STANDING COMMITTEE ON HUMAN SERVICES

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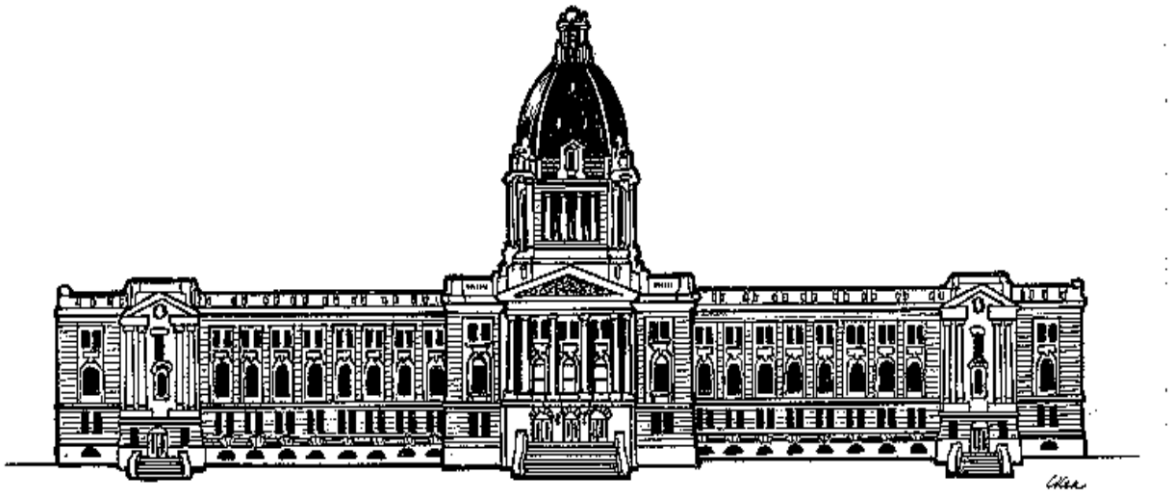

Legislative Assembly of Saskatchewan

Twenty-Eighth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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Published under the authority of The Hon. Corey Tochor, Speaker

[The committee met at 15:00.]

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Welcome to today's meeting of the Human Services Committee. We are reviewing vote 32, Health, central management and services, subvote (HE01).

Mr. Minister, welcome. Today we have with us MLA [Member of the Legislative Assembly] Hugh Nerlien, MLA Muhammad Fiaz, MLA Nadine Wilson, MLA David Buckingham, MLA Mark Docherty, and for the opposition, MLA Danielle Chartier. Mr. Minister, if you would introduce both ministers and your staff please, as they come up.

Hon. Mr. Reiter: — Thank you, Mr. Chair. At the front table with me I have my friend and colleague, the Hon. Greg Ottenbreit, Minister of Rural and Remote Health; and also Max Hendricks, the deputy minister of Health. We have quite a number of officials with us today, so I'll ask them to introduce themselves as they partake in the discussion.

To start with, Mr. Chair, if I could, Ms. Chartier asked a number of questions on Thursday, I believe it was when we were last in committee, that we didn't have the information available at that time. I believe there are still a few of the questions that work is still being done to get the information, but ministry officials would be prepared to answer several of those questions now. So if that's okay with everyone, I'd ask Deputy Minister Max Hendricks to direct the traffic with ministry officials and to attempt to answer those questions for you.

Mr. Hendricks: — Okay, there were two outstanding questions. One was how much of the seven and a half million in administration to long-term care front line was achieved and how much was actually redirected to staff, as well as clarification on the audiologist numbers. And for that, I'm going to invite Assistant Deputy Minister Kimberly Kratzig to the front to speak to that.

Ms. Kratzig: — Hi there, I'm Kimberly Kratzig, assistant deputy minister. So following up from last week, the question around the 7.5 million admin reduction: so as of January 31st of this year, 4.9 million had been saved. The regions are forecasting to save an additional 1.2 million by the end of the fiscal year. So that means for the fiscal year, we will have saved in the region, 6.1 million in administration costs or 81 per cent of the 7.5 million target.

Now in terms of what's been reinvested into long-term care, as of January 31st, it was $549,000, and regions are forecasting an additional 500,000 by the end of the fiscal year.

Ms. Chartier: — Thank you for that. So the end of the fiscal 2016-17, but by the time Public Accounts are . . . like is that what . . .

Ms. Kratzig: — Yes, the end of '16-17.

Ms. Chartier: — Okay. Thank you. Of the 549,000, do you know how many positions or what . . . Is that all new money redirected then?

Ms. Kratzig: — That's money redirected into the front line of long-term care. I don't have the specifics of exactly where that has gone. We can try to follow up to get that. If you're looking for a position-by-position sort of allocation, we can see what we can do.

Ms. Chartier: — That would be great. I'd like to see where that has . . .

Ms. Kratzig: — Okay. I may not be able to get that for tomorrow if we don't have it. But I think we have some of it, so we might be able to.

Ms. Chartier: — Okay, and we're back on Wednesday too for the bill also.

Ms. Kratzig: — Oh right. Okay.

Ms. Chartier: — Yes.

Ms. Kratzig: — For sure.

Ms. Chartier: — That would be great.

Ms. Kratzig: — Okay. And then on public audiologists, there was some follow-up on that. So we had a discussion last week. You had just started the conversation about the hearing aid plan, and we got into a bit of a discussion around how many public audiologists are there.

So I just want to clarify. So there are 12 publicly funded audiologists involved with health region service delivery. The Ministry of Health also funds the audiologist that's involved with the SPARC [Saskatchewan Pediatric Auditory Rehabilitation Centre] program, so that's a partially publicly funded audiologist. It's also funded, that position, by some charitable organizations. And there is an out-of-scope clinical manager in the RQHR [Regina Qu'Appelle Health Region] hearing aid plan, who is also licensed as an audiologist. So that is 14.

So in terms of actually working in the system, I guess we would say there's 12 publicly funded and an additional one in SPARC. So that's seven in-scope audiologists in Saskatoon and five in Regina Qu'Appelle.

Ms. Chartier: — And how many of those were . . . So it had been broken down for me, I'd understood, in the numbers that I had received. Again, I had received the number of 10 HAP [hearing aid plan] audiologists, so I know you're . . . and then four in . . . So you've given me seven in-scope in SHR [Saskatoon Health Region], but how many of those will be directly affected by the cut to HAP?

Ms. Kratzig: — So none of the audiologists are exclusively dedicated to HAP, which makes it a bit more difficult to give

you a definitive answer in terms of who's a HAP audiologist and who's a health region service audiologist.

In terms of the changes to the hearing aid program though, the reductions that we are looking at . . . And again this has not been finalized. We continue to work with the programs in Saskatoon and Regina to ensure that the adequate staffing is in place to deliver the services that we have committed to delivering, of course the reductions to the hearing aid plan proper. So what we are looking at though, is that there would be two remaining audiologists in Regina and five remaining publicly funded audiologists in Saskatoon, and the SPARC audiologists would continue. So that would be seven sort of region operated and the SPARC audiologist as well, so a reduction from 12 to 7.

Ms. Chartier: — I guess we're off on HAP right now, so we might as well keep along this line then. So I understand in Saskatchewan there are only two individuals who work with . . . two publicly funded individuals who do cochlear implants, the mapping, and they were both with HAP. So I'm wondering, what happens with their roles?

So obviously the minister said we're keeping the cochlear implant program, and the surgery will still be funded, but a big part of that is the assessment before, which is done by audiologists, and the work afterwards in supporting those who have had the cochlear implant. So I understand through word of mouth that there's been some impact. One of the audiologists who has been trained to do cochlear implants, I understand, will be impacted. But can you clarify that for me?

Ms. Kratzig: — Sure. So I think as a starting point for the question, I'll walk through the programs and services that will continue to be delivered in Saskatoon around cochlear implant and other programs.

So first of all, the cochlear implant program will not be impacted by the reductions. They will continue. Again that program, that includes the preoperative evaluation and the post-operative rehabilitation following cochlear implant surgery. The internal device will continue to be covered the way it was and treated the way it was. The external device also is part of that, and there's no change there.

The additional cost to the client — the cable replacement, the batteries and repairs — that continues to be a patient-pay issue as it was previous, so again no change at all. Maintenance visits for people with cochlear implants, that continues to be covered in the same way. So there's no change. School-aged children with cochlear implants continue to be covered and seen the exact same way they would've been before in terms of working with the school divisions and working with the SPARC audiologists, so there's no change.

So we've been really clear in working with Saskatoon that the expectation . . . And they've assured us that there would be no change in the cochlear implant program. So we can move on to some of the other programs that are continued. But the mapping that you talk about, that will continue. All of that, those audiologists will be in place.

Ms. Chartier: — So just through the grapevine then, and obviously you have discussions on different levels than I do, but I had understood that one of the audiologists who does a bulk of her work for HAP and does cochlear implant — this was a conversation of a couple of weeks ago still though so — had understood that she wouldn't be in that position anymore.

So there are only . . . So you're assuring me and people of Saskatchewan that there will be those people who do cochlear implant mapping and all the work and maintenance will still keep their jobs as publicly funded audiologists.

Ms. Kratzig: — I can't speak to the individuals who are actually providing the service because I don't know which audiologists can provide exactly which level of service, but Saskatoon has assured us that as the program changes are made to the hearing aid plan, the cochlear implant program, and all of the ancillary services that are provided to people right now will continue. And they are managing that transition for us. So yes, that's the assurance that we've been given.

Ms. Chartier: — Okay. Because there's no private audiologists who do the cochlear implant mapping. And there are, again from my understanding, only two in Saskatchewan who see children with cochlear implants, and one is with HAP and the other one was with SPARC.

Ms. Kratzig: — Yes. And again the program in Saskatoon in particular is really quite interwoven in terms of HAP and services that are provided. So again Saskatoon on the ground is managing the transition but we have been assured that there will be no changes to the program. That's the minister's expectation, and that's certainly the work that we've been having with Saskatoon is assuring of that, yes.

Hon. Mr. Reiter: — If I could as well, you know, you mentioned people with the concerns. That's going to happen when there's changes. If you'd like, whether it's an organization or a private individual, if there's some concerns that you're mentioning you're hearing from people, if you want to provide names, we'd be happy to have either ministry officials or the appropriate official in the health region contact them to answer their questions.

Ms. Chartier: — Okay. Just in terms of, you've mentioned how interwoven HAP is with the SHR audiologists, so I'm wondering if you could tell me a little bit. So I'm seeing this in a . . . And I think people in the public are seeing this vastly different or people who work in this area are seeing vastly different as we're having this discussion.

Again, so I'm wondering, so the HAP audiologists are paid for from ministry money or from the Saskatoon Health Region. Is it money directed to SHR or RQHR and it comes out of their budget? Or can you tell me how that funding flows for the audiologists in HAP?

Ms. Kratzig: — Regardless of whether an audiologist is in the HAP program or working in the other specialized regional programs, all funding is through the regional health authorities. So the Ministry of Health does not, sort of, line fund any of the programs.

Ms. Chartier: — So if you're a . . . But there's the expectation

that the HAP, up until this budget, that HAP, some money comes from the ministry to the region to fund HAP. So if you're reassuring people that don't worry, these services will be maintained, I'm wondering what you're going to save money on. Like, it's $3 million that will be saved, so I'm wondering what will be saved.

