Hon. Mr. Duncan: — Sorry, we do have the number. So '12-13, the last year that we have numbers, Regina Qu'Appelle, just under 7,500 clients in home care in Regina Qu'Appelle.

Ms. Chartier: — Just under 75 did you say?

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — And how about previous years?

Hon. Mr. Duncan: — I don't have the previous year for Regina. We'll look to find that but I don't have that in front of me.

Ms. Chartier: — Okay. Because when we're back here, if you could get it, that would be great. Okay. In terms of projections going forward, what are you, both with respect . . . Now that you're in the second year of Home First/Quick Response in Regina, what are your projections both for home care and utilization in Home First?

Mr. Hendricks: — Our '14-15 budget is based on a 5 per cent increase in both home care clients and home care service units. As we look at the services that we provide to seniors and to individuals with challenges with independence, I think increasingly we will be looking at and evaluating home care as an alternative to institutional care. It's much more cost effective, and what we know from that clientele is they would much rather remain at home and independent. So it's a program that we think has a lot of promise.

Hon. Mr. Duncan: — And I believe when we announced it last year in the budget, the intention was that we would pilot it in Regina Qu'Appelle for two years. So this would give us the second year of that pilot. We then, as you know, we subsequently have announced expansion into Saskatoon and Prince Albert. But I think what we initially had contemplated is that we'd pilot it for two years in Regina Qu'Appelle.

Ms. Chartier: — Okay. Going back to the wait list in RQHR, so we've got the new referrals where you had 11 waiting as of last week. And so we're not sure where they're at. But in terms of what I've heard and an anecdote that I've told you, what about service cutbacks where people have had home care services and have had a reduction in services?

Mr. Hendricks: — So what I would describe, the situation in Regina or the situation that Regina's currently experiencing is a short-term one. Obviously they would like to, and have said that they're going to, adjust the number of home care workers to meet the current and growing demand. But just staffing those positions, you know, in the near term is presenting some challenges.

So the minister had mentioned that there's triaging going on

with new clients that are referred from the community. There's also a triage of existing patients, so if new patients coming online do require more intensive services, and existing patients, you know, through an assessment, might be able to get away with fewer. In some cases there might be a realignment of services. And the other thing with home care, too, is you have to remember that service needs of the client are continually reassessed. So that might just have been a natural progression of the program where home care, or sorry, a continuing care aid or a nurse made a decision that that client could get by with few services. But I hope it . . . You know, obviously we want to hear about cases where the client feels that's not the case.

[16:15]

Ms. Chartier: — And that wasn't the case. It wasn't staff thinking that the individual needed less care. And so I think that there's some concern there where you've got vulnerable people who maybe can't always advocate. So someone is telling them you're getting less service now, and in fact they perhaps don't have the capacity to advocate for themselves for that continued service. So there's some concerns that we have around that.

Mr. Hendricks: — So where those clients do present, I think that, you know, there is the opportunity through . . . The region does have quality of care coordinators, right? And they're closely tied in with the ministry. And those are the types of cases that we would like to hear about, because we don't want there to be gaps, and we don't want people to be left needing, by changes, and I'm certain that that's not the intent. When you are going . . . You know, obviously Regina is trying to triage the services where they're needed most, but there would be no intent to leave somebody in need. So please refer those to the quality of care coordinator in the region.

Ms. Chartier: — Fair enough.

Mr. Hendricks: — Or give us a name.

Ms. Chartier: — Yes. I think one of the challenges, and it was actually a staff of home care who had called me and had said that . . . this was the week after the budget, and you hear the announcement that this money's going into Home First and this individual is having to tell clients . . . you've got nursing clients and then sometimes if they need home health aids or — excuse my lack, my terminology here — you have to . . . you can't . . . you have to apply or if you don't decide that as your . . . on your own. And his frustration was he provides nursing care for this individual, needed additional supports for her, and couldn't get them.

And his frustration was, okay we've just heard a budget announcement of this money being spent here, and this woman needs this to be able to stay in her home and wasn't going to get it, so that . . . And this is coming from someone who's worked in home care for a very long time, expressing some frustration with the scaling back of services. Whatever the reason is, it's still been frustrating for both staff and clients.

