STANDING COMMITTEE ON PUBLIC ACCOUNTS

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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[The committee met at 09:03.]

The Chair: — Good morning, everyone. Welcome to Public Accounts. I'm Danielle Chartier. I'm the Chair. I'd just like to take a moment to introduce our members here today. We have Mr. Hart, Mr. Doke, Mr. Merriman, Mr. Weekes, Mr. Michelson, and Mr. Nilson is substituting for Mr. Wotherspoon today.

Welcome to the folks from the Provincial Comptroller's office. We have Terry Paton who is the Provincial Comptroller, and Chris Bayda, the executive director of the financial management branch. Welcome to the Acting Provincial Auditor, Judy Ferguson, and her staff, and to all the ministry officials today and folks from eHealth and the respective health regions. Welcome to PAC [Public Accounts Committee] today.

We have a couple of items. We need to table a few documents here. We've got PAC 42/27, Ministry of Finance, reporting of public losses for the period from October 1st, 2014 to December 31st, 2014, dated January 30th, 2015. And we'll table the PAC 43/27, Ministry of Health, reporting of public losses for the period from October 1st, 2014 to December 31st, 2014, dated January 30th, 2015.

Our first agenda item today, we will start with eHealth and various Provincial Auditor . . . or the 2014 actually, Provincial Auditor report volume 1. So with that I will pass it off to Ms. Ferguson, the Acting Provincial Auditor. And then Mr. Wyatt, the deputy, acting deputy . . . sorry, no, assistant deputy minister, pardon me, for Health to make some remarks after that and to introduce your officials as well. So, Ms. Ferguson.

eHealth Saskatchewan

Ms. Ferguson: — Thank you very much. Good morning, committee members, officials. With me today I've got Mr. Bashar Ahmad. Behind is Ms. Tara Clemett and behind also is Kim Lowe. Mr. Ahmad is the deputy provincial auditor responsible for the health portfolio within our office. Ms. Clemett, behind, and also Ms. Lowe worked on a number of the audits that we'll be discussing this morning.

What we plan to do is actually just follow the ordering of the agenda and present each of the chapters as individual presentations there, with pausing after each to allow for the committee's consideration and dialogue with the officials. So at this point I'm just going to turn it over to Mr. Ahmad to present eHealth.

Mr. Ahmad: — Thank you, and good morning, Madam Chair, and members of the committee. Chapter 9 describes the result of our audit of eHealth processes to share patient data among health care professionals.

The chapter begins on page 55 of our 2014 report volume 1. eHealth is responsible for creating a system for comprehensive electronic health records for patients, often called provincial EHR [electronic health records], and for providing health care professionals access to those records. Ultimately a provincial EHR that makes the key patient data readily available to health care professionals will improve the delivery of health care.

The focus of eHealth's EHR initiative is to compile patient data into provincial repositories and provide access to data through two main ways — electronic medical records, that is EMR, and a web-based viewer called eHR Viewer. Many agencies, including eHealth, regional health authorities, the Cancer Agency, and the Ministry of Health play roles in identifying and collecting and providing patient data. We examined the effectiveness of the eHealth processes to share patient data for the 11-month period ended February 28th, 2014. We did not assess EMRs in use at physicians' offices or the authorities. We concluded that eHealth had effective processes except for matters covered in our five recommendations.

First, on page 61 we recommend eHealth establish standard data requirements for all provincial repositories. We found eHealth did not always have established standard data requirements. Without standard data, physicians may not have relevant and timely information to make the best decisions.

Second, on page 63 we recommend eHealth define strategies to identify and collect key patient data required for the provincial EHR. We found that eHealth had not documented its priorities, strategies, or timelines for obtaining the data it required. The completeness of the provincial repositories is contingent on the completeness of the source of information and the willingness of professionals with patient data to share it. Documented data requirements along with strategies to address data gaps will help ensure the provincial EHR contains key patient data.

Our third and fourth recommendations on page 63 relate to eHealth controlling and managing the provincial repositories. We recommend that eHealth obtain the responsibility from the Ministry of Health for the drug and immunization repositories and obtain responsibility from the regional health authorities for the diagnostic images and reporting repository to facilitate development of provincial EHR. We found that the nature and extent of eHealth's responsibilities for the various repositories was impeding its ability to develop and make changes to the repositories and in turn the development of provincial EHR. Without having lead responsibility for provincial data repositories, developing the provincial EHR is an inefficient and time-consuming process.

Fifth, on page 65 we recommend that the Ministry of Health allocate IT [information technology] capital funding based on the provincial strategy for electronic health records. We found that some health authorities continue to develop their own IT solutions for expanding electronic health records within their regions. Also, the ministry did not require health authorities to coordinate IT development with eHealth. This will result in inefficient use of public resources as some authorities' IT developments are not necessarily compatible with eHealth visions or technologies. And that concludes my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Wyatt, if I could pass it off to you for any remarks, and if you'd like to introduce your officials with you at the table, that would be great.

Mr. Wyatt: — Thank you very much. Good morning to the Chair, to members, to the Provincial Auditor, and staff. I'm Mark Wyatt, assistant deputy minister. And joining me today

are a number of members from the Ministry of Health, but also regional health authorities and eHealth. So I'll introduce a number of them at this time.

Joining me to my right is Cindy Fedak, the director of operations and internal audit. To my left is Denise Junek, vice-president of business relations from eHealth Saskatchewan. Also attending from the ministry are Kimberly Kratzig, assistant deputy minister; Karen Lautsch, assistant deputy minister; Tim Macaulay, director of environmental health, population health branch; Valerie Phillips, director, patient safety unit; Linda Restau, acting executive director, community care branch; Brenda Russell, executive director, financial services branch; Marsha Munro, manager of revenue and audit; and Larissa Flister, our intern in the deputy's office.

We also have joining us today from eHealth, Roseann Anderson, vice-president of finance and administration; and for some of the upcoming items, Georgia Hutchinson, regional director, long-term care and community hospital; and also Sharon Nicolson, regional director of nutrition and food services from the Five Hills Health Region. And joining us from Sunrise Health Region is Roberta Wiwcharuk, vice-president of health services.

Just very briefly, Ms. Chairperson, the Provincial Auditor plays a vital role in ensuring that government remains effective, open, and accountable. At the Ministry of Health, we firmly believe in these same principles. They guide not only our overall strategic direction, but the day-to-day operations of front-line care.

Progress has been made on a number of the auditor's recommendations that we will be addressing today, and work continues in many areas at both the ministry and with our partners on areas of specific concern. Our ultimate goal is to strengthen and improve health services for all Saskatchewan residents. And we are pleased to take questions from the committee.

The Chair: — Thank you very much, Mr. Wyatt. And just in questioning if . . . I know you've been introduced, but just for Hansard, if the folks who answer questions, whomever comes to the table could just say your name, that would be great. I'd like to open up the floor for questions. Mr. Nilson.

Mr. Nilson: — Good morning, and thank you for being here to answer questions. It's nice to reverse the role of Mr. Wyatt. He spent many years asking me questions so it's a . . . But I've forgotten all that so . . . But no, my first question just relates to the overall system. The eHealth care organization takes in a whole number of previous operations that are there, and perhaps you could explain for us what's included in eHealth and what's not included.

Mr. Wyatt: — I may ask you yet another question. Just if you could provide some clarification around, as you are inquiring about previous operations, I mean I would certainly say that right now we have the operations of eHealth and then, as the audit identifies, there are the respective IT responsibilities for the individual health regions. And so I'm just wondering, are you looking at previous iterations of organizational structure in government? Or maybe just to clarify . . .

Mr. Nilson: — I mean one of the things that jumps out at you when you read this is that half a billion dollars spent in this field over a number of years — well I think it's 15 years or more than that, 17 years — and so the question becomes who and how was that money spent? And what do we have now? And I think, I mean I think this is basically a pretty good report for eHealth in the sense of the auditor has been working with you to get more accountability.

My question is, and part of it relates to just having an explanation of where eHealth comes from and why it's eHealth. And there is some information here, but I guess my specific question relates to, how was this organized originally? And is it now getting into a point where we can actually, with 1.1 million people, have one system related to electronic records?

And I guess ultimately the taxpayers' question is, well how much more money is it going to take to do this? But I'm not going to ask that one yet. I'm just curious as to where and how this comes together. And then I think it relates specifically to I think the fifth recommendation here in this report which is, is it possible finally for the Ministry of Health and eHealth to come up with a provincial strategy? And so that's . . . I mean that's why I'm asking the question. But I think for many people who haven't been really closely involved with this, they don't understand where it all comes from and how you can spend that much money and still end up having some questions.

[09:15]

Mr. Wyatt: — I'll hopefully address a number of the questions that have been raised by the member. eHealth has the overall responsibility for the development of the electronic health record and also works with individual regional health authorities around the interoperative elements of information technology systems. And I think it's important just in I guess speaking to the issue around the funding that has been expended by taxpayers, both provincially and nationally, towards the electronic health record, to understand that the $500 million figure that was . . . $502 million that's identified in the auditor's report is a combination of two elements, one of which is the development of the electronic health record. And the report itself identifies that total at 184 million was spent on development costs for implementing new systems, and 318 million was spent on operating costs for ensuring that systems implemented are maintained and available.

I think the other important issue to understand is that when we look at that $318 million figure, this is not necessarily related to some of the electronic health record platforms that we are talking about really making up the body of that electronic health record. That includes all of the day-to-day operations of regional health authorities and the other provincial organizations, so something as simple as desktop maintenance and support services to help to support the individual employees of the health region.

There are also a number of electronic systems within the health regions, in the hospital setting, for example, where . . . I can speak to I guess some personal experience recently, working on some improvement work in the lab with their phlebotomists and so that that interaction between a phlebotomist who is moving around the hospital and getting blood results from a patient,

blood tests from a patient, feeding that back to the laboratory, certainly requires . . . There's an electronic dimension to that. But we wouldn't look to that and say that that is part of the grand electronic health record system.

And so there are many other localized IT, electronic information systems that are functioning within the regional health authorities, within different service lines, that are captured and represent the majority of the investment that's gone into IT systems across the province. The lesser amount out of that 502, of 184, is that which is identified as being related to the electronic health record development.

It's also important to note that of the EHR costs, a significant part of that has been funded by Canada Health Infoway. And I guess, just to the part of your question around where does this come from, I mean it takes you back to the direction that came forward nationally in I think over the course of the 2000s and probably going back into the 1990s, of the creation of a national electronic health platform. And Canada Health Infoway has supported all provinces in developing some common data repositories and systems that then form the basis for, whether it's radiology, laboratory, pharmacy, the many systems that make up that overall patient health record.

I'll stop there and probably may not have covered all of the bases but I hope that . . .