Ms. Kratzig: — So in addition to the audiologists that we talked about, there will be other FTE [full-time equivalent] reductions in the regions in terms of support staff who are providing support to these programs. So that's where the annualized savings will come from as well. So there'll be a total of . . . 18.69 FTE reductions is anticipated and about 2.95 million annualized savings.

Ms. Chartier: — So in terms of services to people then, what should people anticipate being cut in terms of services? If you're cutting audiologists, what does this look like for people? So you've got the cochlear implant program maintained, but one of the things with children with hearing aids . . . Children are different than adults in that you can't be off line at all as a child. It impacts your speech and your development.

[15:15]

And so I'm wondering, what will that look like in a reduction of services to people? What services are being cut?

Ms. Kratzig: — So the hearing aid plan itself, which is the program that we're talking about, operated in Saskatoon and Regina. Essentially it provides audiology evaluations, hearing aid fittings, hearing aid sales, counselling, and education. So that is what is being eliminated and people will be going to private audiologists and private hearing aid sales for those services.

What's being retained is the very specialized services, as we talked about, cochlear implant, bone-anchored hearing, some very specialized services for school-age children, children with disabilities. That's what's being retained. So you sort of have to think of it as a separate program that's being eliminated, but there still will be hearing services, specialized hearing services in the health regions.

Ms. Chartier: — So I want to understand the integration or the interwoven nature between HAP and the audiologists in both . . . well in SHR particularly. I understand that that's where the bulk of the other . . . Again I'm going back to how it was pointed out to me that there were 10 HAP audiologists and then three SHR ones.

So can you tell me a little bit about what else would be, what else . . . I'm really struggling here to see the difference. And what you're telling me, there is no difference in the HAP program and SHR. So the SHR audiologists, there's some who work at RUH [Royal University Hospital] — is that correct? — doing the infant evaluations?

Ms. Kratzig: — Again I think in Saskatoon, in our discussions with the Saskatoon Health Region, they have not been stating that they have X number of HAP audiologists and X number of other audiologists. They had audiologists who worked together in different programs. So the work going forward and the discussions that we're having with them is to ensure that we retain those specialized programs — the cochlear implant, the bone-anchored hearing. And the other more, I don't know if you want to use the word "general" hearing aid plan services, are the ones that are being eliminated. So we're working closely with the region to ensure that the specialized services are there. And the ones that are part of the hearing aid plan — which again is the evaluations, the assessment, the sale of hearing aids — that will be done through the private audiologists.

Ms. Chartier: — Are you anticipating children should be going to private audiologists for the evaluations and assessments?

Ms. Kratzig: — Some children would be if they're not part of the specialized programs that we've talked about. Again many would be covered as part of the programs that we've talked about in terms of some of the specialized services, but there would be . . . There are audiologists in the private sector in Saskatchewan right now that are seeing many children. So, yes.

Ms. Chartier: — Okay. And children . . . How many audiologists in Saskatchewan, private audiologists, see children?

Ms. Kratzig: — In the work that we've done with sort of preparing for the change, there are 12 audiologists that provide services to children now. And I should mention, as part of this transition we are meeting with a group of private audiologists just to ensure that we have a deep understanding of the services that are provided, ensuring that the transition is a smooth one, and that again there aren't any areas that we might be unaware of so there isn't a gap.

When we've met with families and talked to them about some of their concerns, most of them were addressed by the services that are continuing to be provided. But if there are some questions around the transition to the private sector, we want to talk to the private audiologists a bit more to really understand the level of services and if there is any type of a gap that we might be unaware of.

Ms. Chartier: — And if there is the gap, will you, if private audiologists determine that they can't provide the level of service that HAP could . . . Because what I understand from HAP audiologists, so your hearing aid goes down, you get a loaner. And often with kids there's issues that are very different than seniors, that need attention promptly. And it's easy to get an appointment. There's not a waiting list. And that's one of the challenges . . . Or there isn't a waiting list for kids. Kids get priorized because it's a big problem for kids to be off their devices for any length of time.

So how are you anticipating that the private sector can do what the private sector needs to do, is provide service but make a profit, when it's very labour intensive working with children?

Ms. Kratzig: — Those are the discussions we'll be having with them. We have no reason to believe they can't provide the services. Certainly in many provinces in Canada it is the private audiologists that are providing services for children, so we have no reason to believe that Saskatchewan would be any different in that way. We'll continue to have those discussions and, as the minister has said, we are taking a very thoughtful approach to

this transition to ensure that services are there for the people.

Ms. Chartier: — So any sense on cost impact to families? So with HAP again, the advantage of public audiologists is there isn't a profit motive at all. So you can see the audiologist as many times as you need to see the audiologist.

But just in conversations that I've had with folks, there's a huge concern that there isn't going to be the ability for private audiologists to provide the level of service to children because children have huge needs in this regard. So what provinces are private audiologists providing services to children?

Ms. Kratzig: — In terms of hearing aid plans, provinces that provide no public hearing services: Ontario, Quebec, New Brunswick, Manitoba, Alberta. So they have integrated the private sector into their service delivery model. I think I also will provide a bit of context that you might be interested in, in terms of how many hearing aids have been sold to children versus adults in the hearing aid plan. So we do have some information from 2016 from Regina and Saskatoon. So the total number of hearing aids sold last year is 1,642 hearing aids, and of those, 104 hearing aids were for children. So that's just a bit of context for you.

Ms. Chartier: — So when you say no public hearing services in Ontario, Quebec, New Brunswick, Manitoba, and Alberta . . . So when you say that there's no public audiologists in practice in any of those provinces, that's not my understanding. I've had a number . . .

Ms. Kratzig: — I think it's about the hearing aid plans and the sales again. I'm sure that they have specialized . . . I note many of them have cochlear implant programs. So, much like Saskatchewan, I think it's not necessarily as clean as a you are one or the other, but like Saskatchewan many of them do have cochlear implant services that are supported by public audiologists. So just like Saskatchewan will continue to employ public audiologists and have a fairly robust public audiology service regime in the province, we are eliminating the hearing aid plan, which is a part of that.

Ms. Chartier: — So right now the hearing aid plan in Saskatoon, there are four audiologists with HAP who work with children and there are wait-lists, I mean under HAP. So I'm wondering if any of the audiology positions being eliminated work with children.

[15:30]

Ms. Kratzig: — I don't have that specific information. But again in our work with Saskatoon to have a very thoughtful and planned transition, we have been assured that the programs for children that I talked about earlier — the cochlear implant, the bone-anchored hearing; I might talk about a couple of other programs that will continue to be offered — that those will continue to be provided to children. So while I can't answer that specific question, I can tell you a little bit more about what will be provided.

So the bone-anchored hearing devices program will continue to be offered. That's located in Saskatoon, and that will be the internal and external device. One of the items that is important I think to families is the auditory brain stem response testing. This is the mapping in the brain pathways for hearing that we talked about. That will continue. Specialized hearing services for children will continue. Complex audiology exams for . . . not limited, but for children, for example, with Down syndrome, cleft lip and palate, children with multiple comorbidities, all of those will continue to be offered.

Saskatoon and Regina will still continue to offer support for school-age children with hearing aids. Those are assessments that are completed annually. So again I think we are retaining quite a robust public audiology service for children in a very specialized way. This is about eliminating the hearing aid plan, again, some of the numbers we talked about earlier. Clearly there's a large portion of adults who are getting hearing aids of that 1,600.

Ms. Chartier: — So the complex audiology is the two-tester . . . So when you have a child with comorbidities, the two-tester clinics will continue to be offered?

Ms. Kratzig: — I'm assuming so, yes. And some children — for example, Down syndrome, cleft lip and palate — they might require multiple visits in a year. That would continue.

Ms. Chartier: — So you said the specialized . . . Okay. You said bone anchor, a hearing device, so that's a cochlear implant.

Ms. Kratzig: — Bone anchor and cochlear implants will both continue.

Ms. Chartier: — Okay, and then the mapping will continue.

Ms. Kratzig: — Yes.

Ms. Chartier: — And then you said specialized . . .

Ms. Kratzig: — Yes, some specialized hearing services for children.

Ms. Chartier: — That's the piece that I didn't get.

Ms. Kratzig: — Okay. So there's early hearing detection and intervention program. So Saskatoon of course has the comprehensive newborn screening program. That continues. That's not impacted by this at all. Children who are zero to five who are identified in that program might continue through if they have some specialized needs.

Also, as you might recall, there is child health clinics where all babies are seen at 2 months, 4 months, 6 months, and 12 and 18 months, and there is hearing testing done there. The public health nurses talk to moms or dads about how the baby is doing in terms of hearing, and they do some testing there as well. So that continues.

And then within the audiologist side of things again, the complex audiology exams and some of those other referrals that we talked about — school aged children with hearing aids, and some of the neonatal intensive care unit referrals — that would stay in the hearing aid plan as well.

Ms. Chartier: — Okay. So I think the . . .

Ms. Kratzig: — Pardon me, not in the hearing aid plan, in the publicly funded audiology services, yes.

Ms. Chartier: — Okay, so the early hearing detection, obviously that only happens in Saskatoon in a most universal way. But what I understand is those kids, if you are flagged in that early detection, you're flagged and you see a HAP audiologist. So you had said children zero to five identified in that will receive the services, once you've been identified, if you're an infant who's been identified as needing support.

Ms. Kratzig: — No, it will depend on the child's needs in terms of . . . But if they're identified and they have one of these specialized needs that we talked about, then they would get the support, yes.

Ms. Chartier: — So if my daughter, her only disability was hearing — and it's not my daughter — I'm just . . .

Ms. Kratzig: — Yes.

Ms. Chartier: — Just to be clear. If my daughter had a hearing disability and nothing else compounding that, the expectation is she'd be identified at RUH and then have to go to the private system.

Ms. Kratzig: — The specifics, to answer that question, are actually one of the items that we'll be discussing in our upcoming meetings with the private sector audiologist to really have a deeper understanding of how the referrals from the newborn screening program could work in terms . . . in a timely way. So I don't have a definitive answer now, but again back to my earlier response, we need to understand how that process will work so that families and parents know exactly what they need to do and aren't left searching for support.

Ms. Chartier: — Do you have any concerns — I guess you via, or the minister via you — the fact is the number of audiologists we have in Saskatchewan is, per capita, isn't great, from my understanding. There's huge wait-lists. Is there any concern around the fact that we're cutting public audiologists who spend up to seven years in training? You need a Master of Science to become an audiologist here in Canada, and up to seven years of training. So we're losing, we're cutting audiology positions, and there's no guarantee that they'll work in the private sector. We may end up losing them completely here in Saskatchewan. And there are currently wait-lists for both children and adults. There never used to be wait-lists for children, but that has grown.

Hon. Mr. Reiter: — Yes, that's a fair question. I think, to me there's kind of a twofold answer to that. First of all, there's sort of the broad number of audiologists in the population that serves overall, and then there's the questions that you had geared specifically to children. So I guess to that one first, to the one on children, I'm going to look to Kimberly to help me with the number she just went through a few minutes ago. I think you said there's 12 audiologists that'll deal with children and there was 140 hearing aids . . .