Mr. Hendricks: — As I said, you know, this is short term in nature, right? And again, if there is a client whose needs are not being met, that would be a concern to us and we would be willing to take their name. I would describe this as growing pains. We're trying to expand the Home First program to provide better care to seniors in the community. And so sometimes with that you experience some unforeseen challenges. So again, if we could have that name or names, we would be pleased to follow up.

Hon. Mr. Duncan: — I would just add to that in terms of the announcement of the budget. Certainly I think the deputy minister has done a good job of outlining the concerns that we would have in those specific-type cases and, you know, certainly have had, I think, a good discussion over the last couple of weeks and this afternoon as well on this particular issue. But obviously with the announcement of the $4.5 million, notwithstanding maybe frustrations from that particular staff member, what I think that that does do is allow us to hopefully transition those people that don't need to be in the emergency room.

There certainly is, you know, better care that we can provide if it doesn't have to be in a setting that isn't maybe appropriate for that individual. And there's obviously cost implications anytime somebody shows up in the emergency room, let alone saying anything about, you know, the backlog of people that we have that do need emergency services. So you know, notwithstanding maybe the frustrations of hearing that announcement, I think overall it is going to be one that I think has already been effective. And as the deputy minister has said, you know, we're working through some growing pains with Regina Qu'Appelle and the program.

Ms. Chartier: — Do you know where RQHR is with respect to . . . So currently they have 485, for all intents and purposes, FTEs. What are they looking at hiring and what are some of their challenges to being able to hire more staff to meet demand?

Hon. Mr. Duncan: — So at this point we wouldn't have specifics on that. First of all, Regina Qu'Appelle is . . . Now that they have an idea of what is in the budget in terms of their allocation, they'll be now building their budget for this year, and that'll be approved by their board later this spring. We do know that, just in terms of the conversations that the ministry has had with Regina Qu'Appelle Health Region, that they've indicated that they do intend to hire additional staff into home care. But at this point, you know, we wouldn't have a number on what that would look like for the entire year.

Ms. Chartier: — Okay. Again, just going back to the question around number of clients. I know you said you'd get that, but that would be helpful in terms of some of my questions and having a better sense of . . .

Hon. Mr. Duncan: — Absolutely, we'll provide that. As I said before, in the last six years we've seen across the province about a 12 per cent increase. So you know, what that breaks down to Regina Qu'Appelle, we'll certainly provide that information.

Ms. Chartier: — Okay. Can you tell me, I know that we're just about out of time here this afternoon, but could you tell me a little bit about how Saskatoon and Prince Albert's programs are rolling out, the pilots there?

Hon. Mr. Duncan: — I'm a little less familiar with the specifics of how those two programs are compared to the Regina program, so we'll maybe just take a few seconds to get that information.

So with respect to, I'll maybe start with Prince Albert. So Prince Albert Parkland Health Region didn't launch their program until February. So it's early days for actually putting the program together, and I will provide that information as we can provide that. But they still are kind of building what the program will look like.

Saskatoon is a different story though. They've had . . . So their program, they've done a good job of putting it all together. They've actually, and I have some information that I'm very pleased to share with the committee, they've had some I think some great results with the Home First/Quick Response program. So I'll walk through a little bit of that. I'll try to be brief for members. So they currently are meeting their target outcome of a 5 per cent increase in the number of clients that utilize home care services.

Here's some of the results of the program. Seniors, prior to emergency room visits, seniors that had admissions within the last 60 days, they've seen a decrease in that by 50 per cent. Saskatoon reported that currently they have 61 per cent of their clients with at least one chronic disease diagnosis and another 20 per cent above that would have severe dementia. ER visits have decreased overall by more than 50 per cent in the last three months. Let's see here.

So those are some of the early results. If I could, I don't know if the member would be interested in a bit of, kind of a description of how the program works, using an example.

Ms. Chartier: — No, I am curious about how it works.