Mr. Nilson: — No, but I mean I think it's helpful for all of us to understand what it is that we're looking at here. So in the operation itself then, it basically covers whatever . . . Well I guess in the Ministry of Health, there really are very few health records. Would that be an accurate statement, that most of the health records are in the regional health authorities and the Cancer Agency? Is that correct?

Mr. Wyatt: — I think that's an accurate assessment, that most of the electronic records would be found in the delivery system itself. You do have examples within the Ministry of Health of, particularly I would mention billing systems. So when it comes to the claims management for drug plan claims, for medical services, payments to physicians, and people travelling out of province or out of country, those would be a couple of examples of the larger IT systems that we operate within the ministry. But the clinical systems would be primarily managed and operated through regional health authorities and eHealth.

Mr. Nilson: — Okay. Does the system include the Athabasca Health Region across the North?

Mr. Wyatt: — Athabasca has, I guess being a much smaller region, it often depends on other regional health authorities to support its activities. And in the case of electronic health management, Kelsey Trail Health Region, which I guess represents the part of the province with Melfort, Tisdale, and Nipawin being some of the major communities, Kelsey Trail helps to support Athabasca in its data support and entering and I guess participating in the contribution to the electronic health data registries.

Mr. Nilson: — So then basically it does include the whole province, but Athabasca comes in through Kelsey Trail. That's what I was curious about, how those records were included.

Obviously everybody has been wanting to have this system in full operating form with all its bells and whistles for decades now, I guess would be the best way to put it. And that's been a, you know, elusive goal not just in Saskatchewan but right across the country. Is this question, which once again I come back to recommendation 5 around having a provincial sort of — how's the term they use here? — a provincial strategy for electronic health records, are we close to that, or can you tell us how all the things that are happening now are moving toward that? And then I'll come back with some specific questions.

Mr. Wyatt: — I think there has been some significant developments over the last couple of years. And a lot of the work that's been undertaken over the past decade, developing some of these data platforms which really come together to create that electronic health record that health providers and ultimately patients will be able to rely on to provide those basic foundational elements of the electronic health record, are starting and in many cases have been implemented across the province.

So we have examples of . . . The electronic health record now includes patients' prescription information from community pharmacies, laboratory results from health regions, and the Saskatchewan Disease Control Laboratory immunization histories, chronic disease management. There are some other elements that are, I would say, in development. I note the auditor's report has even acknowledged that there is work around synoptic reporting as another . . . I would say a newer element that is coming forward around how we take some of the information from clinician records, and the example that we're moving forward with around breast cancer results, is now one of the new elements that's coming forward.

So what I would say is there's a combination of some of the major pieces, those radiology medical imaging results, laboratory, pharmacy. Those are some of the underpinnings as well as a lot of the groundwork that had to be done I guess in order to support that around provider registries, patient . . . having the patient registries in place, and those feed into all of the different platforms that make up that electronic health record.

We're now at a point where those, some of those core foundational pieces are in place. I think the auditor's report certainly addresses that there are in some instances, either it may be a regional health authority or it may be a group of providers that hasn't either fully . . . that isn't in a position yet to fully upload information or doesn't have access to the viewers. But for the most part those core elements of the electronic health record are in place and now it is a case of filling in some of those gaps that have been identified by the auditor.

I'll just maybe add . . . I was probably remiss off the top in not starting out with a summary of I guess, kind of a summary of where we would identify that eHealth in the system is in respect to the specific recommendations, and I'd be happy to do that. At this point, I guess new to the job, I forgot that that was one of the standard steps here. And I can either come back and walk through each of them or maybe address them individually as they come along.

The Chair: — I think one thing, Mr. Wyatt, that's very helpful for us as a committee . . . Now we have your status update which walks us through all those recommendations, so I'm sure everybody's gone through that. Does the committee want to hear about every recommendation or just in terms of the questions of the reading that we've done? Mr. Weekes.

Mr. Weekes: — I think that's the standard procedure so maybe we should go ahead with what we normally do.

The Chair: — Sounds good. Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I agree with my colleague, Mr. Weekes. I think if we could just go through each recommendation and just a progress report . . . I don't know if we need to get into specific details, but just a progress report on where things are at for the committee would be beneficial.

The Chair: — That sounds good.

Mr. Wyatt: — I'd be glad to do that. And I think they're not extensive remarks on each of the recommendations, so if there is follow-up, we can certainly go into any of the recommendations in greater detail.

So I'll maybe start with the first . . . Let's start with the first recommendation. And I'll preface all of these by saying that the status for each of the recommendations with eHealth is that they are in progress. We don't present any of them as having been fully implemented, and so I guess I'll introduce all of them on the basis that these are, that there is work under way towards addressing the recommendation but we are not putting forward any of them as being completed.

So with recommendation no. 1, eHealth has set data standards for certain repositories such as the lab and pharmaceutical information program. I'd also note that the Panorama and medical imaging systems are also examples where we do have common data standards for those repositories as well. eHealth will continue to work with key stakeholders such as the regional health authorities, health care providers, and the Ministry of Health to define and implement data standards for other provincial systems.

Setting standards requires co-operation from all data providers and common data configurations for systems that supply information, interprovincial repositories. And the target for completion around the first recommendation is March 2017.

I'll move to the second recommendation. As part of the strategic planning process . . . And this recommendation, just to introduce it, is to define strategies to identify and collect key patient data required for provincial electronic health records. As part of the strategic planning process, eHealth aligns supporting data needs with key health system priorities. An example of this was the addition of the chronic disease management system and data that's now provided on the electronic health record viewer.

[09:30]

With the addition of radiology reports available through the eHR Viewer which came on board in the fall of 2014, eHealth has established all data repositories identified as key patient information by the Canada Health Infoway electronic health record blueprint. And I think that speaks to I guess the question around where we are in terms of those core elements of the Canada Health Infoway direction that was set. eHealth continues to work with patient and provider groups to identify additional data that is considered key to patients and providers and to improve the availability of information through the eHR Viewer. This recommendation is also expected to be implemented by March of 2017.

Moving to recommendation no. 3, and this is the first of the two recommendations which deal with the question around the responsibility for the different repositories, with respect to this one, eHealth will work with the Ministry of Health to determine the most appropriate model for trusteeship of the pharmaceutical information program. Currently eHealth and the ministry work together to ensure that PIP [pharmaceutical information program] data is incorporated in the electronic health record system. The ministry and eHealth have been working on the development of a new . . . Moving from pharmaceutical to immunization, the ministry and eHealth have been working on the deployment of a new immunization module to go live in this month, February 2015, replacing the current aging system, and will capture information about family health which is currently recorded in paper records. And that is the Panorama system.

Moving on to recommendation no. 4, also dealing with the responsibility over electronic repositories. At the eHealth information advisory committee meeting held in January 2015, eHealth committed to explore options for transitioning responsibility from the RHAs [regional health authority] for the RIS/PACS [radiology information system/picture archiving and communication system], the radiology information system and picture archiving system, and so that recommendation is also being explored by eHealth and the other system partners.

And moving to the final recommendation, no. 5, this one I would note will be perhaps different than what was provided in the notes that were pre-circulated in following up with respect to this recommendation. We can advise that eHealth is working with regional health authorities, the ministry, providers, and patients on a consolidated five-year information technology road map to meet the needs of our patients and partners. And I think this speaks more directly to the recommendation perhaps than what was originally provided. There is work under way that is directly responding to that recommendation to develop a plan or road map for the future development of the EHR.

The Chair: — Thank you for that, Mr. Wyatt. Mr. Nilson.

Mr. Nilson: — Thank you for those comments directly about what's . . . you know, the recommendations here.

I note in the report as it relates to recommendation no. 1, there's a direct comment on page 60 that says, "eHealth noted that it has not developed a complete operational plan for the provincial EHR because its funding is decided on an annual basis." Is there any plan to deal with that particular question, to give eHealth a multi-year funding formula so that this doesn't become a roadblock in getting this work done?

Mr. Wyatt: — I think that's been a long-standing challenge I

guess for eHealth but also more broadly for the health care system. And I would say that the regional health authorities and Cancer Agency would probably fall into the same category, where we certainly develop strategies and plans which can set long-term goals in terms of the overall goals but also the work plan in support of those goals. But I think with each of those, including a long-term electronic health strategy, there is the challenge of making sure that the investment, the supporting dollars are there.

And so typically what we have often done is develop those plans, really identifying the priorities for a particular area and bringing forward the requirements in order to support those priorities. But I think it is a reality and I would say the current financial situation that we're in being a good example, where the ability to commit to long-term funding blocks without taking into account the real time financial picture becomes a real challenge in being able to necessarily deliver on the funding support that may be identified over a longer term strategy.

And so while that's I think the whole intention of a long-term information technology plan, will be to identify those next stages of development and rollout for the electronic health record, I think that that presents an ongoing challenge in being able to make those five-year commitments without accounting for the reality of the day-to-day budget position of the province.

Mr. Nilson: — Well said. This clearly is the history of the electronic health record in Saskatchewan, is that you work with the resources that you've got, whether it's Canada Health Infoway money or provincial money.

I'd be curious to understand . . . This, you know, first recommendation ties in actually with the fifth recommendation around the provincial strategy quite closely. But how much or how many dollars are in the regional health authorities and the Cancer Agency versus eHealth as it relates to this work?

Mr. Wyatt: — The consensus response is that we don't have that information with us today, and we'd be happy to get back to you with that information.

Mr. Nilson: — Okay. That would be helpful because I think it's a bit of a reflection on what is happening here. Now one of the things that strikes me, listening to the explanation, reading the report from the auditor, and your comments is that this has aspects of sort of the whole 3sHealth [Health Shared Services Saskatchewan] model as far as coordinating between regional health authorities. And so is that ultimately the plan, that there would be one central IT operation for the province where the regional health authorities would obviously then all be working on the same platforms and the same data sets?

Mr. Wyatt: — I think that's a valid observation around the parallel to 3sHealth, and I would say with the major components of the electronic health record in I guess at different stages over the past decade, we have had examples where regional health authorities have wanted to pursue a one-off product or a one-off response to part of the, you know, one of the platforms or systems in the electronic health record. And it has been, I would say . . . You know, I don't want to be critical of that approach because in some cases it is a region that has identified a priority or a real problem in a particular area and just doesn't want to wait for the rest of a provincial solution to come along.

But I think there have been some examples where that approach has been taken and I think overall it's been demonstrated to be contrary to the approach that we are wanting to take with the interoperability, the ability to train, whether it's a pharmacist or somebody doing data entry in one region who may move to a different region and be doing radiology, X-ray entry, or something along those lines, that if we have new systems in different parts of the province, not only does it become more difficult for that information to flow across boundaries but it also becomes more difficult for people to both input and I guess manage those systems when you have different platforms.

So I would say certainly for the last number of years, the idea as we've been moving to I guess the mantra that we approach this and many other issues, is think and act as one system. And I think all of the decisions that we're making on the large eHealth platform areas is that we want these to be provincial approaches. And I would say the approach we take in a five-year strategy would be looking at I guess a principle underlining that which states that these should be provincial systems so that we have the benefit of data flowing across what are really artificial regional health boundaries from a patient's perspective.