Ms. Kratzig: — Hundred and four hearing aids.

Hon. Mr. Reiter: — 104?

Ms. Kratzig: — Yes.

Hon. Mr. Reiter: — And that was how many . . . [inaudible interjection] . . . Sorry, that was 12 clinics. So I assume, in some, there's more than one audiologist that'll deal with children, I think was what the officials were intending. So that's the number of hearing aids sold to children. And the actual number of children would be less than that because, in some cases, it's two hearing aids. Right?

So in those instances, you know, with that number of audiologists, I think officials are just doing the due diligence to make sure nothing slips through the cracks. That number of clinics handling that number of children seems, you know, on the surface, more than reasonable. But they're following that up to ensure that, with children overall.

The number of audiologists to provide service to the general populace, you know, I would assume in cases like this that, you know, private industry is going to probably expand to meet that. I would assume a number of the public audiologists would look for positions in private audiology clinics. It would just make sense to me if the demand's there that they'll rise to the occasion.

Ms. Chartier: — Well I guess we'll have to see. That is a concern because if you don't have roots and you . . . There are all kinds of things that keep people here.

So children are one concern. So obviously in your discussions, I hope you're having discussions with the public audiologists as well. So you're meeting with the private audiologists to say, hey, what can you fill in. But you need to have a clear understanding of what services the public audiologists are currently offering, so I hope that they're in all of these discussions.

I know that there's been one discussion last week that people still feel that the ministry isn't and the minister isn't fully understanding the impact of this cut. So one of the challenges is around cost and people's ability to pay. So when you're . . . I would prefer that this cut not happen at all, to be perfectly honest. I think it's short sighted. But if it is going ahead, in your discussions with private clinics — like the fact that the public audiologists provides kids loaners, those kinds of things — are those conversations that you're having with the private clinics to ensure that that happens?

Ms. Kratzig: — In our meetings with parents, probably some of the same parents that you met with as well, we definitely heard about the concern about loaner hearing aids. And that will be one of the discussions that we will be having with the private audiologists as well to see what they offer in that regard.

Ms. Chartier: — Loaner hearing aid and access was the big piece, timely access to ensuring you're not off-line as a child.

One of the things that . . . Have you done any analysis . . . So obviously you've maintained that, if you're on family health benefits or supplementary health benefits, you will have your hearing aids covered. So it's a very select number of people who will meet that criteria.

But the reality is HAP actually has many negotiated contracts with hearing aid companies so they get hearing aids at cost, so that keeps the cost down for the ministry. Have you done any number crunching on how much this is going to cost a family in supplementary health benefits?

Ms. Kratzig: — In just doing a comparison of our numbers, we appear to have a bit more work to do to ensure that we can give you a number that would be accurate. So we will commit to, within the next few days, trying to get that to you.

Ms. Chartier: — Okay. I just want, just on the record, what number are you . . . to make sure we're . . .

Ms. Kratzig: — Oh, the cost of what this would cost the supplementary health and family health benefits, the additional cost.

Ms. Chartier: — Okay. No, that would be great. I just wanted to make sure we were on the same page.

Ms. Kratzig: — Okay. Yes.

Ms. Chartier: — I may come back to HAP tomorrow, but we've got lots of things to cover here today, and that's already been 50 minutes. So I may . . . If it's taking a long time for answers, I may ask if you can table things at some point.

So I want to move on to the health accord.

Hon. Mr. Reiter: — Ms. Chartier, we can do whichever you like. We do still have some answers from some of the questions last week though, if you'd like those or, the health accord, come back to that later.

Ms. Chartier: — Oh, so you've got further . . .

Hon. Mr. Reiter: — That was just the first one. I think there's — what? — two more.

Ms. Chartier: — And on which two topics do you have?

Mr. Hendricks: — On the out-of-province ambulance transfers for pediatric general surgery and the physician numbers for the children's hospital.

Ms. Chartier: — Can you table those?

Mr. Hendricks: — They're not in a form I can table them today. I'd rather the out-of-province transfers, it's more of a . . . It will require some explanation, if that's okay.

Ms. Chartier: — Okay, sure. And then if the docs, if you could table that, that would be great.

Mr. Hendricks: — Okay. So I'll ask the assistant deputy minister, Mark Wyatt, to come up please.

Mr. Wyatt: — So I'll introduce myself. I'm Mark Wyatt, assistant deputy minister with the Ministry of Health. And so based on the request from last Thursday, what we've identified is the number of both out-of-province transfers and in-province transfers for pediatric general surgery.

And we've also looked at it relative to the total number of surgeries performed on children and youth from zero to 17 years of age. And so we have that for three fiscal years, and so I can walk through each of those starting with 2014-15.

Ms. Chartier: — Okay. Sure.

Mr. Wyatt: — Okay. So for 2014-15, the number of out-of-province transfers was one, and that was a transfer from Saskatoon to Edmonton's Stollery. There were also five in-province transfers, and those were from Regina General Hospital . . . Sorry, they were from Saskatoon to the Regina General Hospital. So in '14-15 then we had a total of six transfers: the one out-of-province, five in-province. When we look at the rate of transfers, that would be six.

So this is the part where it gets possibly a bit confusing. Not all surgeries performed on people under 17 are necessarily performed by a pediatric general surgeon. So we've broken them down by the number of all surgeries performed by a general surgeon on somebody. I'm just going to check if it was 17 and under. It's 0 to 17, so 17 and under. And then also a comparison of the number of transfers to the total number of surgeries by a pediatric general surgeon. And so for '14-15, 0.4 per cent of all surgeries performed by a general surgeon for somebody 0 to 17 were transferred either in province or out of province, and it was 0.7 per cent of all surgeries performed by a pediatric general surgeon. And I can give you the raw numbers if you want those as well.

Ms. Chartier: — No, that's okay. I'm just conscious of the time here.

Mr. Wyatt: — So moving on to 2015-16, there were no out-of-province transfers reported to the ministry. In 2015-16 in terms of in-province transfers, there were three transfers from Regina to Saskatoon, and that was related to just gaps in pediatric general surgery coverage in Regina. And looking at the percentage of total surgeries related to those three transfers, of all surgeries performed by a general surgeon it would be 0.2 per cent, and of all surgeries performed by a pediatric general surgeon it would be 0.35 per cent.

Moving on to 2016-17, we had three out-of-province transfers. They were all from Saskatoon and they were all to Edmonton Stollery, and they related to coverage of pediatric general surgery in Saskatoon. And just to note that there have been no transfers reported to the ministry since September of 2016.

For in-province transfers, we've had five transports from Saskatoon to the Regina General Hospital again relating to coverage in Saskatoon. And when we look at the percentages, in 2016-17 that would represent 0.5 per cent of all surgeries performed by a general surgeon and 0.8 per cent of all surgeries performed by a pediatric general surgeon.

Ms. Chartier: — Okay, thank you for that. That's great. Okay, moving on to the health accord. Thank you. I'll just let you get settled there. So could you outline the terms of the 10-year health agreement that we've signed with the federal government this past few months ago, January?

Mr. Hendricks: — Okay, so what was agreed to with the

Government of Canada is that it really was an outline that would provide targeted funding for health care over 10 years for investments in home care and mental health. The actual money that the federal government at the time that that agreement is providing under this framework hadn't been actually passed in the federal budget bill yet, as subsequently they have the language in their budget bill. But right now, there are bilateral discussions going on with provinces around the framework for that, what the accountabilities, the parameters around the funding will be. So we're still working — not just Saskatchewan; all provinces and territories — on exactly what that will look like.

Ms. Chartier: — You don't have an agreement yet, a signed agreement with the federal government yet.

Mr. Hendricks: — All of the provinces have agreed to the funding level and the streaming of that funding level over the next 10 years. The specifics about what will be measured, how that will be tracked, those sorts of things, are things that we're still working on with the federal government.

Ms. Chartier: — Okay. And when are you anticipating those performance indicators for the . . .

Mr. Hendricks: — Those discussions are ongoing. And you know, all provinces and territories are really eager to get this money flowing as quickly as possible, so that's been our discussion with the feds is, giddy-up, you know.

Ms. Chartier: — Yes. Are you anticipating . . . In '17-18 obviously, that's . . . You're anticipating money will flow from that 10-year agreement with the commitment to mental health and home care this year. So I'm just wondering, nothing is . . . Well there's an agreement but are you saying that the specific money set aside or earmarked for mental health and home care hasn't flowed?

Mr. Hendricks: — The money hasn't flown to the province yet. The agreement for the funding level has been agreed to, and that was what was signed off, but the money hasn't actually flowed to the province yet.

Ms. Chartier: — Okay. So you need to have the performance indicators and the targets . . .

Mr. Hendricks: — The bilateral agreement with the federal government on all of those things.

Ms. Chartier: — So do you have a . . . Have you been told when that might happen or what is . . .

Mr. Hendricks: — We've been told a couple times that that was forthcoming. I think that, you know, collectively, provinces are . . . would like to see this money come as quickly as possible. As recently as last week, there was a discussion involving this between me and my federal-provincial-territorial colleagues, so it's getting worked on. We want to see, kind of, an agreement as quickly as possible on the specifics.

Ms. Chartier: — Okay. How much have you budgeted for knowing the amounts that you're getting, or what was agreed to? I'm wondering what the incremental amount is for mental health services that you've put into your budget for the '17-18 year.

[16:00]

Mr. Hendricks: — So just for clarity, in the '17-18 fiscal year, you know, in the funding agreement that was signed, the dollar amounts are relatively small. They tend to kind of amplify in later years, and so the investment for home care is $6.34 million and $3.17 million for mental health.

You know, I think that what we have to keep in mind here when discussing this federal accord is the federal government's position is prioritizing certain areas of work that there's a strong interest in. Not that we have dissimilar views from the federal government; these are very big priorities for the province. But what came off the table was that there was a 6 per cent escalator that the federal government had been providing. So at the end of the day, Saskatchewan is seeing a reduction in federal transfers in '17-18, and I don't think we've made that a big secret. That was kind of what the feds put on the table.

Ms. Chartier: — It's down to 3.2. Is that what the escalator, just . . .

Mr. Hendricks: — 3.5.

Ms. Chartier: — 3.5 is what the escalator is now? Or 3.2? I think it's more than 3. It's more than 3.

Mr. Hendricks: — [Inaudible] . . . three and a half, and then bring it down afterwards?

Ms. Chartier: — To 3.2 possibly. Meet in the middle.

Mr. Hendricks: — Okay. It's just . . . yes, there were numbers flying all over the place when we were out there.

Ms. Chartier: — Yes.

Mr. Hendricks: — But what I do want to, you know, I think we want to make a point that, in this year's budget, which was a very challenging environment, one of our investments is around something that we call patient flow and ED [emergency department] waits to expand community-based health services.

So this is entirely in keeping with . . . So there was a $12 million investment announced, part of which will go to establish accountable care units in hospitals and part of which will be invested in the community. That's entirely in keeping with what the federal government was thinking around the home care. In fact they're phrasing it, home care, community care to strengthen community services to reduce the reliance on our tertiary facilities. I think anybody in health care knows that we have to make that shift over time. It's just really challenging to make that shift.