Hon. Mr. Duncan: — Sure. So here's an example. This has been all de-identified, so the individual's name has been redacted. So I'll call her Mrs. D. So Mrs. D is a 93-year-old lady with dementia who lives with her daughter. A few weeks ago, Mrs. D fell and broke her fibula. Home First/Quick Response received a referral from QRP [Quick Response program] to help provide intensive support during her convalescence.

So a Home First/Quick Response home care OT [occupational therapist] was able to go to the client within a day and put equipment in place to assist the client. She also made a consult to a physical therapist at that time. The CCA assistance was put in place, as well as respite for the daughter once a week.

Case managers kept in close contact with Mrs. D and her daughter. Within a couple of weeks it was apparent that the daughter had become exhausted, as Mrs. D required assistance throughout the day and night. Home First/Quick Response home care is arranging for private service to provide overnight respite twice a week for a couple of weeks to ensure that the caregiver, the daughter, gets rest and will be able to continue with providing care for the mother.

It's hoped that as Mrs. D improves, these supports can be decreased and that Home First/Quick Response home care will then refer the client into regular home care services.

Ms. Chartier: — Thank you for that. I'm curious, and you said P.A. [Prince Albert] you don't know, or don't . . . They just launched in February, so you're not sure of the details of how that exactly works. But I'm curious, it sounds like it's moving quite smoothly in Saskatoon. What is the — and Saskatoon is the largest health region — what do you think the difference is with the challenges in Regina versus Saskatoon on the home care front?

Hon. Mr. Duncan: — Thank you for the question. Just in terms of, just back to P.A. just for a moment, so they . . . While it is still early, and I don't have a date of when these would be accurate to, referrals into the program from acute care, so the emergency room setting, there have been 12 of those. From the community itself, there's only been one.

So I think it kind of shows that they've put, you know, a pretty good focus on having that contact in the emergency department. And that would lead me to suggest that it'll be more along the lines of what Regina's doing, with more of a focus in the emergency department. But still they're . . . I think it's still fairly early in terms of their development of the program.

You know, with respect to I guess the question about the challenges in Regina versus maybe not so much in Saskatoon, we're not sure about that. We don't really have an answer for that. It just may be a part of, for whatever reason, just more growing pains in rolling out the program in Regina versus Saskatoon. But that's really just speculating on my part.

Ms. Chartier: — Thank you. Just in terms of budget here, and you talked about the global budget of 177 million on home care across the province, do you have any idea what the number for RQHR is that they've spent on home care, separate from the pilot project last year and this year, but on regular home care services?

Hon. Mr. Duncan: — In '13-14 it was $41 million.

Ms. Chartier: — And can you tell me about previous years?

Hon. Mr. Duncan: — I don't believe we have that with us, but I'll endeavour to provide that for you.

[16:30]

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — No. It doesn't look like that's here. No.

Ms. Chartier: — Okay. Well I think I know that our time is up for this afternoon. So I do have many more questions, but we've got many more hours together here.

The Chair: — Thank you very much, Mr. Minister. If you have any closing remarks or comments.

Hon. Mr. Duncan: — Just very briefly, knowing that we'll be back here for a couple more hours I think in the next couple of weeks, I just want to thank Ms. Chartier for your questions and members of the committee for having us here this afternoon.

I also want to, if I forget to do it in one of our next available opportunities, I do want to thank the women and men of the Ministry of Health and our regional health authorities for all the work that they do on a day-to-day basis, but as well as the work that they do to prepare us to be able to come to estimates. There are a number of them that are here today, but for as many as you see here today at committee, there's many, many more that you won't see who are back at their desk doing their job. And so I just express my appreciation to them.

Ms. Chartier: — I just want to say thank you again to the minister and all the officials — I know that there's lots of, many questions from many different areas — and to the other committee members. And we'll be back here soon enough.

The Chair: — Thank you one and all. At this time I would ask a member to move a motion of adjournment. Mr. Merriman has moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned to the call of the Chair. Thank you, one and all.

[The committee adjourned at 16:31.]