In terms of the question around whether we're looking at I guess the reorganization of IT staff and supports in the province, we don't . . . You know, there's been no decision, you know, no decision taken around something along those lines. I guess I would just say that there will always be a requirement to have information technology analysts and support staff located in the regional health authorities because again as we look at where the majority of the dollars are spent, the majority of it is really supporting those front-line operations and systems as opposed to, you know, the work that's gone into developing the broad electronic health repositories.

Mr. Nilson: — Okay. I'm just curious on this first item which relates to standard data requirements. I know that many of the announcements around the new children's hospital were that it was going to be a paperless facility, and clearly we're not there yet. And so how did that affect the design of that hospital? Has it got both room for paper and room for no paper, or can you explain that?

Mr. Wyatt: — So with the plan as we move into the new children's hospital, certainly the intention and the ideal of moving to a paperless system was an opportunity as we looked at that new facility. Currently the plan does, however, account for the recognition that we are not going to be in a position to fully move to that paperless system. So the space planning does account for some desktop computers, some countertop, some of the physical requirements that would still account and allow for the use of paper in that facility.

There's certainly a goal of the children's hospital advancing towards that ideal of a paperless system, but right now the intention is not to open on a fully paperless basis.

[09:45]

Mr. Nilson: — Okay. Well thank you for that explanation. Moving on into the second recommendation, there's a comment on page 61 that, sort of the bottom of the page, "According to eHealth, providing patients with access to electronic patient data is being considered." This is clearly the forefront of sort of modern patient data management and we know that Microsoft and a lot of these big companies are moving into this field. Can you explain what possibilities there are for Saskatchewan people to actually have access to their own records.

Mr. Wyatt: — I'm going to ask Denise Junek with eHealth to maybe address that one directly.

Ms. Junek: — Yes, so we have had conversations with patients. We wanted to be really sure that we went out, we understood really what patients wanted. They've been pretty clear that they want access to their own data. If we have it, they believe they should also have it, so we've been continuing to work with them quite closely. We've got a patient advisory group that we're working with. I mean we're hoping to pilot with a portal, or what we end up naming it, but a way that the patients will be able to view their own information. But we also want to take a look at it. It's not just about their information. It's perhaps about what tools they might use to actually improve their own care and be part of their health care team. So we are looking into that space.

Mr. Nilson: — Are there any timelines for when the trial project might work and when it might be something that we would see across the board?

Ms. Junek: — The timeline to do what we're calling the limited production rollout, pilot, whatever you want to call it, is this year, so this fiscal. And then we'll be at decision point at the end of fiscal as to rollout or what we do with it beyond that.

Mr. Nilson: — So that means December 31st this year or March 31st . . .

Ms. Junek: — Oh, I'm sorry. It's in the next fiscal year we'll be piloting, and then at the end of that year.

Mr. Nilson: — And you're talking provincial fiscal year or does . . .

Ms. Junek: — Provincial.

Mr. Nilson: — Okay. So you're on the same fiscal year as the province is as opposed to some of the Crowns.

Ms. Junek: — Yes. Sorry.

Mr. Nilson: — Okay. And I guess all I would say is that that's something that I think is beneficial both for the health system and the patients, and there are a lot of very encouraging pilots around the world on access to health information. So keep working on that front, and keep working to get money from the department to do the work.

Just on that same second recommendation area, there's a note that there is, and I think you said this yourself, that there were some regional health authorities that just don't have the information to put into the system, and it's a reference here to Heartland around their electronic lab depository. Is that something that's going to be corrected, or has it been corrected? Or what's happening?

Mr. Wyatt: — Page 62 includes a table that shows lab results are the first item on that table and identifies Heartland and Keewatin Yatthé as two regions identified as missing lab information. Heartland Regional Health Authority has, since the time of this audit, now been added to the LIMS [laboratory information management system] or the lab management system. Keewatin Yatthé is outstanding, and the time frame for Keewatin Yatthé is under discussion.

Mr. Nilson: — Thank you for that. Now the next section is the recommendations 3 and 4, and you've made some brief comments about this. And it does go to the bigger question asked around the 3sHealth model, which sounds like that's one of the goals for eHealth as well. I guess the question becomes, what's the best model to do this kind of work? And obviously there's a long history of doing this kind of work within the ministry versus within a separate agency. Is that still a discussion about whether it's appropriate to move some of this information out of the Ministry of Health, or has that kind of a hurdle been crossed already and it's more just the practical aspects of the dollars involved?

Mr. Wyatt: — With the recommendations through the auditor's report there, we've had some of those follow-up discussions to look back at I guess what the rationale was for a system developing and being held within, or the responsibility being held within the ministry and then either through those data-sharing agreements or the other . . . Or either through data-sharing or joint service access policies, managing that relationship with eHealth.

In some cases there is actually a legislative foundation for acquiring the data and for the Ministry of Health to hold that data on behalf of patients. And so one of the issues that has been identified, looking at immunization data as an example, so it's gathered under *The Public Health Act* and so there, as we look at what are some of the issues that need to be understood, are there existing legislative requirements that authorize the ministry to gather that data and then share it? And we would then go on to share it through data-sharing agreements and other means. And so as we look at the transfer of responsibility to eHealth, we need to I guess look at both the origins and the legislative requirements.

But also there's the issue around who the business owner is. And I think the approach that's been taken is that, in looking at something like the pharmacy or immunization programs, that the provincial business owner has been the Ministry of Health, our drug plan, extended benefits branch, or population health branch. And so I guess as we look at the recommendation and certainly appreciate the potential benefits that the auditor has identified around having the responsibility moved to eHealth and the ability for them to I guess direct and to manage at a provincial level, we are looking at those and I guess looking at I guess the trade-offs with the existing arrangement which really does have the program owner in the case of the drug plan, for example, having the ability to I guess make some of the decisions and to be responsible for the operations of that system.

The Chair: — Mr. Nilson, Ms. Ferguson just has a question or a clarification.

Ms. Ferguson: — I just wanted to make sure that the members understood that we're not talking about the overall responsibility for the repositories in both recommendation 3 and 4, if you notice, that really we're only talking about the responsibilities that relate to the development aspect. During the course of the audit we did have very good conversations with eHealth and the whole aspect of the trusteeship, you know, and the legislative aspect. So the recommendations were intentionally narrow just to focus on that development aspect.

And there's a number of ways that we think that could occur. It may in essence be, in essence like another service agreement between the two to hive that off. You know, so we do recognize that both the regional health authorities for recommendation 4 and Health, they need some ability to control aspects of those repositories. So really we're just focusing on that developmental aspect so that again it's really an efficiency aspect so we can avoid what we're currently seeing in the course of the audit where there's a bit of disconnect. And frankly, you know, it takes eHealth a lot more time and a lot more effort, you know, and it's costing the taxpayers money at the end of the day. So it's just that component. So it's not overall.

The Chair: — Mr. Nilson.

Mr. Nilson: — You know, and thank you for that explanation. And I can see that in the recommendations. But I think the bigger issue relates to vital statistics and what happened when it was moved into a registry corporation and then had to be moved back because of some of these exact concerns here. And so that's kind of where my questions come from is, you know, what kind of discussions there, and it appears clear that people see the disruption that caused in one sense, but now it's vital statistics is here in eHealth. And so that's where my questions were coming from.

So I assume that that, what was learned in that process, is being used as we look at all of this information. I would say that the basis for many of the long-standing pieces of legislation as it relates to health do relate to this, you know, the strong concern that the public has for their private information. And this whole area is one where I think the responsibility being as close to the ministry as possible is one where that's what the public would want. And so, you know, work carefully and efficiently obviously, but be very careful.

Just another question that relates to this and your comments around how the regional health authorities are working together as one system, have you been looking at what's happened in Alberta where they just have one regional health authority that's the whole province? Because that I guess eliminates some of the problems that you're having here because there's one central budget. So is that part of the discussion?

Mr. Wyatt: — We're not aware of any I guess of any evaluation or analysis of the Alberta health services model and what the implications have been. I would just say that we're not looking at moving to that single system.

But I guess I would answer this question maybe by coming back to the earlier discussion around the reality and challenge of operating with 12 regional health authorities, AHA [Athabasca Health Authority], provincial Cancer Agency, other provincial bodies, and the ministry. And I think the approach we've taken and are taking to a greater extent really is that we need to function as closely as possible as a single system.

And so to the extent that, I think to the extent that there is a, you know, a definite recognition that within regional health authorities there are those local services and supports that have to be provided, and that's well understood. But I think when we are talking about those systems that then translate into shared information crossing, crossing both facility and service lines within a regional health authority but then moving more broadly to the provincial system, the importance of having those coordinated processes, committees, and I guess the development and upgrading of systems to make sure that we are . . . You know, if we're not one system, we need to as closely as possible function as a single system when it comes to that development and transportation of patient information.

[10:00]

Mr. Nilson: — Well keep working on this. I'm always reminded when you travel and you can stick your bank card in and get cash in whatever, you know, denomination there is in another country, people kind of expect that the health system might do that with their health information at some point. But we all know that costs a lot of money. But that's maybe the ultimate goal is to have easy access like that.

I just have a couple . . . Well I don't know; I shouldn't say that. I'll have a few more questions, and then I'll let some others ask. But going into this last recommendation or going on to page 65, there's some comments there, but right in the middle of the page, specifically the last sentence, "The Ministry does not require the RHAs that it funds to coordinate their development with eHealth." This is around the IT projects. Is that changing or is that something that we'll see some information about? Because I think it . . . I mean there is a perception and obviously from the auditor's side too that you have these one-off programs that may eventually then be worth zero after spending quite a few millions of dollars on them. So can you comment on that particular paragraph.

Mr. Wyatt: — So through groups like the provincial CIO [chief information officer] forum which has the chief information officers from the regional health authorities, Cancer Agency, and working with eHealth Saskatchewan, the discussions around, I guess, the coordinated procurement, development, management of provincial information systems are moving through those groups. And I think there is a much greater emphasis around the provincial coordination and avoiding those one-off processes.

I think we've seen some examples where there have been individual regions that have wanted to either step ahead or step in a different direction, and I can say that in many cases we have asked those regions to bring it forward in a coordinated way. And I think as we look at the development of that next generation through the five-year road map, I would expect that would be one of the principles that would be introduced into

that, is the continued requirement that we're moving this forward on a provincial platform.

Mr. Nilson: — Thank you. I think that's what we wanted to hear and what the public wants to hear, so that's good. Just out of curiosity, and I think this may be my last question for now unless something else comes up with other questions people ask, is how many employees are there at eHealth? And yes, I guess there's that simple question.

Mr. Wyatt: — There would be approximately 340 employees. If you wanted that confirmed, we can also do that.