And so we have invested some additional money there without knowing for certain when the federal dollars would be there, but assuming that they would be. You know, that's going to help people with chronic diseases. That's going to help people with mental health issues and the community management of those. So there has been a $12 million investment, as I said, kind of in

keeping with that federal funding commitment.

Ms. Chartier: — Okay, but let's back up here then. So I just want to make sure . . . So obviously that was the whole issue around the escalator decreasing. And obviously the provinces didn't want that to decrease, but the bargaining chip was to have additional . . . So you accept 3.5 and then entrenched money, or money directed for home care and mental health.

So the number that you gave me, Mr. Hendricks, of 6.34 million for home care and 3.17 for mental health, was that additional money that you . . . That was the money that you saw coming from the feds, or that you've budgeted for coming from the feds this year? You gave me the number of 6.34 million.

Mr. Hendricks: — So no, this is the federal government. So when each province signed on, provinces were given a sheet outlining the funding amounts — and I think those are pretty fairly well known — over the next 10 years, kind of where they laid out what would be provided incrementally to the 3 or three and a half per cent for those priority areas. And so as I said, they kind of . . . They're small in the initial years and then kind of increase as time goes forward.

Ms. Chartier: — So it won't be the 19 million for home care this . . . So the 10-year agreement was 190.3 million for home care and 158.5 million for mental health. So you're saying that in '17-18 that it won't be 15.85 million for mental health and 19 million for home care.

Hon. Mr. Reiter: — If I could, in this first year the dollar amounts that Max gave you, just slightly over 3 million for mental health, just over 6 million for home care, they're not even increment amounts. Sort of they didn't take . . .

Ms. Chartier: — That's what I'm asking. Yes.

Hon. Mr. Reiter: — The total and divide by 10. They didn't. It'll accelerate. It starts with the amounts he's just given you and it'll increase slightly over the next two or three years, each year, and then at some point it sort of reaches a maximum, I guess if you will, and then stays consistent for the balance of the 10-year agreement.

If I could just quickly, to a comment you made earlier. And I think you're well aware of this, but sort of the predicament we found ourself in was we weren't happy with the escalator clause. I think it's fair to say none of the provinces were, but we were in kind of this quandary where you also have to get on with business. And the two priority areas, the mental health and the home care that the federal government named, are obviously very significant priorities for us too. So it became, like I said, a bit of a quandary where we want to increase supports in those areas, but we were concerned about the overall drop in the escalator. But at some point we just sort of felt, you know, you can sort of bog this down. And there was all kinds of issues being played out in the media. But at some point, we felt it was just appropriate to try and reach agreement on what the parameters are around that funding and get on with business.

Ms. Chartier: — No, fair enough. So, Minister Reiter, you've just said . . . You sort of laid out that it accelerates over the years, and so the bilateral agreement hasn't been . . . All the details haven't been signed. But I'm wondering what details you're working with because obviously you're working with some if you've just laid out for me that you get X amount now and it accelerates. So my question around the 10-year health agreement, it hasn't been signed yet, but I'm wondering what details we do know of it.

Hon. Mr. Reiter: — So you're testing my memory here. I'm thinking that some of the comments I just made were probably from the federal-provincial-territorial ministers meeting about how the money would flow. So we'll try and get some more detail for you on that, more specifics.

But to your question, what officials are working on right now with federal officials is more the, I would call it the parameters and criteria for the funding: what programming would qualify, what expenditures in general, for both home care and mental health, would qualify for that funding. That's what they're working on right now, trying to find out. We fully intend to make use of that funding. Again, both those areas are very significant priorities for ours. So we want to get those details done between officials, provincial and federal officials, and get on with it.

Ms. Chartier: — Will those performance indicators, will that information be made public once it's in place? I mean obviously I was hoping that you'd have a 10-year agreement signed and we could talk about it and you could table it and we could have a good discussion about that. So once that 10-year agreement is signed, will all those performance indicators for the transfer and the targets be made public?

Hon. Mr. Reiter: — I was just asking my deputy if those kinds of things are typically public. I think they are, so I think that would be the intent. I would just put the disclaimer on it, just in case something comes out of the discussions with the federal government that for some reason parts of it might be sensitive for some reason. I don't know what those would be. But I think the general intent is to make those issues public.

Ms. Chartier: — And again, Mr. Hendricks, you're not quite sure. You said you're hopeful this will speed up and hurry along here, but do you have any . . . like in terms of an anticipated timeline?

Mr. Hendricks: — You know, I think it will really depend on putting a draft bilateral agreement in front of us, having us see what's there, you know, having the discussions with the federal government. So I'm optimistic that can take place quickly, but it will depend on what the federal government, what they have in mind.

[16:15]

Ms. Chartier: — Okay. And what kind of things are you hoping to be, as indicators of your position at the table, when it comes to setting those parameters for the dollars? What are you hoping will constitute mental health spending?

Mr. Hendricks: — You know, we've tossed around some thoughts, ideas on what kind of things we might measure. You know, there's a question of measuring outcomes versus outputs, and so we're having that discussion. But at this point we really

haven't actually had a document from the federal government to react to. So you know, I think we could speculate all day long, you know, and that sort of thing, but it would be interesting to see what their opening position is first.

Ms. Chartier: — Okay. So obviously we'll talk about home care and mental health, but in terms of the 3.17 million so targeted for mental health, do you have a number for what you constitute as mental health spending here in Saskatchewan and in this budget, including that amount?

Mr. Hendricks: — So the regional health authorities are still finalizing their accounts for the '16-17 fiscal year. We don't have that number. But to give . . .

Ms. Chartier: — Sorry. So I know they're finalizing public accounts, but last year you would have set out an amount, a budgeted amount.

Mr. Hendricks: — We don't budget line item for each program. There's discretion on the part of regions to allocate money between various programs. So we don't set specifically the investment in mental health, but we do set various priorities for the health regions.

Ms. Chartier: — Okay.

Mr. Hendricks: — But to give you an idea, in '13-14 the regional expenditures on mental health were 241.350 million. In '14-15 it increased to 248.379 million, an increase of 3 per cent. And then in '15-16 it went to two hundred and sixty million, seven hundred and fifty-six, an increase of 5 per cent. And so, you know, there have been those incremental adjustments in those fiscal years.

Ms. Chartier: — Okay. So are you anticipating, with the money set aside for mental health here, what are you anticipating? I know you said you don't budget line items, but obviously the ministry has made this a priority; it's part of the accord or will be a part of the agreement. So is there an expectation for the '17-18 budget year? What will be spent in total?

Mr. Hendricks: — We haven't specifically . . . You know, we've stated our actions in terms of the mental health and addictions plan, you know, what our priority areas are on that. We've continued to make progress on a number of them. However because of the situation financially, a few of the items that called for, you know, larger levels of investment, unfortunately we couldn't do this year. But we do continue to make progress on specific elements of it. So no, I don't specifically have that.

Ms. Chartier: — Okay. So forgive me here, but . . . So I'm very familiar with the mental health and addictions action plan. But in terms of your priorities out of the action plan, I mean there were recommendations, but what does the ministry see as the priorities out of that action plan?

Hon. Mr. Reiter: — Sorry just to clarify, so are you asking where we would spend the incremental federal money or . . .

Ms. Chartier: — Well I get that. But Mr. Hendricks just said that the government, around the mental health and addictions action plan, you know what your priorities are. And I haven't seen the government's mental health and addictions . . . [inaudible]. So I'm familiar with the document and the recommendations, but I'm wondering what the ministry has priorized out of that.

Hon. Mr. Reiter: — Oh, I see.

Ms. Chartier: — Because Mr. Hendricks had referenced the ministry's priorities.

Mr. Hendricks: — So what I'm going to talk about first is some of the efforts that have been under way and the work that's been under way to support the recommendations of the mental health and addictions action plan.

Ms. Chartier: — Before you start, sorry, Mr. Hendricks, I don't mean to cut you off here, but I am familiar with lots of things that have flown out of that. But has there been anything . . . So out of those recommendations, so I know that you've funded one more position on the PACT [police and crisis team] team, and Regina has the PACT team. And I've got the update from Fern, Dr. Stockdale Winder, that the health region had, and then I heard about the money being spent in your opening comments.

Like I know of some of the actions that you're taking, but I know you had mentioned the priorities of . . . So I'm wondering, because there wasn't anything priorized or anybody identified as being connected with all those recommendations, so I'm just wondering, I know you said the ministry has priorities in mental health, and I'm wondering what those priorities are. Are they housing? Are they like, what kind . . . are they making sure that everybody has access to the support worker they need, whether it's a social worker or psychologist? So I'm like those are the kinds of things that I'm wondering if Mr. Hendricks had mentioned priorities.

Hon. Mr. Reiter: — He's not certainly not trying to answer questions that you don't want the answers to. But the action plan, certainly all the recommendations are priorities for us. So we'd assumed that you meant sort of wanted to run through which of those that we're investing in. But is that, that's not what you're asking?

Ms. Chartier: — Well there's many recommendations, and then they haven't all been acted upon.

Hon. Mr. Reiter: — Right.

Ms. Chartier: — So if things, when you priorize things, you act upon them and put money in them and resources in them. So I'm wondering if the ministry has identified . . .

Hon. Mr. Reiter: — I think that's what he was going to do. I think, if you like, he can start down, if that's not the road you were wondering about, you can interrupt and we'll start over.

Ms. Chartier: — Okay. I'm less looking for individual . . . like there's lots of little pockets of really good work, but I'm wondering if there's sort of overall themes that you've pulled out of that mental health and addictions action plan, and then

obviously things fit into those themes. But you had mentioned the ministry's priorities, so that's what I'm just wondering what the ministry's priorities are around mental health.

Mr. Hendricks: — So if you look in our '17-18 strategic plan, we specifically outline the key actions that we're planning to undertake in this fiscal year or continuing to advance. So one, the first is:

> Lead the inter-ministerial efforts to implement the Mental Health and Addictions . . . Plan as part of a broad approach to improving government's response to individuals with mental health and addictions issues.
>
> Implement a stepped care framework to ensure that mental health and addictions services are based on assessed needs. This will be supported by the implementation of a standardized tool to assess needs, Level of Care Utilization System and provincial electronic client record.
>
> Increase access to effective mental health treatment for anxiety and depression through an innovative partnership with the University of Regina's Online Therapy Unit.
>
> Prevent opioid overdoses by increasing access to a Take Home Naloxone Kit for individuals at [high] risk of overdose.

And so we've set some performance measures as well:

> Number of individual who receive internet based cognitive behavioural therapy . . . [for] treatment of anxiety and depression
>
> > In 2017-18, there will be a 25 per cent increase in the number of individuals who receive I-CBT.
>
> [And the] Number of sites that offer a Take Home Naloxone kit to individuals at risk of opioid overdose.
>
> > In 2017-18, Take Home Naloxone Kits will be available in all health . . . [regions].

The use of I-CBT [internet-based cognitive behavioural therapy] and the expansion of that is, I think, a really important element. The Canadian Mental Health Association was on CBC [Canadian Broadcasting Corporation] this morning talking about, you know, best practice for treatment of depression, anxiety. And certainly something that we've gotten into and are expanding is the cognitive-based therapy. So a really good mechanism, particularly if you're in a remote area too, to have that mobility to reach and undertake that therapy.