Mr. Nilson: — That's helpful. And they're primarily located in Regina? Would that be accurate? Yes. And so there's an acknowledgement that they're primarily located in Regina. How many are related to the vital statistics work versus the other work?

Mr. Wyatt: — If you combine both vital statistics and the health registration, that's about 50 employees.

Mr. Nilson: — Thank you. And I'll defer to some other questions and I'll think up some more before we're done. Anyway, thank you very much.

The Chair: — Mr. Doke, and then Mr. Hart.

Mr. Doke: — Thank you, Madam Chair. Just a little bit of clarity on reporting. Is it mandatory that health regions, pharmacies, and physicians report?

Mr. Wyatt: — I would say it differs based on the platform that you're talking about. So with physicians, for example, we don't have the full implementation of the electronic medical records through their offices, and so when we look at something like the chronic disease management quality improvement program, which is one of the examples that we are developing across the province, that is I guess, providing information is first contingent on having an electronic medical record. I could be corrected. There may well be paper reporting available as well with that program. But I guess feeding it into an electronic system, from a physician's perspective, would be based on having an EMR. And then there are some programs, the chronic disease management being an example, where physician participation is at this point a voluntary effort.

Now when you look at, I would use the pharmacy information or now with the radiology information system, once a hospital is connected with the radiology RIS/PACS system or a pharmacy working with the pharmaceutical information program, the expectation is that the data is required through those systems. Now I think there are . . . I should be careful because there is the ability for patients who don't want information to be available that it can be screened through the system, so that would be one I guess caveat I should place on that as well.

Mr. Doke: — So a physician then isn't . . . It's not mandatory for a physician to report on everything that they do and see with a patient.

Mr. Wyatt: — That's correct. The minority now of physicians in the province are still operating by paper records, so when you do an appointment, you'll still see physician offices with the file folders of paper records. Some of them are continuing to work on a paper-based system.

Mr. Doke: — So is there a will by the ministry or by the health regions to make that mandatory?

Mr. Wyatt: — I think we have been, I think we have probably been working more with the carrot than the stick over the years. There have been financial incentives for physicians to first of all adopt an electronic medical record. And I think part of the challenge has been when we've talked about making EMR uptake mandatory. If we go back five years to a time where we didn't have these repositories that are available today, you would be making it mandatory to be part of that EMR program, but you wouldn't have access as you do today to your patient's lab records, your patient's X-ray, their pharmacy records.

And so I think now there is a much better business case for a physician who wants to sign on to the electronic, to bring an EMR into their office because you now have access to a lot of the data that will actually save your office money in terms of eliminating the need for, eliminating from a cost perspective the need for traditional mail and faxes and the like, but also in terms of the turnaround time for information coming back from a lab, for example. There is now a much better business case and I think we're seeing the continued progression of physicians moving to the electronic medical record as the benefits become more evident from a patient care perspective.

Mr. Doke: — Okay. And eHealth, is everybody in one facility now?

Mr. Wyatt: — Yes, the staff in Regina are now located in one property.

Mr. Doke: — And that's in the Cornwall Centre, is it?

Mr. Wyatt: — That's correct, yes.

Mr. Doke: — And enough room?

Ms. Junek: — Yes.

Mr. Doke: — Yes? Okay, thank you.

The Chair: — I just want to follow up with Mr. Doke's questions with some clarification here. So for example, my doctor's been using eHealth, or e-medical records for a very long time but I think that there's a misconception out there. Her medical records, if I show up, if I go see her today and show up in the hospital in two days, those systems aren't linked. So even if all doctors are using EMRs right now, they won't know it at St. Paul's Hospital in Saskatoon in the emerg that I was at my doctor the same, or a day or two previously. Like those systems are not connected. Is that correct?

Mr. Wyatt: — Yes, I think right now the physician EMR has the capability through the viewer to access and to receive information. The ability for your physician to then upload the I guess the results from a particular patient appointment and then feed that into the provincial system, that does not exist. I know

that as we look at the evolution of the broader electronic health record, having that patient appointment information is an important part of it and of that destination. But right now you're correct. You don't have the ability, even for those who have an EMR in the office, to upload appointment information on to a provincial platform.

The Chair: — Thank you for that. Mr. Hart.

Mr. Hart: — Yes, thank you, Madam Chair. And just a follow-up to that question. So why doesn't that . . . Why isn't that available? I would think that's pretty important that if an individual sees their physician and then has a medical event and ends up in the emergency ward, that information should be available. What are the barriers there? Why aren't we moving in that direction? Why isn't that done?

Mr. Wyatt: — So I'll answer that with a couple of points, one of which is the starting point has been looking at being able to feed emergency room visit information into that provincial repository. And so I guess the example would be if a patient has had an emergency visit, that that information would then be available on the provincial repository and accessible to your family physician through the eHealth viewer. And so that's the first step I guess in making those interactional, those transactional appointments available.

The next step does involve working with family physicians and specialists using those EMRs. Like the development for any of these large platforms, it starts with making sure that you have the standard, the IT standards in place. So that, coming back to the earlier discussion that it is shareable across different platforms, in the province we do have two different EMRs. And so first of all we need to make sure that those two different EMRs are feeding into a common patient record platform. So that work around developing the standard for the sharing of patient information to the broader provincial platform, that's under way.

And I guess, like any of these systems, it moves from then the developing of the standard to putting the systems in place.

[10:15]

Mr. Hart: — Just staying with the IT component of this which I mean this is what we're talking about, but . . . Is part of the problem in moving this along, do health regions have different IT systems that have difficulty communicating with each other and with the provincial system? Is that a problem or has it been a problem in the past where, you know . . . Could you make some comments in that area.

Ms. Junek: — Denise Junek. This one's mine. I promised I wouldn't get too technical, so if I do, please ask me for clarification. I think one of the things you need to remember in this journey too is technology is taking a journey and changing on us so quickly. So to answer that question, the modern-day systems, we're seeing this convergence where the idea of sharing information and the ways we do in a modern health care system are considered in the development of those what I'll call legacy systems. Older systems, absolutely that was a barrier; it's becoming less of a barrier. I'm not going to tell you it still doesn't exist. It still is in some cases a lot of effort to get that to communicate but . . . And again, back to the conversation about always starting with standards, right. The start is figuring out the standard way that information will be communicated. So less than it was at one time.

Mr. Hart: — And so if I heard you correctly then, earlier on in this process we didn't have the standards as far as the type, you know, what's required and in what form and that is, that's been one of the barriers then or that's been one of the issues that have been impeding the progress on this, on the development of electronic medical records.

I mean this is one of the recommendations that the auditor's put, had set forward here in 2014, and as my colleague, Mr. Nilson, said, this has been ongoing for a long time. When I was first elected back in 1999, you know, we talked a lot about SHIN [Saskatchewan Health Information Network] and well SHIN has evolved into eHealth here and so, you know, there's . . .

I realize that in the IT world things change quite rapidly and so on but, you know, if we're just now defining the standards in 2014 as to what form and what format we require in this information, it seems we're a little bit behind. This may be something that should have been done earlier. But again, I mean I realize that things have changed and perhaps standards have to evolve also as the technology evolves.

Mr. Wyatt: — So I'll maybe start with an answer and see if Denise has something to add as well.

I think this is a good example where the challenge that the auditor has identified and some of the other recommendations around ensuring that we are developing things from a provincial perspective. This is a good example of that issue, where I know if I look back over the last five years, we've had any number of individual clinicians and regional health authorities that have been incredibly enthusiastic and ready to just jump right into a particular product.

You do have a lot of national IT vendors who will come out and present on a particular way of producing a patient viewer and portal and sharing records between physicians, between a GP [general practitioner] and a specialist. And so this is an example where I guess if we were moving as expeditiously as possible, we probably could have had small-scale examples of this in either individual clinician's offices or regional health authorities. And I think we've taken the approach that we're not interested in supporting the proliferation of 1,000 different examples of physician offices sharing their records with patients or sharing records with their local specialists in a particular community. We need to have that standard across the province so that, you know, it's not good enough to share a record with your neighbouring specialist but that doesn't apply if that patient moves to a tertiary centre in Regina or Saskatoon or moves to a different region.

So the importance I think here around both making sure that we have the provincial platform, but I'll also say it comes back to making sure that before we jump into new platforms and registries, we actually have the existing ones that we are working on completed. So when we talk about getting Heartland and Keewatin Yatthé brought into the laboratory

system, it would be easy to start moving on to the next, you know, the next one or two or five things, but I think probably equally important or more important to make sure that we are capturing all of those regional health authorities and customers with some of the existing products. So I think that also speaks to the balance between jumping in to something new and making sure we finish the job properly with some of those existing products.

Mr. Hart: — Thank you for that because that leads me to the next question that I have as far as accountability within the health region, accountability to the ministry in this area. You know, you were talking about some health regions or physicians, there's a new IT system out; they're jumping into that. What's the accountability for health regions when they are looking at making some changes and so on? Do they have to come back to the ministry? I mean who's watching this on a . . . I would hope that the ministry's watching this on a provincial basis so that, you know, in the future all the systems can talk to one another.

Because I heard you say that we'd like to get to one system, but it doesn't sound as if we are there but at least have a couple of systems that are fully operational and can communicate with one another. So could you speak to the accountability of the, you know, holding the health regions accountable, or at least making sure that everybody's on the same page, that we don't have a health region going off in an area that we'll find that they can't talk to other people, at least in certain, you know, certain records? Is that accountability there?

Mr. Wyatt: — Yes. I think, and again I would draw on a few, you know, some examples that come to mind for me where you have, a lot of times with some of the more advanced systems, it really is Regina and Saskatoon that have an interest. And there are definitely examples where one or the other location has wanted to start down a path with a particular product. And I think our starting point is always, you know, if there is the funding and the support to move forward on something, to make sure that we have, as a minimum starting point, Regina and Saskatoon working together from the outset so that we don't have a case where one location decides to go with one vendor and the other region decides to go with a different vendor. And so I think we, from an accountability perspective, I mean, you know, always our approach would be to get the agreement and the understanding.

And I would say that's becoming an easier conversation in recent times with the CIO forum group and at the CEO [chief executive officer] level really to bring them back to that philosophy of what's in the best interest of patients, to have a single common platform or to have these localized systems that can't communicate or there's great cost required in order to create the — what's the word I'm looking for? — the bridge between two incompatible systems.

I mean I think we're far more successful now than in the past in making the case around the importance of regions moving down a single path. Ultimately there are accountabilities through funding and ultimately the responsibilities of the ministry and the minister that are available, but I would say the need to draw on the minister's authority certainly is not the commonplace requirement. Usually we're successful in getting regions moving in a single direction.

Mr. Hart: — Well I think that's, you know, really important. And I mean I think many of us have had the experience where someone sends us some information in an email and we find that we can't open the darn thing because we don't have the program. And I mean if this is going on in a larger scale within our health regions, I can imagine the problems that we have.

Maybe I'd just conclude with an observation, I suppose. As I said, you know, this has been around for a long time, and it kind of reminds me of a movie I saw many years ago or watched about the painting of the Sistine Chapel, where Michelangelo worked for four years and the pope of the day would come in every so often and ask, when will it be finished? And the answer was, it'll be finished when it's finished.

I would hope that we could move forward on that, you know, and I'm hearing some good things with the pilot that's rolling out there and so on. But I mean I think we have some good recommendations here from the auditor, and I think making sure that everybody's on the same page out in health region land I think is quite important. That we have systems that are compatible and work with the provincial system I think is hugely important. Thank you, Madam Chair.

The Chair: — Thank you, Mr. Hart. Mr. Michelson.

Mr. Michelson: — I just want a little bit of clarification on 2,000 authorized users on the system. Can you tell you us who has the authority to get into this system and where they're from? Is that a lot?

Mr. Wyatt: — So that number, which has since increased to 3,400 authorized providers, would include physicians, nurses, pharmacists, other health providers. We have another 1,000 that are going to be moving onto the authorized list — I guess a large group from the Prairie North Health Region — and it would be those who have requested authorization.

Mr. Michelson: — So those would be professionals, as the system expands, that they would have access to the system. Is that it basically?

Ms. Junek: — Can you clarify your question maybe for me . . . [inaudible] . . . expands?

Mr. Michelson: — Well the system isn't totally in place yet. Is that right?

Ms. Junek: — No, it's there. So really all a provider needs to do if they are an authorized health care provider is to give eHealth a call and work through the process, the application process, and they will be granted access.

Mr. Michelson: — Okay. Then how many people will eventually have access? Is there any idea?

Ms. Junek: — In terms of numbers, you know, ideally we would have every physician using the system and then most health care providers within the system as well. With that though, I do want to say that some users won't access it directly but, in example, with an EMR, might access that data coming

in. So the number is a . . . It's not quite a match, the number of providers, is what I'm saying.

Mr. Michelson: — All right. Thank you. That's all I have.

The Chair: — Okay. Thank you. I actually have a few questions myself, seeing no further ones from around the table, just in terms of page 62 where we talk . . . the figure no. 3, gaps in Saskatchewan's provincial repositories.

The ministry had an announcement and eHealth had an announcement about a month ago talking about the core components being built. But in terms of I think sort of the general public's understanding of what information is available, when we talk about lab results . . . If we could maybe walk through those things that are available, so lab results, and at the time of the auditor's report, missing lab information from Heartland and Keewatin. And you explained that.

So this announcement as of a month ago was the core components are available and lab results from health regions are now available, but that's just from the public labs. Like that's like the lab in the hospital. That's not the private lab that you go to to get your blood work done. And I'm wondering what percentage of labs that includes . . . or not labs, what percentage of lab results that includes?

[10:30]

Mr. Wyatt: — So that does include the private laboratories in centres where you do have a private collection system, and so the collection system would then move into the laboratory and those results would be entered.

The Chair: — Does that include also when we talk about diagnostic imaging? I'd been under the understanding that diagnostic imaging, unless it's coming out of a hospital, that it's not included in the system.

Mr. Wyatt: — That's correct. The examples in Regina where we do have private MRI [magnetic resonance imaging] and CT [computerized tomography] facilities in operation, they are not currently on the RIS/PACS system.

The Chair: — What percentage does that account for in terms of imaging that is ordered?

Mr. Wyatt: — We don't have the direct breakdown for CT, MRI. It would be the minority of your scans, all of your hospital CT in-patient scans would still be done through those hospital machines located in the hospital facilities.

It's your outpatient electives that are done through those clinics relative . . . I mean there are some growing volumes at both the MRI and CT facilities though. So it would be . . . I've the number 5,000 CT scans in my head, but I just don't know what the denominator would be.

The Chair: — Okay. Thank you for that. I will go back to that in a moment here. But when we talked about hospitals or health regions all being on board now and having the capability, does that include all facilities in all health regions?

I know in Saskatoon Health Region, I'd understood that the Humboldt Hospital doesn't have the capacity. So we might say that all health regions are part of the EMR, not the emergency medical records, but the viewer. But the reality is there's many facilities that aren't part of that. Is that the case?

Mr. Wyatt: — Your question, I think, is accurate in saying that there continue to be some smaller facilities that don't have access to that and we are continuing to add facilities to those systems. And it becomes an assessment of, I guess, the resources available in the work plan to continue to add additional locations to something like the RIS/PACS system.

The Chair: — Can you give us a sense of how many facilities are not able to participate?

Mr. Wyatt: — We don't have that information right at the moment.

The Chair: — Is that a number that you could get us?

Mr. Wyatt: — I believe we could, yes.

The Chair: — Okay. That would be very helpful. And in terms of this chart here too, when we see discharge summaries — are they available, yes; are they complete, no — only includes Saskatoon RHA. I know that in this announcement a month ago announcing the completion of the core components, has this changed at all now with the discharge summaries that it is complete?

Mr. Wyatt: — The status hasn't changed from what is reported in the audit. Saskatoon is currently the one region that is providing discharge summaries.

The Chair: — Can you give me an example of what that looks like on, again just sort of painting a picture for the members here what eHealth looks like? So if Saskatoon RHA provides discharge summaries . . . So I have an accident. I end up at the hospital — again St. Paul's or RUH [Royal University Hospital] — but I'm from Prince Albert and I go back to Prince Albert. I'm told to go talk to my family doctor. There won't be a connection. My family doctor will . . . If the accident happens in Saskatoon they'll know in P.A. [Prince Albert] but if it happened in P.A. and I'm from Saskatoon, they won't know.

Mr. Wyatt: — So the current system would involve the hospital where the patient has an emergency visit. At the point of release there would be a . . . Discharge information would be posted on to the provincial repository which would then be available to family physicians at the moment, because it is only the Saskatoon hospitals that are providing that discharge. It would be based on where the emergency visit took place, not where the patient resides.

The Chair: — Okay. Just to clarify then, if the accident happened in Prince Albert and I was discharged from the hospital and came back to my home in Saskatoon, that's not on the viewer.

Mr. Wyatt: — That's correct.

The Chair: — Okay. So there's still many, many gaps. When

we talk about having eHealth records, we are a long way from having a complete picture.

Mr. Wyatt: — Yes. I mean I would use that as an example of one of the additional repositories that's being developed. And I guess coming back to I guess the earlier conversation around when is the electronic health record complete, certainly the elements that were identified through the provincial and Infoway model, identifying those fundamental core repositories, that's the work that I think has been the focus for the past decade.

When you start to look at things like the hospital and ultimately the physician record, things like chronic disease management information, synoptic reporting, those I think are examples of some of the subsequent features of an electronic health record that will continue to evolve over time. And I mean, I guess, just like the example of an airline or a bank, I would say that, you know, the Bank of Montreal would never say that their electronic systems are done. And I would say that's probably an accurate assessment of any industry, that you will always have continued improvement and features that will be added to the core of the EHR.

The Chair: — Thank you. I understand we talked a little bit about systems and IT and how all those things connect, but in some of the conversations that I've had with health professionals, one of the challenges I also understand is not that we're going to have all of Danielle Chartier's health records are going to be in one place, but that identifying those key pieces of information from my doctor's visit or wherever it is, is a bit of a challenge. I know that there's been many conversations, and there's a group that meets and the auditor talked about that and I think you mention that in your action plan as well. But is one of the challenges still coming up with those key pieces of information that will be shared in some of those repositories?

Mr. Wyatt: — I would just describe that as one of the complexities. And one of the past, current, and future challenges is around the complexity of health delivery where you have this combination of acute care, primary health care, long-term care, and then you have the range of different kinds of providers from those who are employed by regional health authorities to those, like using a physician or a pharmacist as an example, working in a private business. And so I think that's definitely one of the complexities around both the assembly of the information and then developing those platforms which can then return the information, not just to a series of bank, you know, Bank of Montreal branches, but we have this range of regional health authorities which have multiple service lines and providers working, but then these private contractors working in the system.

And I think that is really part of why the time and investment has gone in, because this is not a simple model of just developing, you know, a system that is for hospitals. It's a recognition of the much broader range of services and range of providers who have to be part of the system.

The Chair: — Obviously, and as you've all not just alluded to this but said that this is an ever-evolving system, but when it comes to . . . I know I'm thinking about my own family doc who has some frustrations around her system and connecting to the broader universe of sharing these records. Are you close to coming up with those pieces of information that in terms of coming to consensus on what should be shared and how that will be shared, or is that, when we talk about that five-year technology road map, that's a part of that?

Ms. Junek: — Yes, I think in terms of . . . So I always think of the EHR as, you know, we've built the repository as we've said. We've really kind of focused on that core, as Infoway defined — here are really the key pieces of information — and that was defined by providers across the country that said, this is really the core set of information that we believe is important to share. And I think, you know, when we say complete, I mean that's a dimension of complete. We've got the data stores for that, completely recognizing there's gaps to fill in and bring in data sources yet.

I think in terms of the what-next conversation, we are having those conversations. And I don't want to go too Steve Jobs on everybody, but I do think as providers start to use this information and start to access it in a different way, they are going to identify new needs for us, either for functionality or for information that they require.

So it is evolving. When we talk to providers, they don't always have a common opinion on what they need. A specialist might want different information than a GP might need. And we're constantly having those conversations with those stakeholders to make sure that what we're putting in the record is what is needed by the providers, but also by the patients.

The Chair: — Just addressing the five-year technology road map here . . . sorry, and I know this was said. So that road map is not yet complete? Not complete in terms of the five years, but you're in the process of developing that road map right now? Just if you want to clarify that.

Ms. Junek: — Yes. We're in the process in that. In fact we're actively meeting with the CIOs, and we'll be delivering a report on progress at the end of March to the CEO council.

The Chair: — Thank you for that. Just a couple other sort of minor questions here. So just again going back to the number of diagnostic imaging and reports, just a clarification here. So at the snapshot in time when this audit was done, it was about 30 per cent of images and reports in the province that there was no agreement in place. Has that number changed since that audit in terms of diagnostic imaging in the private sphere being available?

Ms. Junek: — We've made some progress. We've begun conversations with both private radiologists and with the vendors in terms of the complexities and what would be involved to get that done. So the answer to the question, do we have more of those in? No. Have we made some progress and advanced those conversations? Yes.

The Chair: — And it's still at about the 30 per cent. Okay. Thank you. In terms of Infoway's funding of the 184 million that's been spent on building the system, so Infoway helped fund the building of the systems, or the development and what's needed? I'm just curious. Of the 184 million that's been spent, what percentage of that was Infoway money and which was

provincial dollars?