Ms. Chartier: — Okay. And also, Mr. Hendricks, you mentioned there were larger items obviously you mentioned, because of the fiscal situation, that you couldn't go ahead with this budget year. So I'm wondering what those larger items were.

Mr. Hendricks: — So in terms of the 10 lead-out recommendations that we really want to focus on, we want to make services easier to find so that we create and consistently update a comprehensive, reliable directory of services, so the ability for people to navigate the system and to have self-management tools for home use.

Internet-based cognitive therapy is kind of one of those things. Decrease wait times for mental health and addictions treatments so that we have services and supports to meet or exceed public expectations. Every month when we do look at our measurements across the system in the ministry, this is something we keenly look to is, you know, the wait times for adults, children, people with addictions, and always want to make sure that we're meeting benchmarks there.

Help primary care providers fulfill their vital role as first contact and ongoing support for individuals with mental health and addictions issues. Reduce wait times and improve response in emergency departments for mental health and addictions issues, and improve transitions back to the community.

One of the things that we really want to focus on, and this is part of this patient-flow initiative, is to provide better chronic management of mental health issues in the community so that people are not showing up in our emergency rooms unnecessarily.

Increase community capacity, as I said, to support people living with persistent mental health and addictions issues. Improve the response of a growing number of people with mental health and addictions issues coming into contact with police, courts, and corrections. And so you know the work that we've undertaken with PACT on that, which I think has been very successful, as has our hot-spotting initiative.

[16:30]

And then, change the service culture to one that's person- and family-centred and that promotes the fullest possible recovery. Improve the coordination of services across all sectors so that any door is the right door for people with mental health and addictions issues. And then, partner with First Nations and Métis people in planning and delivering mental health and addictions services that meet community needs. And then, strategically align and invest across government to reduce the impact and economic costs that result from mental health and addictions issues.

So this is our plan out until 1920. We prioritized things and we're kind of ticking them off. You know, some of them don't require additional funding. Some is about working better as a system and working more smartly as a system. And so those things that we can do, we're trying to do now to improve mental health services. You know, for sure I think it's been a huge priority, certainly of the ministry, of this government. When we have funding available to address mental health, you know, we'll be going and making advances on these recommendations.

Ms. Chartier: — Okay. So you talked about your lead-out recommendations, but I'd asked what you've . . . You had said to me there were some larger items that you couldn't go ahead with because of . . . So you've told me about your lead-out items and where you'd like to get. But so I'm wondering what you would have done this year that didn't get on the table.

Mr. Hendricks: — So generally I think where we would like to emphasize and strengthen mental health services, were funding available, you know, for that would be definitely in kind of those community and residential services, making sure that the supports exist in the community, improving access. It's not just psychiatrists. It's a range of providers that provide care to these individuals. So that's definitely where we would like to see services increase. And again, going back to the reasons I stated earlier, is so that we can prevent cases from entering our emergency room department or becoming acute. And so you know, that will require some investment. But that would definitely be where our priority is and I think where we would look to direct increased federal funding that would flow through the accord once we get an agreement worked out in the future.

Ms. Chartier: — Okay, thank you. Just a few things though that aren't sitting quite right with me. So you've just identified that community and residential services are really important, and that's something you'd like to work on and expand. And I completely and wholeheartedly agree that we get a big bang from our buck from community organizations. You talked about community capacity so people aren't showing up in the emergency room or not costing us Social Services money or Justice money. You talked about how hot-spotting has been successful, and PACT.

Anyway, the comments around community and residential services and the fact that we need better community capacity, I'm wondering why, in light of the fact that we've identified mental health as a priority here in Saskatchewan, that we're cutting money, 10 per cent. There's been a directive from the ministry to cut 10 per cent from our CBOs [community-based organization], our health CBOs.

Hon. Mr. Reiter: — Well again, that funding . . . I don't have to tell you, in the fiscal situation that we're in right now, health is the biggest expenditure in government. So there's no way we're going to be able to get our fiscal house in order without having an impact on Health.

To the CBOs though, as I think we've talked about in question period, where we're at right now is the health regions are going through that. They'll be discussing this with CBOs. That doesn't mean a 10 per cent across-the-board CBO cut. There might be some areas where there's no cut to a CBO's funding and other areas where there's a larger cut than that or perhaps even an elimination of funding. So those decisions still need to be made. As you know, as we've said, mental health is obviously a priority for this government, and I think, you know, it's fair to say that, as health regions go through their recommendations on where those cuts would be and then ministry, we'll be keeping that front of mind.

Ms. Chartier: — Again though, the CBOs are the area where they do the work at a much smaller cost, at less cost than government. So I don't know how you could say in January, when you come to an agreement with the feds, our priority is mental health, and then you've got a mental health and addictions action plan. And I recognize it might not be 10 per cent across the board, but lots of these organizations are really — I'd argue all of them are — about saving the system money in the long run. You think about something like the Lighthouse in Saskatoon. And Mr. Hendricks has just identified the fact that showing up in emergency rooms is not cost effective, going into justice . . . or into police cells is not cost effective.

I wrote a letter to you in that regard, and hoped that you would have advocated to the Minister of Social Services to keep the per diem funding for folks on social services because it does in fact have a larger impact on health. And that community spending is a way to ensure we're getting the best bang for our buck.

So what is your directive in terms of review? What is your expectation? So your expectation is 10 per cent, maybe not across the board. But what have you directed the regions to do?

Hon. Mr. Reiter: — The regions are going to be consulting with the various CBOs. The regions then will go through their budget process. They'll make recommendations to the ministry, and then the ministry will look through it and make recommendations from there.

Ms. Chartier: — So what if the regions or any of them or all of them come back saying, these are essential services to ensure that we are not spending more money in Health, Social Services, Justice, all those places? So have the regions been told, you have to come up with 10 per cent savings?

Hon. Mr. Reiter: — Well again, in a difficult budget there's a lot of difficult decisions that have to be made, so the regions have been directed to make recommendations to come up with funding equivalent to a 10 per cent cut. So we'll see what they come back with. After they've done their due diligence, the ministry will review and we'll take it from there.

Ms. Chartier: — I would argue that those cuts are going to be counterproductive and go . . . I mean Mr. Hendricks has just identified priority of the ministries on community and residential support. And many of these organizations provide those very supports.

One of my concerns here . . . Sorry, I'm just looking back to my numbers. So 3.17 million for mental health. Sorry. Okay, 3.17 million for mental health from the feds, so that's designated money. My concern is that there's money that's going to go down. So as Mr. Hendricks identified, there's less money from the feds, but there's some targeted money.

My concern here is that money that we already spend on mental health. So you can say yes, we'll spend this 3.17 million this year from the feds, but my concern is in things like this 10 per cent cut, that it'll start to chip away at what we've spent. Is there a guarantee that mental health funding . . . So you've got the 10 per cent . . . You've got the 10 per cent . . . [inaudible interjection] . . . Well you don't even know what the question is yet — sorry, Mr. Minister.

Hon. Mr. Reiter: — I know what the topic is.

Ms. Chartier: — Yes, you've got 10 per cent where you've identified CBO spending, and you've got some money coming from the feds. Can you assure people that mental health funding will remain intact? So the number . . . You don't have the '16-17 number yet, but I would trust that that number, that mental health spending won't drop. Is that the goal?

Hon. Mr. Reiter: — You're asking me to presuppose what the health regions will come back with. You're also making the . . . Well you're just simply asking me to presuppose what they're going to come back with. I don't know yet. There are no guarantees at this point. We need to see what the recommendations are going to be. And as we go through it, we will very much keep front of mind the fact that mental health is a significant priority. But again, we need to allow the regions to do their work and the ministry to do their work.

Ms. Chartier: — So the regions come back with . . . I'm not just talking about the 10 per cent though. I'm talking about the number . . . '15-16 it was 260.756 million that was spent on mental health that you identified for me. And I'd like an average . . . or not an average, an estimate. I know you don't have hard and fast numbers yet for '16-17, but I think I'm looking for reassurances in light of the fact that we've identified, as a province, that mental health and addictions is a priority of ours — we're getting designated dollars from the feds — that we're not going to reduce the amount of money that we're spending on mental health this year.

Hon. Mr. Reiter: — You know, I've said several times today already and many times in the past that mental health is a priority for this government and that we fully intend on using every available federal dollar that we can to enhance supports.

Ms. Chartier: — Do you anticipate finding . . . Well I shouldn't say that. You are obviously anticipating that because you're asking CBOs to come up with or regions to come up with 10 per cent in cuts, which again I think is a wrong-headed move because that is where we save money, is on organizations that are doing that cost-effective front-line work for us.

In terms of PACT, just a quick question here. So I know you often talk about the benefit of PACT. It rolled out as a pilot project in Saskatoon and it's in Regina now. But just in terms of coverage for PACT, can you just let me know . . . I know it's not 24-7. If you could just let me know how much in both Saskatoon and RQHR that gets covered.

[16:45]

Mr. Hendricks: — Sorry for the long delay, and we'll actually have to get back to you as to what the exact hours that they're covering are. So there's two shifts in Saskatoon and one in Regina, so we would have to see in Saskatoon whether that's 24-7, that sort of thing.

Ms. Chartier: — I think in Saskatoon it's . . . Well police officers work 12-hour shifts, so it's one 12-hour shift and then another 12 hours. So police officers work four on, four off, so the coverage is . . . It's a great program, but coverage . . . You're lucky if you've got someone covered. And do they work the 12-hour? I think I want the clarification, too, if the PACT worker is working with the police officer for that 12-hour shift too.

Mr. Hendricks: — Yes.

Ms. Chartier: — Thank you. Thank you for that. And in Regina there's only one shift, so one police officer and one PACT employee. So that's one shift out of . . . like when you've got four platoons.

Mr. Hendricks: — Correct.

Ms. Chartier: — Okay. And hot-spotting you had said was working well, Mr. Hendricks. So is the plan to continue on with both hot-spotting and . . . It's called Connecting to Care in Saskatoon and hot-spotting here, is that correct?

Mr. Hendricks: — I believe it's called Connecting to Care here in Regina.

Ms. Chartier: — I got it backwards?

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay.

Mr. Hendricks: — So in Regina, to date they've had 101 patients served, 76 active patients. The cost in the top 5 per cent has been reduced mainly due to reduced acute care stays. So they are making a lot of progress in terms of connecting with clients. Saskatoon, 57 patients have been served to date and with 26 active patients.

And so, you know, in terms of the teams that have been assigned to those in Regina, you have a full-time kind of pilot manager, a primary health care nurse, a primary health care counsellor, and then client wellness advocates, one social worker, and a paramedic.

And then in Saskatoon, a palliate manager; as well, a nurse practitioner, a psychologist — all three of whom are halftime — two and a half FT [full-time] social workers, and then a point seven FT elder. Yes, those programs are producing, I think, very good outcomes.

Ms. Chartier: — They just got rolling full time. So they were funded a couple of years ago and it took a while. I know there were privacy issues in figuring that out. So was '16-17 the first fiscal year for both of them to be in, like in full operation?

Mr. Hendricks: — Yes.

Ms. Chartier: — And the plan is to keep those going?

Mr. Hendricks: — That's the plan, yes. There has been no discussion of . . . [inaudible].

Ms. Chartier: — And how much money has been allotted for both hot-spotting and Connecting to Care?