[10:45]

Mr. Wyatt: — Okay. So if we take the total $180 million cost, 72 million of that would be attributed to the development, and then the remainder, actually the majority, would be around the implementation of the systems within the health regions. So when we look at the development costs in the 72 million towards development, 54 million came from Infoway and the remaining — what is that? — 18 million would have been provided by the province.

The Chair: — Is Infoway money still flowing or is that done?

Mr. Wyatt: — There are still some projects that involve funding coming through Infoway.

The Chair: — Thank you for that. Just a couple more questions here. Mr. Nilson asked the question around the new children's hospital, and you had said that it's designed now to be both, to accommodate paper. But prior to the redesign last spring, had that been the case? Had it been completely paperless? Or because eHealth isn't where everyone thought it would be, did it have to . . . Was there some rejigging, not just because it was too small but because of the paperless issue?

Mr. Wyatt: — I would say as the plans were being developed for the hospital and moving into the detailed plan around the information flow, that the concept or I guess the ideal of paperless, once it moved into the planning, has accommodated some paper flow in the process. So there has been I guess the identification of the need for paper as the planning has been undertaken.

The Chair: — So just a clarification then. Last spring there was an announcement by the minister that there'd be additional money put in to support the redesign of the children's hospital because of space, and one of them was the bed issue. But I'm just wondering if that redesign — and it wasn't a whole en masse redesign; I recognize that — but just clarifying that that redesign wasn't just about beds but about the need to accommodate for paper storage and use.

Mr. Wyatt: — The information we have available to us would say it was related to the beds. Nothing to suggest that IT was one of the considerations.

The Chair: — Thank you for that. Just in terms of what this committee . . . I think some of the questions that you haven't been able to answer, if you could endeavour through the Clerk to let us know how many dollars in RHAs and the cancer agencies flow for eHealth records versus eHealth, that would be great.

Mr. Wyatt: — I have that information.

The Chair: — You have that? Oh, wonderful. Okay.

Mr. Wyatt: — For 2013-14, regional health authorities spent 50.5 million on information technology.

The Chair: — The regional health authorities. Okay, thank you. And the question around which facilities in health regions are not on the system, if you don't have that information available or if someone didn't get it for you in the last five minutes, if you could endeavour to get it to the committee via the Clerk, that would be great.

Are there further questions? Seeing none, I'm wondering what the will of the committee is with respect to these recommendations. Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. If I could group the recommendations on the 2014 Provincial Auditor's report volume 1, chapter 9, recommendation 1 through 5 inclusive, that I concur with the recommendation and note progress towards compliance.

The Chair: — Thank you, Mr. Merriman. Mr. Merriman has moved that for the 2014 Provincial Auditor's report volume 1, chapter 9, that this committee concur with the recommendations and note progress on the five recommendations. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Thank you so much for your time. I guess we're on to the next chapter now. We really appreciate the information that you provided today. It gives us a much fuller picture, so thank you.

So moving on to the next item, the Five Hills Regional Health Authority, the 2012 Provincial Auditor report volume 2, chapter 28. Can I recommend that we take a brief 10-minute recess? Okay. So we will recess for 10 minutes.

[The committee recessed for a period of time.]

The Chair: — Welcome back everyone. Welcome back to PAC, the Public Accounts Committee and the review of the Provincial Auditor's reports. We will be moving on to the 2012 Provincial Auditor report volume 2, chapter 28, the Five Hills Regional Health Authority. And I'll pass it off to Ms. Ferguson for her remarks, and then, Mr. Wyatt, I'll give you an opportunity to do that as well.

Five Hills Regional Health Authority

Ms. Ferguson: — Thank you very much, Madam Chair, officials, and members here. This morning the second presentation, it's the Five Hills Regional Health Authority, nourishing, safe food services in long-term care facilities, chapter 28 of our 2012 report. This chapter reports the results of our audit to assess whether the Five Hills Regional Health Authority provides nourishing and safe food services in its owned and affiliated long-term care homes.

One thing I just noted though, I was remiss at the last presentation. I'd like to do that now, to actually thank the eHealth officials along with the Five Hills officials for the excellent co-operation that we received in both of these engagements. So without further ado, I'm just going to turn it over to Mr. Ahmad to present the findings in this report.

Mr. Ahmad: — Thank you. Chapter 28 begins on page 204 of

our 2012 report volume 2. Under *The Regional Health Services Act*, regional health authorities are responsible for the delivery of health care in the regions including long-term care delivered in their facilities or facilities operated by their affiliates.

Nutrition is essential to the health of long-term care residents. Well-prepared nutritious food can help older people retain their health, prevent and manage their chronic conditions, and help residents maintain a better quality of life. Five Hills had 10 long-term care facilities in the region and over 500 long-term care beds. We assessed whether the Five Hills provided nourishing and safe food services in their owned and affiliated long-term care facilities for the period from January 1st, 2012 to July 31st, 2013. We concluded that Five Hills processes could not always ensure that nourishing and safe food services were provided to residents of long-term care facilities. We made 11 recommendations.

First, on page 208 we recommend the authority to confirm that all long-term care facility menus comply with Canada's Food Guide. *The Housing and Special-care Homes Regulations* require basic daily food to be provided in accordance with the Canada's Food Guide. We made this recommendation because we found that the manual used by authorities did not completely comply with Canada's Food Guide. Also the authorities did not have its registered dietitians confirm that its menus met the requirements of Canada's Food Guide and the requirements of the residents.

Second, on page 209 we recommend the authority review and update its nutrition and food services policy and procedures manual. The manual sets out policy and procedures for the delivery of food services, including procedures for such things as food preparation and mealtime assistance. We made this recommendation because the manual was outdated. The manual was created in 2005. Many policies had not been reviewed and updated since then. Without an updated policy manual, the authority cannot ensure that the food practices of its long-term facilities meet the standards it has adopted.

Third, on page 210 we recommend the authority implement a standard system of tracking individuals as to dietary needs and changes to those needs. The authority's method of tracking residents' individual dietary needs and changes to those dietary needs were inconsistent throughout the region. Inconsistent tracking increases the risk of serving inappropriate or wrong meals to the residents.

Fourth, on page 210 we recommend the authority develop guidance for when a registered dietitian should review dietary needs of residents. We noted that the dietitians did not always review a resident's dietary needs upon admission or on a periodic basis. Dietitians only reviewed the dietary needs of the residents when asked for a consultation by care staff. The authority's registered dietitians should periodically review the dietary needs of each resident.

Fifth, on page 210 we recommend the authority obtain annual average food costs per day information from its affiliates to confirm that a reasonable amount is being spent on food for residents of long-term care facilities. The authority prepared reports of actual revenue and expenses for each dietary department of its own facilities; however, such information for the affiliates were either not received or reviewed. As a result, the authority did not know whether affiliate spending for providing food services was reasonable.

Sixth, on page 212 we recommend the authority require a registered dietitian to regularly review menus to confirm the meals served met nutrition standards. We found that not all meals delivered to residents were consistent with the menus. We recognize that sometimes menus need to be modified; however, it is important that the food served to the residents is nutritious and healthy. A registered dietitian could help ensure that the residents receive the appropriate type and amount of food to meet nutrition standards.

Seventh, on page 213 we recommend the authority follow its policy and procedure to serve food at the appropriate temperature and texture. We observed that the serving staff either did not take the temperature of food before serving or did not properly document the temperature in writing as the policy required. Lack of such procedure increased the risk of food-borne illnesses due to bacteria and toxicants.

Eighth, on page 213 we recommend the authority provide timely assistance to residents to ensure they are served meals at the appropriate temperature. During the audit we observed a resident in need of assistance was not assisted until at least 30 minutes after the food was served. As a result, the resident consumed cold food.

Ninth, on page 214 we recommend the authority follow its policy for quality improvement by conducting annual risk-based audits or reviews of its food services. We made this recommendation because the authority did not follow its policy of conducting annual audits of its facilities to ensure they follow established policies and procedures.

Tenth, on page 214 we recommend the authority periodically survey the residents of all long-term care homes and their families about the authority's food services. We found that only one affiliated facility in the region conducted a survey of food services on an annual basis. Conducting regular surveys could help ensure the authority's long-term care facilities served safe and nourishing food to the residents in a cost-efficient manner.

Finally, on page 215 we recommend the authority implement procedures to document, monitor, and address complaints from residents of long-term care facilities and their families about food services in those facilities. The authority did not have a formal process to receive and respond to complaints about food services in its long-term care facilities. As a result, it might not know any issues relating to food services and may not take action to address those issues. And that concludes my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Wyatt, if you would like to introduce folks or your representative from the Five Hills Regional Health Authority and make any remarks that you would like pertaining to these 11 recommendations.

Mr. Wyatt: — Thank you very much. I'll start by introducing Sharon Nicolson who is joining me at the front table. Sharon is the regional director of nutrition and food services for Five Hills Health Region. We also have joining us, from Five Hills

region, Georgia Hutchinson who is the regional director of long-term care and community hospitals.

I will perhaps start out by a brief summary of the recommendations and provide that off the top at this time. And I can, maybe by way of overview, just indicate that since 2012 and the time that the audit was reported, that there has been substantial progress across the board on these recommendations. We would see that the region has complied with the majority of those 11 recommendations and there are four that remain in the category of making progress, while the other seven are considered to be having been achieved.

So I'll just briefly speak to each of the 11 recommendations, starting with no. 1. The region has addressed this recommendation by having a registered dietitian review and adjust the menu to be compliant with Canada's Food Guide. Any future menu changes will be reviewed prior to implementation.

Moving to recommendation 2: the regional director of nutrition and food services has currently reviewed 60 per cent of the regional food services policies, and this recommendation is expected to be fully implemented by June of 2015.

Recommendation 3: the region has completed standard work for processing diet changes for long-term care residents. To identify the dietary needs for each resident, the Kardex system is used in larger facilities and a binder system in smaller facilities. The Kardex system consists of each resident having a card with which all dietary information is recorded from the time of admission until the end of their stay. Dates and initials of both the person initiating the order as well the person completing the order are required. Processes in affiliate locations are being reviewed. This recommendation is expected to be fully implemented by September of 2015.

Recommendation 4: the region has addressed this recommendation by implementing the med pass program. The program provides a minute nutritional assessment on each resident to assess their nutritional status. Depending on the results of the assessment, a registered dietitian may perform a complete assessment, with a follow-up by a clinical dietitian scheduled every two weeks thereafter.

Work continues to address assessments, that assessments are completed within 14 days of admission with quarterly assessments thereafter.

[11:15]

Recommendation 5: the region has addressed this recommendation by requiring affiliates to provide food cost information to the regional finance department.

Recommendation 6: the region has addressed this recommendation by requiring all modified menus to be reviewed by a registered dietitian to ensure that meals served meet nutritional standards. The work standard of submitting menu substitutions has been developed. Compliance is continually monitored.

Recommendation no. 7: food temperature compliance charts have been developed for all facilities in the region. A set of screens have been purchased to check for texture consistencies. In June 2014, screen testing was completed at Moose Jaw Pioneer Lodge with very good results reported. Screen testing will continue at all other long-term care facilities in the region. This recommendation will be implemented by December 2015.

Recommendation 8: the region has created a working group to develop dining experience guidelines which includes an education program for food service and nursing staff. Some facilities have staggered meal services and some locations have changed resident seating to accommodate those requiring help. Nursing staff are now involved to assist residents at mealtime. There will be further collaboration with nursing staff throughout the region as well as educational opportunities to improve the dining experience. The educational component will continue to be rolled out to staff and other departments responsible for assisting residents during mealtime.

Recommendation 9: the region has created a schedule for conducting resident surveys. Accident prevention and sanitation audits have been completed to date. In addition, an education component is being introduced; for example, training is scheduled for food safety and the dining experience.

Recommendation 10: all regional facilities participated in the resident survey in 2013. Results were tabulated for each facility with deficiencies discussed and improvement strategies planned. The data is currently being compiled for the 2014 survey, and surveys are conducted annually.

And the last recommendation: the region is working to develop a policy for each facility to address complaints and standard work is under way. The use of comment cards, comment boxes and cards has been implemented in all facilities. Comment cards are readily accessible in all dining areas throughout the region. Nutrition and food services is now on the agenda at all resident family council meetings, and this recommendation will be fully implemented by February 2015.

Those conclude my opening remarks.

The Chair: — Thank you, Mr. Wyatt. Mr. Nilson.

Mr. Nilson: — Thank you for your comments. I have to sort of own up to a couple of things. I've visited every one of the facilities that are listed here before, either officially or with relatives, because I have so many relatives through your health region. And also my mother is a dietitian, so I always watch these things very carefully. But my question isn't for you. It's for the Provincial Auditor. How did you choose Five Hills to do this survey?

Ms. Ferguson: — Thank you very much for the question. What we're always trying to do, in terms of when we're selecting our work, is we actually selected the subject matter first, actually looking at nutrition in part because of complaints that we'd heard from others in our office. The reason that we selected Five Hills, we tried to look across the arena as to what work we've done within the regional health authorities and to create coverage across the authorities as a whole. So we didn't select Five Hills because we thought they were particularly good or bad. It was frankly just from coverage. What we're hoping in all

of these audits is that all the regional health authorities will take our criteria and also our findings and look at them and see where they stack up.

Mr. Nilson: — Yes. Thank you for that answer. That was what I assumed had happened here, but I wanted to make it clear that Five Hills didn't have any specific problem that arose. It's more to confirm the kind of work that you're doing. I appreciate the report, and I just have a couple of questions. One question relates to the med pass. What exactly is that? Is that like an acronym or is it a program? You know, what is a med pass?

Ms. Nicolson: — Would you like me to answer it?

Mr. Nilson: — Yes.

Ms. Nicolson: — The med pass program was a simplified method that we introduced in order to trigger dietitian visits to the residents. On admission, all residents are given . . . a mini-assessment is done of their nutritional needs. That mini-assessment is done by the nursing staff.

The Med Pass itself is a product we use as a supplement that is given with medications if the resident scores that they're either malnourished or at risk of malnourishment on admission. We've had very positive results with it. Anyone that scores low is immediately visited by a clinical dietitian, and a meal plan, a food plan, supplements are developed. And they're monitored very closely for a matter of six months, a year, etc. on a quarterly basis.

So in the past we were using a lot of supplements for our residents and found that many, many times the supplements would sit on the bedside table or on the dining room table and not really be taken, so of course it was a lot of money wasted with no benefit to the resident. So now every time a resident is prescribed the Med Pass, the certain supplement — it's only an ounce to 2 ounces given three, four times a day — it's recorded. It's given by the nurse, and it's recorded on their med sheet. So now we know what the resident is actually receiving and not going down the garburator and down the drain.

Mr. Nilson: — Okay. So the term med pass, does that mean . . . Is it an acronym or is it . . . You know, what is it?

Ms. Nicolson: — We call it med pass simply because the supplement that's being used is a resource; it's a supplement higher protein. And the med pass signifies the fact that it is recorded, that the resident actually receives that supplement, and it is given by the nursing staff.

Mr. Nilson: — So does m-e-d mean something?

Ms. Nicolson: — No.

Mr. Nilson: — No, it doesn't. Okay. So it's a shorthand that you use to . . .

Ms. Nicolson: — Yes, it's a way a supplement is given, recorded that it has actually been ingested, that it's actually been taken.

Mr. Nilson: — Okay, and is this common throughout the province, that this kind of a system is used, or is this something specific to Five Hills? Or do you know?

Ms. Nicolson: — For our other regions that do use med pass to record and ensure that residents are receiving the supplement, it's been very effective in a lot of different conditions, including wound care. So some areas use it specifically for wound care. Others will use it as a supplement replacement for other supplements that aren't being taken.

Mr. Nilson: — And so the term med pass doesn't mean anything specifically, like . . .

Ms. Nicolson: — No. No, it's a just a way of recording. I guess what it means specifically is it is a supplement that is recorded and given with medications so that we always have documentation on what is being taken by the resident. In the past, as I said, many of the supplements were set on the bedside table or the dining room table and not necessarily ingested and taken. So it was always guess and by golly. Is this person improving? Isn't he improving? Once improvement is noted, then this particular supplement, resource point 2, is often discontinued.

Mr. Nilson: — So you're using that process of passing medications . . .

Ms. Nicolson: — For documentation and for triggering the need of full assessments and follow-up with our residents. Yes.

Mr. Nilson: — Okay, and so then that allows you actually to have better information about all of the patients, which then complies with the recommendation.

Ms. Nicolson: — Exactly, exactly.

Mr. Nilson: — I have no further questions. Thank you very much.

The Chair: — Mr. Hart.

Mr. Hart: — Thank you, Madam Chair. My question is for the auditor. How long has the Provincial Auditor's office been doing this type of review of long-term care homes? Is this something anew or have you been doing this for quite some time? I've never seen a chapter like this before, so that's the reason for my question. Not that I'm saying you shouldn't, but I just would like some history.

Ms. Ferguson: — Yes. Our office has actually been doing work beyond the financial audits actually since the early 1990s. So we're into, you know, what is that — 10, 15 years or so? And so the areas in which we look at — you know, like earlier this morning we looked at information technology — in this particular area, we're looking at food, the nourishment of foods.

Mr. Hart: — That was my question more specifically, you know. I mean you have some recommendations here about temperature of food and that sort of thing. And so how long has your office been actually going into nursing homes or long-term care homes and observing, you know, the procedures of the meals, the temperature of the meals, and the food preparation and food storage, and that sort of thing? How long has your

office been doing that?

Ms. Ferguson: — So that the work directly within long-term care homes is relatively recent. Earlier on when regional health authorities were set up, or district health boards, we tend to focus on terms of, like things that helped organize them because they were bringing in terms of consolidation. So over time, we're looking at different dynamics of a regional health authority and, in this case, it's long-term care.

In our last report, you'll find that we look at medication planning, and again that was in long-term care. But previously we had looked in the acute care setting for that same subject matter.

Mr. Hart: — And yes, you know, it's like I said, I haven't seen this before. And you know, I'm not saying that this shouldn't be done. Certainly all these things need to be monitored, you know. But the question that I had when I was looking at this is, you have people that have some expertise in this area, particularly when, you know, there's some of the recommendations talked about puréed food and choking, and food storage and temperatures, and that sort of stuff — you know, all valid concerns, all valid recommendations. But I'd like some assurance that you have the people with the knowledge and training and expertise in these areas, you know, to make these kind of recommendations. I'm certain you do, but I would like, I'd like that information presented.

Ms. Ferguson: — Excellent question. Actually in these types of subject matters, what we do as an office, we engage . . . like in this case we engaged a dietitian to assist us on this engagement. And so, you know, what we do is we recognize that there's some . . . in some areas we can have the expertise housed directly within the audit office. In other subject matters it's not efficient to do that. It's more cost-effective for us to actually engage the expertise for the particular engagement. And when we do that we always vet the individual that we're engaging with the organization that we're auditing so that they too agree that the individual that we're using or individuals are credible within the area that they're looking at.

Mr. Hart: — Thank you. That certainly answers a lot of questions. And as I said earlier, I mean, these are certainly areas that need to be looked at. And, you know, one of the recommendations of surveying residents and families, you know, recommending that health regions do that, you know, I certainly concur with probably . . . with all the recommendations. It's just I wanted some assurance to make sure that, you know, that this is quality work. And you certainly have given that assurance. So thank you for that.

The Chair: — Are there further questions from around the table? I have some around recommendation 8 actually if . . . around the recommendation around providing timely assistance to residents to ensure all residents are served meals at the appropriate temperature, and some of the fixes that you've endeavoured upon — creating the working group and staggered meal services and nursing staff now involved to assist residents at mealtime and for their collaboration.

I know one of the things that's come up here in the last year and a half has been staffing in long-term care facilities, and as the Health critic I hear frequently from both residents, families, and front-line staff around the issue of staffing and the question of whether or not there's enough staff. So I see here that you have nursing staff involved in assisting residents at mealtime. How has that impacted . . . And that actually is one of the issues that has come up sort of time and time again, that residents don't get the assistance with meals. So I'm wondering how you've made that work within your existing staff complement, or have you hired additional staff? What does that look like?

Ms. Nicolson: — I can assure you we have hired no additional staff throughout the region. This says that nursing staff have just started assisting residents, and that's a misprint or a misunderstanding. Nursing staff have always assisted residents in the dining room. Food service staff will do the serving — take the plates, pour the beverages, etc., etc. — but when it comes to actual assistance and particularly feeding, it is the CCA [continuing care assistant] that's trained in that procedure. We also have recreation staff in the various facilities that are expected to be in the dining room to assist at mealtime and provide all hands on deck. In some facilities we have our housekeeping and maintenance staff even assisting with wheeling the residents to the dining room. So it is a teamwork, lots of teamwork in long-term care.

[11:30]

The Chair: — So with respect to this particular recommendation, and so perhaps it's sort of a misunderstanding or miscommunication here with nursing staff are now involved . . .

Ms. Nicolson: — They always have been.

The Chair: — But . . . always have been, but obviously the auditor had identified an issue with some people not eating until 30 minutes after their meal had served. So I'm wondering how this particular, that comment about nursing staffing helping, have you increased — well, you said not the staff complement — but have you changed anything on the staffing with respect to supporting residents to get their meals in the . . .

Ms. Nicolson: — To this point in time all the food service staff have gone through a lot of education with pleasurable dining in the dining room and expectations, and it's being rolled out throughout the region to the CCA, the nursing staff. Other than that there have been things like staggering the mealtime in various facilities. Changing seating arrangements also has been an assistant, has assisted care staff. So there have been, you know, different options tried, and I'm sure that a 30-minute wait for a plate is not happening at this time.