Mr. Hendricks: — Okay. So far over the last three years we've invested 2.63 . . . six five million dollars, sorry, in the hot-spotting initiative. So in '14-15 it was 1,053,000. It dropped in '15-16 to roughly 454,000. That wasn't because we were pulling money back. It was just because they had a slow start. And then in '16-17 the funding was $1.128 million.

Ms. Chartier: — Okay. And that was in Saskatoon or Saskatoon and . . .

Mr. Hendricks: — That's combined.

Ms. Chartier: — Combined.

Mr. Hendricks: — Saskatoon and Regina.

Ms. Chartier: — Okay, thank you. Okay, just going back a moment here to the amounts that you were giving me for mental health spending, did that include the capital for the hospital or was that just operating for programs?

Mr. Hendricks: — No, the capital for SHNB [Saskatchewan Hospital North Battleford] is in the Government Services budget, Central Services.

Ms. Chartier: — In Central . . . I was wondering. I noticed that there wasn't any big spending but I . . . So it's not accounted for in what you consider your mental health spending. That's just . . .

Mr. Hendricks: — No.

Ms. Chartier: — Okay. Again just with the '16-17 numbers for the mental health spending, do you have a ballpark figure? I know you said the regions haven't finalized their number yet but do you have a ballpark?

Mr. Hendricks: — I don't have a ballpark. Like, you know, it would have likely increased by, for sure, whatever the costs were, you know, kind of the salary costs and that sort of thing across the sector, but we don't have our '16-17 materials here to kind of guesstimate it.

Ms. Chartier: — Okay and that's . . . So Public Accounts comes out at the end of June or in June. So when will the regions have, when will you have all that information around the '16-17 numbers?

Mr. Hendricks: — In June, I believe. Just checking with my CFO [chief financial officer]. Yes, in June.

Ms. Chartier: — In June. Okay. In terms of the home care numbers . . . So we talked a little bit about the mental health numbers coming from the feds. What do you have coming from the feds for home care this year, the incremental amount?

Mr. Hendricks: — The funding amount is $6.34 million for '17-18.

Ms. Chartier: — Sorry, six . . .

Mr. Hendricks: — 6.34 million.

Ms. Chartier: — For home care. Okay.

Mr. Hendricks: — Home and community care.

Ms. Chartier: — Home and community. How would you . . . Sorry. Forgive my ignorance here, but could you tell me the difference between home and community care?

Mr. Hendricks: — Well home care, you know, is a pretty narrow definition if you kind of use the traditional sense about home care worker going into home. And yes, we would like to expand that. But you know, there are other community supports that can be provided by different types of health professionals. And so the federal government has broadened its definition of kind of that area as well so . . .

Ms. Chartier: — That day programming, would that be included in . . .

Mr. Hendricks: — It could include any of that type of thing. You know, it could include the work that we're, you know, talking about expanding in Regina, where expanded or extended primary health care teams are, you know, engaged in interventions with chronic disease patients, you know, visiting them more frequently, connecting with complex patients in the community, so that kind of range of services, or more about moving, as I said earlier, from a tertiary to a community-delivered service.

Ms. Chartier: — Do you have those numbers? You gave me some equivalent numbers for mental health. Or do you have those equivalent numbers for home care, for the 2014-15, what's been spent for home and community care in those years?

Mr. Hendricks: — So for home care, now this is the very narrow definition of home care. What I just talked about in terms of community services, those are often budgeted in different envelopes than this one. But we know you always ask about this one, so we have it. So in '13-14 it was 169.818 million. In '14-15 it was 175.286 million, an increase of 3 per cent. And in '15-16 it was 187.727 million, an increase of 7 per cent.

Ms. Chartier: — Okay.

The Chair: — Before we . . . Okay, you can finish your answer, but we'll take a five-minute break.

Ms. Chartier: — Okay, thank you.

[17:00]

[The committee recessed for a period of time.]

The Chair: — Okay, we will resume. Mr. Hendricks, you may finish your answer, if it's not finished. Well, then we'll move on to Ms. Chartier.

Ms. Chartier: — Thank you for those numbers on dollars spent. Do you have the utilization rates of home care, the numbers of people served for those years?

Mr. Hendricks: — So we have several statistics on home care clients. So how far back would you like?

Ms. Chartier: — Is it a document you could table?

Mr. Hendricks: — I suppose we could. I'll read them into the record. Is that okay?

Ms. Chartier: — How many . . . like are they simple numbers?

Mr. Hendricks: — Just the clients for '13-14 is 37,151, 6 per cent increase from the previous year; '14-15, it's 40,922, it's 10 per cent increase; and 43,104, 5 per cent and that goes back to

’06-07. It’s not in a table in format tonight because there’s other stuff on here.

Ms. Chartier: — Okay. So sorry, what was ’14 then? Did you say 49 . . .

Mr. Hendricks: — So for ’15-16, 43,104.

Ms. Chartier: — 43,104. Okay.

Mr. Hendricks: — ’14-15 was 40,922.

Ms. Chartier: — 40,922. Okay.

Mr. Hendricks: — And ’13-14 was 37,151.

Ms. Chartier: — Okay. And those are people being served across the province?

Mr. Hendricks: — Yes.

Ms. Chartier: — And is there a breakdown between home care and Home First/Quick Response in those numbers?

Mr. Hendricks: — We don’t have the numbers for Home First/Quick Response, but we do have supportive care clients. So that would be your straight home care. And so those would likely, well obviously, include the home care quick response. So the numbers are . . . In ’13-14, 20,617; 19,282 in ’14-15; and 18,971 for ’15-16.

Ms. Chartier: — So sorry. You said those . . . Can you explain what . . . I’m sorry. I don’t understand what those numbers are.

Mr. Hendricks: — So supportive care clients are those that receive service on an indefinite basis so, you know, remain in the community whose supporters require respite or for whom neither palliative nor acute care services are required. So that’s the meals, the homemaking, the nursing — the traditional kind of home care that . . .

Ms. Chartier: — Okay. And then the other numbers that you gave me for those same years, those are not . . . Are those client numbers or discrete visits or would . . .

Mr. Hendricks: — That’s number of clients.

Ms. Chartier: — Number of clients. Okay. So included . . . So the difference here, just for example, of 16 . . . So you gave me ’13-14, ’14-15, and ’15-16 there.

Mr. Hendricks: — The reason that the supportive care clients are decreasing is because the number of acute care clients is actually increasing, so those that require very specific interventions for a period of time. And so those numbers have gone up very significantly from ’13-14. They were 12,903 clients, up 35 per cent. In ’14-15, 15,824, up 23 per cent; and then 17,499 in ’15-16, up 11 per cent. So they’ve kind of traded off and shifted to that area.

Ms. Chartier: — So but that means that people needing supportive care . . . I’m wondering about wait-lists then. So obviously there’s X number of dollars in the budget, and you’ve decreased the number of supportive care clients. I don’t think those needs have decreased. Could you just, while you’re getting those numbers, could you just give me some examples of supportive care clients? So that would be someone who would need help with a dinner or light housekeeping, those kinds of things, over the long term?

Mr. Hendricks: — Yes, that would be correct. So this might be someone that, due to decreased mobility, that sort of thing, requires assistance in preparing meals, housekeeping, you know, certain elements of personal care, that sort of thing.

Ms. Chartier: — Okay. So in the acute care, clients are obviously a shorter term, discharged from hospital and support with bandage changes or those kinds of things.

Mr. Hendricks: — As well as the personal service.

Ms. Chartier: — Personals, yes.

Mr. Hendricks: — So that would be somebody that is coming . . . It’s kind of therapeutic while they’re, after they’ve been discharged from hospital but time limited.

Ms. Chartier: — Yes. So do you track wait-lists across the province?

Mr. Hendricks: — We do. We’re just trying to get that for you right now. Unfortunately we don’t have that with us, and we’ll have to bring that back.

Ms. Chartier: — Could you bring that back tomorrow?

Mr. Hendricks: — We’ll sure try.

Ms. Chartier: — That would be . . . Yes, so that would be great. And so just for my clarification then, the Home First/Quick Response is included in those numbers then, in the supportive care numbers. So you’ve given me total numbers, and then you broke out acute and supportive, so direct . . . The Home First is under the supportive.

Mr. Hendricks: — So to be clear, well first of all, just in conferring with my assistant deputy minister, it’s unlikely that we will have those wait times for tomorrow. We’ll have to generate those, so we’ll have to table that with the committee afterwards at some point.

So I maybe was a little bit off the mark when I said that all Home First/Quick Response would be in the supportive care numbers. It kind of depends on what type of service they need. So as you’re aware, when those folks come into the emergency department, they’re assessed and the type of care that they’re actually . . . [inaudible] . . . they’re connected with those teams. So some of them would require supportive care; some would be the acute type of care. And so they could fall under any of those categories depending on the referral for service that they need. And they might not fall under any category if it was a different type of health worker that could support them in the home or meet their needs or support their needs in the community.

Ms. Chartier: — Okay, so if they’re not getting home care, they wouldn’t be in . . . [inaudible interjection] . . . obviously,

yes.

Why the shift in acute care? What happened there? Or why has that number gone up over just the three-year period?

[17:15]

Mr. Hendricks: — So a good part of the acute home care services is related to the surgical initiative. So money was invested in additional programming there with the surgical funding, just because if people can go home to convalesce, it's better for them and it's better for the system. So providing those types of rehabilitation and home care supports.

Ms. Chartier: — Okay. And then the drop in supportive care?

Mr. Hendricks: — We would have to see exactly why those numbers are dropping. So we'll look at that.

Ms. Chartier: — Okay. Thank you. In light of the fact that obviously home care, home and community care has been identified by the province, and the feds have agreed that that's an important thing, I'm wondering if you've done any analysis, just a jurisdictional comparison of where we stack up on support of home care with other jurisdictions?

Mr. Hendricks: — I don't have an interjurisdictional comparison. I know that just from discussions more anecdotally at FPT [federal-provincial-territorial] tables that, you know, some provinces I think are well . . . and as reflected by the federal-provincial agreement on the funding, the federal funding, there's a strong interest by all provinces in moving more in this direction. And it's been kind of universally said that additional funding in this area would be much appreciated.

So obviously one area that we want to focus on, and you know, in terms of the federal priorities, this was one area that we felt was a provincial priority, you know, increasing funding not just for home care but for community-based supports. We tend to focus on the broader definition. And so, as we look at the federal government, see what the agreement looks like once we have that from the federal government, we'll look at, you know, what possibilities there are in the future.

I do think that, you know, as time goes on, as I mentioned earlier, that the goal is to shift as much as possible from tertiary to community. You know, tertiary is relatively expensive and I think there's been a recognition across Canada we rely too much on that area. So you know, we needed to strike the balance. You can't just do this overnight, pull all the money out of tertiary and throw it into community care. So kind of incremental investment over time would be the direction we would take.

Ms. Chartier: — I should know this, but does CIHI [Canadian Institute of Health Information] track those numbers around home care? You know what? I can search myself for that. We've got lots of things to . . . I was just wondering obviously in light of the fact that it's . . .

Mr. Hendricks: — I can't remember off the top of my head.

Ms. Chartier: — Okay. Okay, just a quick question. We were talking about the health care, the directive to the regions to cut 10 per cent from the CBOs. Have there been any other health directives to the regions? So you've directed the regions, I know, around spiritual care. I've been told that you've cut spiritual care, and that's been a directive that regions can't choose to spend money on spiritual care. So I just want to clarify that.

But the second part of my question is, are there any other directives to the regions on what they can or can't be spending money on?

Hon. Mr. Reiter: — So I'm just going to run through quickly, but in case I miss some . . . And some of these may not be regions, some of these may be provincial. But just so you're aware though, and I'll do this very . . . Well I'll do this first. There was a hearing aid plan. There was podiatry services. There was the continuous positive airway pressure generators, low-cost orthotics, and the pastoral care one. Now in case I miss some, or it didn't get to the point in your question, and any of those sorts of directives were announced publicly on budget day.

Ms. Chartier: — No, for sure. But the 10 per cent wasn't announced publicly. It was because we asked about it that you talked about it. So I'm wondering if there's anything along those lines of that 10 per cent CBO cut. Is there anything like that, that we'll learn about in the coming months, that the ministries have been directed to not . . . or sorry, that regions have been directed to not spend money on?

Hon. Mr. Reiter: — Yes, there's constant flow of information between the ministry and the regions, so I'll just check with them.

Mr. Hendricks: — So on budget day there were the announcements to change, as it were, RHA [regional health authority] programs preventional in nature. But also within the health care budget as we go forward with regional health authorities, I believe we mentioned last time that we've asked them to submit budget plans to the ministry or balancing proposals. And so that work is currently under way. Obviously given their funding levels, you know, there are going to be some things within that work that require other adjustments across the health sector to specific regions.

So I just don't know. It's too early to say yet what that might involve. Obviously the marching orders when we talk to regions and when we work with them is, the smallest impact on patients possible. You know, wherever there's going to be an effect on personnel, that we do everything to reduce that through attrition, whatever. But you can't always avoid it. So there are some of those things that we will see in the region budgets which quite frankly we have to go through and make decisions with the minister on.

You know, I think within the budget in terms of direct impact to clients, those were kind of the key ones that were announced on budget day. You know, there were small funding adjustments made to programs based on utilization or whatever, that sort of thing. Kind of the ups and downs that we always do when managing a budget. So if an uptake is low on a certain program, we reduce the next year's budget for that and, you know, that's

kind of how we manage.

But I can't think of any kind of other universal ones that we've announced already or made a decision on.

Ms. Chartier: — Okay. So I guess, well I guess with the move . . . I've been told around spiritual care that a region couldn't even spend money on spiritual care if . . . There was the announcement with a cut to spiritual care, and I've heard that some places would like to keep it. So there's not even . . . So in a region doing its adjustment — obviously we're moving to one health region — there's no room in a region to make the call that that's what they feel that it's important and want to keep.

Hon. Mr. Reiter: — We recognize the importance of spiritual care which, by the way, it will be region facilities, not affiliate facilities, affected by that. But we are looking for some consistency across the province because there's cases right now where some health regions provide funding; some don't. And as you point out . . . You're right. I mean we're moving to one region, so I think consistency is even more important when that's completed. Again we recognize the importance of it, but we think, for instance, in the regions where funding isn't provided, typically religious organizations step up and provide that sort of care. And we're hopeful that that'll happen in the regions that have been providing funding up until now.

[17:30]

Ms. Chartier: — I don't want to have a debate with you here about that, but it is a very different thing than . . . Pastoral care is very different than spiritual care and is non-denominational and there are people who have master's degrees. And it's a very different thing than pastoral care. And actually this cut will make it impossible for those pastoral care folks, the religious folks, to be able to provide some of their care because it's actually the spiritual care services in places like the Saskatoon Health Region who have the lists of patients and their religious affiliation, and then connect them with their . . . So it will end up having an impact, but I don't want to have a debate with you here about that. I will respectfully disagree, and I think that there's some misunderstanding there.

I did have a mental health question actually going back. So, Mr. Hendricks, you just made some comments. We talked a little bit about the Lighthouse. And you summarized the importance of mental health and expenditures and where money should be spent and you need a range . . . You actually talked about needing the range of providers who can provide services. Sorry, I was just trying to find my notes here. So you talked about needing the range of providers who can provide mental health service.

I'm wondering your thoughts on the cut to the RQHR psychology residency program.

Mr. Hendricks: — So Regina Qu'Appelle has decided to take a one-year hiatus from the CPA [Canadian Psychological Association] accredited, pre-doctoral residency in clinical psychology for the '18-19 fiscal year. The only impact on clients from this move will be positive as increased caseloads can be taken on by RQHR staff who previously needed to spend significant amounts of time supervising these Ph.D. [Doctor of Philosophy] students. There will also be a financial impact of this with savings of about $72,000. There will not be any negative impact on any specific students. And the commitment to training psychologists in RQHR hasn't changed. They're still teaching the undergraduates. They provide approximately 15 to 17 placements a year. It's just that at this doctoral level that they're taking a one-year hiatus.

Ms. Chartier: — Well that . . . Okay. There's lots I think possibly incorrect with what you've got there for the . . . I think there's been some misinformation about the managing, the number of hours that are required to manage.

So this is coming from the University of Saskatchewan who also has a residency program, who is hugely concerned about this. And I know, Minister Reiter, you just got a letter. You may not have seen it yet, but . . . And I've had a conversation with a few folks about this.

But in terms of cost, you've identified that each resident is paid $31,500 per year or about $17.50 per hour for 1,800 hours of work. In return the province receives a full year of work from a mental health provider with approximately nine years of combined undergraduate and graduate education. And just four hours per week of supervision is standard, and since half of that can be provided in regular team meetings to increase efficiency, there's little draw on professional time to support residents. So that's one of the points in your letter.

I think this is a huge . . . I've heard from several psychologists, doctoral psychologists who are hugely concerned about taking a hiatus. So I understood . . . So you're telling me that it's not the '17-18? I was told that it was '17-18, that they'd already hired students for it. And so just can you clarify that firstly?

Hon. Mr. Reiter: — Sorry, if I could . . . I know you're sensitive to the time and so I am too. We can have the discussion, but I'm not sure we're going to be able to sort of answer it in any detail. You're right. Staff just told me a letter came today. I haven't had a chance to see it yet. If you're okay with this, you know, we'll look into it. We'll try to answer it tomorrow. If we can't, we'll answer it as soon as we can. But this is a new issue for us as well.

Ms. Chartier: — Yes, and it's a hugely problematic issue. If we talk about low-cost mental health services of people who are highly trained, this is a program that has helped clear wait-lists up because those folks don't have to manage wait-lists. They just get to see clients. These are people who are highly educated and have what we need to reduce those wait-lists to provide people the supports to get well in a short amount of time. I'd like your comments on this tomorrow once you have an opportunity. This is a program that needs . . .

And there is some risk with taking a hiatus from it as well. It's an accreditation program. I believe accreditation is up next year. And so this puts the program, the whole accreditation program at risk. And I mean it's a wonderful program that draws residents from across Canada. So this is a huge issue.

Hon. Mr. Reiter: — Sure. If you're okay with that, we'll try to provide a response for you tomorrow; if not, as quickly as we can.

Ms. Chartier: — Yes, I'd like to talk about it further tomorrow. This is one of those things that is hugely problematic and needs to be rectified, quite frankly. And I know regions are under a lot of pressure financially, but this is something that in the long term saves us money and ensures people have the mental health supports that they need. So we can talk about that further. You'll have an opportunity to review the letter and we're here again tomorrow, same time.

Hon. Mr. Reiter: — The concerns you raised, certainly we'll look at them. We'll have officials also talk to RQHR officials and we'll do our best to have answers for you tomorrow.

Ms. Chartier: — Okay. The best answer would be to save this very low-cost, like $70,000 program to ensure people got their mental health. That would be ideally the answer that I would like tomorrow, but we'll see what happens.

Just moving on here, this is actually where I had wanted to start, and I just had a few questions. I know we talked about this last week, but on organ donation. Just in reviewing the *Hansard*, I know, Minister, you had said that you would like to go as far down . . . In your conversations with Justice you want to go as far down the presumed consent path we could go. So I didn't ask for clarification. I'm just wondering what that means and what presumed consent . . . I want to know what that sentence means as far . . . You were talking to Justice about going as far down the presumed consent path we could go.

Hon. Mr. Reiter: — So our officials are talking to Justice officials. I'm not a lawyer; I don't pretend to be. But I know there's some, you know, potential Charter issues around this. There's some potential . . . If you do presumed consent, there's some potential opt-out issues. So we just want this sort of fully, completely looked at by legal experts. So that's sort of where it's at right now, and we'll see what they come back with.

Ms. Chartier: — Okay. So just to clarify then, just to make sure that I'm hearing you right, that you're asking Justice to find out if you choose presumed consent, what the obstacles and pitfalls are and if that's even a possibility.

Hon. Mr. Reiter: — I think it's fair to say that would be part of it, but we're not sort of trying to tie their hands or restrict it. Any information, advice they can provide, sort of on the whole topic, we're certainly wanting to look at.

Ms. Chartier: — Okay. And just out of curiosity, I'm curious . . . It was the Premier who in a scrum . . . It wasn't around you or anybody else doing media around organ donation. It was the Premier in a scrum on a very different topic, who then started talking about presumed consent.

Did you have a conversation prior to your . . . to the Premier that that was a direction that you'd like to go as the minister? Or where did the Premier get the notion that . . . A report had just been tabled with the legislature on organ donation, and the Premier, in a scrum, talked about something very different than what was in that report. So I'm just wondering what conversations you had with the Premier about organ donation, if there was any.

Hon. Mr. Reiter: — I have discussed the issue with the Premier on more than one occasion in the past, so I think the, you know, the comments in the scrum . . . No, I'm not sure. I haven't heard the transcript of the scrum. I don't know, sort of, who asked the question or those sorts of things. I've also commented publicly on it as well.

Ms. Chartier: — He just threw it out there as . . . It wasn't a scrum about the . . . It wasn't about organ donation. So I'm just wondering if prior to that . . . As the Health minister you have your report, a tabled report, and I'm wondering if you and the Premier had sat down and you'd shared with the Premier, here's the report, and you guys chose together to take this path. Or what would drive you or him, following the report, to suggest that that should be the way to go?

Hon. Mr. Reiter: — I think through the entire year, but especially when session is on, I typically see the Premier several times a day. So like I said, we've discussed this issue on more than one occasion but I know we also discussed it after we were aware of the contents of the report, yes.

Ms. Chartier: — Was that the path that you had wanted to go down?

Hon. Mr. Reiter: — I'm very comfortable with that. Yes, I am.

Ms. Chartier: — Presumed consent.

Hon. Mr. Reiter: — I can appreciate sort of all the considerations the committee had to make. And as we discussed — I was going to say yesterday — last week on Thursday, there was a dissenting opinion as well. It's not an easy problem to grapple with but as I mentioned to you before, this is an issue that's very important to me personally.

Ms. Chartier: — I just wondered where that idea for presumed consent had flowed out of.

Hon. Mr. Reiter: — I don't think it's a new idea. I think it was probably, as you mentioned last week, was discussed in committee as well, the committee that did the report.

[17:45]

Ms. Chartier: — And it wasn't a strong recommendation. But anyway, I just was curious what all led to that. So thank you for clarifying that for me.

I'm going back here. Sorry. This is as per usual in Danielle fashion here. I'm going back here to ask you about the 12 million that you'd mentioned on ER [emergency room] waits. You had mentioned it in reference to mental health and addictions, and obviously shortening ER waits is tied very closely to mental health and addictions in some regard along the line, and as is chronic disease, home care, all those kinds of things. But can you tell me a little bit about the $12 million and what that will be spent on?

Mr. Wyatt: — Mark Wyatt, assistant deputy minister.

So with the announcement of the $12 million in the budget, we have two general areas that we are looking at: working with health regions to invest to help to improve emergency

department wait times, but the sort of the strategy being to improve patient flow through the hospital and also to try and reduce some of the use of emergency departments and the need for people who become in-patients and contribute to that congestion in hospitals.

So the two major strategies are the one that's already been announced around accountable hospital care or accountable care units. This is based on some initial work that Regina Qu'Appelle has done, starting in one unit, but they've already subsequently begun to introduce it in two additional units at the Pasqua Hospital.

And it sort of leverages several strategies within a hospital in-patient unit, including having dedicated physician support and involving a physician on the unit who works much more closely with the staff on the unit and will have a more consistent understanding of the patient's needs. And support goes a long way towards supporting expedited recovery and identification of what the patient's needs are and developing that discharge plan to expedite recovery.

And the experience with the accountable care units in Regina has been both that it is leading to earlier discharge, but also having an impact on readmissions, on patient satisfaction, on all of the metrics that they are trying to support through that initiative.

So we're looking at rolling that out in Saskatoon as well, and so we've already begun discussions with the Saskatoon Health Region around introducing the accountable care unit in St. Paul's Hospital is the first location that they've identified for that work.

The second area that we've identified, and again I think it takes you back to the earlier conversation that we had around the importance of providing community- and home-based supports in order to both prevent the need for an emergency department and in-patient admissions, it's also a critical strategy for helping pull patients out of hospitals. And so there's a fairly major national discussion around alternate-level-of-care patients who are in hospital but are waiting for some level of . . . Their acute care needs have been met, but they're waiting for some form of placement or community-based support.

And so the other side of the investment that we're looking at making with the $12 million is how do we build up some of those home- and community-based supports so that we can help pull patients out of acute care who are waiting either . . . I mean it's always been traditionally thought that they were primarily waiting for long-term care, which is true that many patients are waiting. But once you start to scratch the surface, you soon discover that there are many patients waiting for other forms of care along with long-term care where other community-based, either home- or community-based interdisciplinary teams can provide that care and help to move that patient flow out of the hospital, which then helps to create the flow through the emergency department.

Ms. Chartier: — So the accountable care units, so what is the cost of role expanding that?

Mr. Wyatt: — We haven't determined the exact cost. We're in the process right now of working with Regina Qu'Appelle and Saskatoon health regions. Those are the two regions that we are primarily working with because they are the two regions that have the greatest over capacity and emergency backups. We're looking at probably less than half of the funding going into the accountable care unit and probably the majority going into community-based supports area.

Ms. Chartier: — So what are you envisioning for the community-based and home-based supports program?

Mr. Wyatt: — We haven't . . . At this point we've held meetings with Regina and Saskatoon. We've been talking about what the proposals might look like in each region. So we don't have approved detailed project plans with either region or funding plans for either region. I can just say generally the idea is to try to identify what are the service needs. And both regions are looking at, looking at the data around emergency department admissions, around acute care length-of-stay patients, and areas of those communities that have high use of in-patient beds, and looking at what are the target services that that population group needs. And in some cases, depending on the demographics, depending on the service needs, it may lead you to different kinds of members of an interdisciplinary team based on what those care needs are. So that's really what we're working through with the regions right now.

Ms. Chartier: — So are you . . . I just am wondering though because there's $12 million and you've talked about the accountable care units and that being a portion of the money. And you've got some legwork obviously to do, but there must . . . And it's about community-based supports. And you said the general idea is to identify service needs, looking at data of ER admissions and acute care length of stay, all those things. But are you thinking — like help me understand — are you thinking about residential care? You must have some idea on how . . . You have to look at the data and figure out the numbers, but I'm wondering what the general plan is.

Mr. Wyatt: — So I'll just come back to saying that we, you know, we don't have approved plans with either region. We've had some discussions. Regina, for example, has a fairly well-developed primary care network system, and so I think they would look to how this investment would be integrated with some of the existing primary care networks and services that they are providing, and looking at how they can align and augment what's currently in place in Regina.

Saskatoon I think, you know, quite similarly, would be looking at how it's integrated with primary care, with home care services. Saskatoon has already . . . Well actually both locations are looking at how they align things like Connecting to Care, Home First, seniors house calls, primary care. There are a number of services that are I guess in some cases funded or delivered differently. But I think in both sites they're trying to see how they bring a more I guess just an integrated method of delivering those services.

And so with the investment through the $12 million, I think we would expect to see both of them looking to integrate some of these services so we're not creating a siloed program, but really looking at integrating with existing primary care and community-based services.

Ms. Chartier: — So it's less about, sort of, new investments and new things, but working with what you've got and making them work better together. Is that what I'm hearing you say?

Mr. Wyatt: — I think that's, I think that's an accurate assessment, yes.

Ms. Chartier: — Okay. And so about how much will go to RQHR and how much to Saskatoon Health Region of that . . . As you've said, most of the money will be for, or a smaller portion will be for accountable care, but of the 12 million how much are both regions expecting to make this work?

Mr. Wyatt: — We haven't committed a . . . We haven't committed a funding level to either region. It will be based on the proposals that they submit. And I think we'll need to assess them and look at both by region and by the accountable care and community care areas, what funding levels would support the services and based on the proposals that they're submitting.

Ms. Chartier: — Okay, so again just to clarify, it's not building new services but building how those services that exist are working together? It's a good chunk of change to get. Will it be annualized? Well obviously it'll be a single health region, but is the goal that that investment would carry on years forward? I'm not quite sure I understand.

Mr. Wyatt: — So this is incremental funding. Unless the funding is removed from budget in a future year, we would expect that it would annualize and carry forward, and that's certainly the basis on which we are developing the plans with those two health regions.

And you're right, it is a significant amount of funding. And so, you know, we certainly are expecting to see an intervention into this area, a significant intervention into this area. But I guess what I'm trying to say is rather than creating new interdisciplinary teams that are working in a silo alongside of home care resources and primary care teams that are working a particular area, we would fully expect that they would be working together and trying to coordinate the service that's provided to that population group.

Ms. Chartier: — Okay. I'm going to ponder that for a little bit, and I may come back to that tomorrow just to see if I have any further questions. So the government has spent money previously on ED wait times. And the original commitment by the Premier was by 2017, March 31st of 2017 there would be no ER waits, and then that was walked back. And so can you tell me where you're at? So it's the next . . . Can you refresh my memory on what the secondary commitment was and where we are in terms of meeting the benchmarks because I believe there was some 2016-17 benchmarks.

Hon. Mr. Reiter: — The target you were asking about, it was 60 per cent reduction by 2019.

Ms. Chartier: — Sixty per cent of which? What was the benchmark year?

Hon. Mr. Reiter: — '13-14.

Ms. Chartier: — '13-14. And so I know, but there were some interim benchmarks in there. I don't have it in front of me, and if you don't have it, I'll bring it tomorrow. But there were some interim benchmarks, if I'm wondering where we're at on meeting that 60 per cent by 2019.

[18:00]

Mr. Wyatt: — So the operational targets that we've had, we've had in-year targets since the time that we moved to the 60 per cent overall reduction. And so the operational targets to the end of 2016-17 would have been a 35 per cent overall improvement.

Ms. Chartier: — And where are we with that? So . . .

Mr. Wyatt: — Basically we've made minimal, or in some cases we're holding on to the baseline. And I think it's important to point out that since that '13-14 year, we've seen a 20 per cent increase in the number of emergency visits across the province during that same time. And so we've been, I guess, trying to improve the performance of the system at a time when we've seen that pretty significant increase.

And obviously, I think the other factor would be the, you know, the finances of the province have not allowed for the kinds of significant investments up until . . . And then this year we do have, you know, probably the first substantial investment that should allow for some of that programming improvement to make some headway on our targets.

Hon. Mr. Reiter: — I would just add that, you know, it was an aggressive target. We've set aggressive targets in the past in other areas. Certainly we generally think . . . We haven't been scared to do that. We think generally if you want to make significant improvements, it's important to set targets. This one is going to be difficult to reach, obviously, but that's not going to stop us from trying to move in the right direction. As Mark mentioned, there's funding in the budget for this year, and we're hopeful that's going to help.

Ms. Chartier: — Just a clarification. So for the '16-17, 35 per cent overall, you said you've made minimal or no, and then you said, or holding on to the baseline. So what does minimal look like in a percentage?

Mr. Wyatt: — I don't have it by sort of percentile for each year, but what I would say is, for example, we saw Regina Qu'Appelle making some modest improvement over a couple-of-year period in their time waiting for an in-patient bed. This past year they've given up some of that ground, and so they're probably back to baseline again.

And so I guess, the trend line of course never stays on a constant line, you know, based on what time of year. You obviously, you know, it's quite typical that you'll see higher wait times during the winter months, lower wait times during the summer months, for example.

So when we look at how we're tracking against the baseline, there are times when we are below it, times when we're above it. And typically during the months of December through March, we're probably above it.

Ms. Chartier: — But your operational target by the end of

2016-17 was a 35 per cent overall reduction by the benchmark year of ’13-14. So we are probably still at that needing to make a 35 per cent reduction.

Mr. Wyatt: — That’s . . .

Ms. Chartier: — Yes, would zero be a fair assessment?

Mr. Wyatt: — When you annualize it out, I would expect that we would fall fairly close to our benchmark.

Ms. Chartier: — Okay, thank you. And I know we’re just about out of time here, but I wouldn’t mind carrying on this conversation tomorrow. Because I know you just said that 12 million is a significant investment in ED waits, but this has actually been a target of the government for a few budget cycles. So there’s been the Connecting to Care and hot-spotting programs.

So I would argue that this has been your goal for some time, and there has been budget investment. But I know our Chair likes to . . .

A Member: — Keep a tight rein.

Ms. Chartier: — He does, yes. So with that, I guess we’ll carry on the conversation tomorrow. So thank you.

The Chair: — Thank you very much, Ms. Chartier. Mr. Minister, we have another two minutes to go if you would like to make any closing remarks or we’re going to have to sit longer tomorrow.

Hon. Mr. Reiter: — I always enjoy sitting with you, Mr. Chair, so if two minutes tomorrow . . . I have an opportunity to thank the committee members and Ms. Chartier after we wind up tomorrow, so I think I’ll leave any comments for tomorrow.

The Chair: — Okay, thank you very much. Ms. Chartier, do you have any comments today? Very short.

Ms. Chartier: — No, I look forward to carrying on the conversation tomorrow.

The Chair: — Okay. Thank you very much. Would someone move that we adjourn? Mr. Buckingham. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned until Tuesday, May 2nd, 2017 at 3 p.m.

[The committee adjourned at 18:05.]