The Chair: — With respect to staggering mealtimes, can you give us a bit of a sense of what that looks like when . . . obviously we get the concept of staggering mealtimes, but what in a facility or two that would look like, when breakfast starts, when lunch, when dinner? What would that look like?

Ms. Nicolson: — Many times there's early arrivals to the dining room, well for every meal, but breakfast in particular is more of a flex meal in our facilities, so as people come, they're served in many cases. When I say staggering mealtime, we also have the request for a lot of residents that require assistance to

receive early meal service so the staff are available to assist with the feeding.

The Chair: — What time of day would that start?

Ms. Nicolson: — Our regular . . . well I can speak for . . . There's a slight variance at different facilities in the region, but I'll speak for Pioneer because that's where I'm located, and our breakfast service starts at 8:15. Noon or the lunch meal is 12 o'clock, supper meal is 5. And then we have two separate dining rooms as well. So the second dining room is 15 to 20 minutes after the first.

The Chair: — Thank you for that. Thank you. Are there further questions? Mr. Nilson.

Mr. Nilson: — One other question I was going to ask as it relates to recommendation no. 5, where it talks about there being a reasonable amount spent on food. And this question may be to the province or the Ministry of Health, if there is some kind of a standard provincially around a reasonable cost for food, or perhaps you can explain what the policy is in this area.

Mr. Wyatt: — We don't have a standard cost per meal that is instituted across the province. We do have the special care home guidelines, and regions are expected to meet the terms of those guidelines in the way that they develop the meal plans. There will be some variation across different facilities depending on things like the patient profile and population, the need for things like nutritional supplements. So there can be some differences that one would expect to see across different locations. We don't have a provincially instituted dietary budget.

Mr. Nilson: — Thank you. I have no further questions.

The Chair: — Mr. Michelson.

Mr. Michelson: — Maybe a clarification from the auditor. On page 211, it says Five Hills should consider having kitchen staff take refresher courses for safe food handling. Has there been a concern there or is that just putting that in? On page 211 at the very bottom.

Ms. Ferguson: — On that one there, it was just a . . . As you can see we did not make a recommendation, a specific recommendation. It was just, you know, an observation that we noted. I think it feeds into the aspect in terms of the texture of the food and the temperature of the food and so you know those things are, in our view, can be part of the food handling for the dietitian.

Mr. Michelson: — So you're suggesting that they just do a refresher course? Like when I read that I think there could be a concern there somewhere but I didn't see one.

Ms. Ferguson: — You're quite correct. It wasn't significant enough to make a recommendation. It was like an observation for, you know, an area that we thought that Five Hills should pause on but it wasn't significant enough to render a separate recommendation.

Mr. Michelson: — Do you have a comment on that?

Ms. Nicolson: — Did you say food handlers course?

Mr. Michelson: — It says Five Hills should consider having kitchen staff take refresher courses on safe food handling.

Ms. Nicolson: — Okay. That's part of our education component and part of the audit process. It's part of the screen testing that we've developed. Saskatoon Health Region actually had spent a lot of time and a lot of money setting up a manual on particle sizes, for instance, for puréed diets and minced diets. And that's what we're basing our testing on to make sure that we are complying with the right consistencies for those texture-modified diets.

Food handling, safe food handling training, I would estimate at least 80 per cent of our staff, food service workers and cooks included, have taken at least one day's training through public health. Some of them have had refreshers already. Although it's not mandatory, it is looked at. A refresher should be given every five years. So we're just starting to do the refresher training with some of our long-term employees.

Mr. Michelson: — Okay. Thank you.

The Chair: — Just a follow-up question to Mr. Nilson's question. Mr. Wyatt, could you refresh the members' knowledge here around the language in the special care home guidelines around food?

Mr. Wyatt: — So under *The Regional Health Services Act*, special care homes and other designated facilities are required to follow standards in the program guidelines. And some of the key standards specific to nutrition within those guidelines — there are about 10 of them — just quickly, they address nutritional and hydration needs. The dining experience for residents must be resident centred, nutritional, social, and emotionally supportive.

There's a requirement or a standard specific to being based on the *Eating Well with Canada's Food Guide*, consistent with cultural, religious, or ethnic preferences. One that's important is that food services, including kitchen, dining, and food storage areas of long-term care facilities, are required to operate in compliance with the food safety regulations and accompanying public eating establishment standards. Compliance inspections by a public health inspector are required.

Another important one is that all staff working specifically in the food handling service must have training in the basic principles of safe food handling, sanitation, special diets, and food presentation. And quality improvement program for food services must be established and reviewed. So those are among the standards that one would find related to nutrition.

The Chair: — Thank you for that. And obviously today here we're talking about Five Hills, but in terms of how you make sure those are followed or carried out across the province, what kind of mechanisms are in place to ensure that every health region and their facilities and affiliates are following those guidelines?

Mr. Wyatt: — Through the standards themselves we would have the expectation that regional health authorities are aware of and complying with these standards. This audit itself is an example of the kind of information that, whether it's related to food services or I guess the next one, around infection control, we would make the findings from this audit available and share those. And, I guess, be following up and working with regions to identify some of the areas that are in relation to Five Hills, and to follow up to ensure that they are following and meeting the requirements of the special care home guidelines.

The Chair: — Thank you for that. Are there any further questions? Seeing none, what is the will of the committee with respect to these recommendations? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. Again I think we can group them into two categories of noting progress towards compliance. And if I can make the recommendation for the 2012 report volume 2, chapter 28, recommendation no. 2, 3, 7, and 11 that we concur with the recommendation and note progress towards compliance.

The Chair: — Thank you, Mr. Merriman. Mr. Merriman has moved that for the 2012 Provincial Auditor's report volume 2, chapter 28, recommendations 2, 3, 7, and 11 that this committee concur with the recommendations and note progress to compliance. Is there any further discussion around these recommendations? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Merriman.

Mr. Merriman: — Thank you again, Madam Chair. Again I will group for the 2012 auditor's report volume 2, chapter 28, recommendation 1, 4, 5, 6, 8, and 10 that we concur with the recommendation and note compliance. I'm sorry. I excluded no. 9.

The Chair: — Thank you. Mr. Merriman has moved that for the 2012 Provincial Auditor's report volume 2, chapter 28, for recommendations no. 1, 4, 5, 6, 8, 9, and 10 that this committee concur with the recommendations and note compliance. Is there any further discussion? No. Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed. Carried. All right. Thank you. Moving on. Thank you for your time, and we will move on to the next chapter now which will be the Sunrise Regional Health Authority, 2014 Provincial Auditor report volume 1, chapter 13. We'll just give a minute here to switch out officials. Thank you. Ms. Ferguson, I will give you an opportunity here to make some remarks on that chapter.

Sunrise Regional Health Authority

Ms. Ferguson: — In the absence of time, I'm just going to do quickly a thank you for the excellent co-operation from again the authority here and turn it over to Mr. Ahmad to make the presentation.

[11:45]

Mr. Ahmad: — Thank you, Judy. Chapter 13 begins on page 107 of our 2014 report volume 1. The authority's responsibility is to deliver health care in its regions including prevention and controlling the spread of infection in all of its facilities including the long-term care facilities.

The authority has 14 long-term care facilities in the region and over 800 long-term care beds. Preventing and controlling infection in long-term care facilities is essential to reducing and managing health and safety risks to residents, staff, and visitors.

We examined the effectiveness of Sunrise Health Authority's processes to prevent and control infection in its long-term care facilities for the 12-month period ended March 31, 2014. We concluded that the authority had effective processes to prevent and control infection in its long-term care facility except for the measures covered in our recommendations.

We made 10 recommendations. First, on page 114 we recommend that the authority expand its infection prevention and control plan to include goals, actions, and targets for its long-term care facilities and have the plan approved by its board. We made this recommendation because the authority's existing plan was not sufficiently comprehensive, as it did not include all aspects of infection prevention and control. Also the plan had limited information related to the authority's long-term care facilities. An expanded plan approved by both senior management and the board would help the authority direct attention to high-risk areas in the long-term care facilities and monitor the results of all infection control processes.

Second, on page 115 we recommend that the authority consistently communicate its practices for infection prevention and control in its long-term care facilities to front-line staff of facilities and the public. During the audit we found that the authority had inconsistent practices of informing staff and public about hand hygiene, infection symptoms, and needed precautions if a resident or visitor has an infection. If staff and the public are not informed about the danger of spreading infections, residents of long-term care facilities would have higher risk of becoming seriously ill.

Third, on page 116 we recommend that the authority implement written procedures requiring readily accessible hand hygiene stations at points of care in long-term care facilities. The authority did not have a written procedure directing its long-term facilities about the location of hand hygiene supplies. During our audit, we found the availability of alcohol rub in the region's long-term care facilities were inconsistent. For example in some cases the closest alcohol rub station was three rooms away. Lack of readily available hygiene product would result in staff and visitors not taking precautions to reduce spreading of infections.

Fourth, on page 116 we recommend that the authority implement cleaning procedures that identify cleaning requirements for all areas of long-term care facilities. At the time of the audit, the authority did not have procedures for cleaning common areas such as public washrooms, sitting areas, and activity rooms. Without specific cleaning requirements for all areas, the facility may not receive the appropriate cleaning.

Fifth, on page 117 we recommend the authority require staff to

document the level of cleaning completed on each area of the long-term care facilities and have the documentation reviewed by a supervisor. We found inconsistent practices of the thoroughness of the room cleaning and completion and review of the cleaning logs. Lack of proper documentation review of that work would result in work not being done as required.

Sixth, on page 117 we recommend the authority to consistently handle and segregate soiled laundry to reduce the risk of infection to staff and residents of its long-term care facilities. We made this recommendation because the authority did not have procedures for staff to follow when handling soiled laundry. As a result, staff may not have clear understanding of what they must do and when. It also increased the risk of infection for staff and residents.

Seventh, on page 118 we recommend the authority to develop a training plan to give formal updates on infection prevention and control practices to staff of long-term care facilities. The authority did not have a formal ongoing training plan for staff on infection prevention and control. Formal ongoing training is important to help staff understand and adopt new practices.

The eighth and ninth recommendation, on page 119 and 120, are related. We recommend the authority to collect information on key types of infection that affect long-term care residents and also routinely analyze that information. We made these recommendations because the authority did not have a system to collect and summarize a report on key types of infection. Collection and analysis of such information could help the authority to better identify the emerging risk of infection to both staff and residents and take appropriate action.

Finally, on page 121 we recommend that the authority give senior management and the board routine written analysis on rates and trends of key infections in its long-term care facilities. At the time of the audit, the authority did not collect or analyze information on key infections. Routine written analysis would help the authority to follow up on trends and recommend action to reduce the number of infections in its long-term care facilities.

And that ends my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Wyatt, if you'd like to introduce your official from the health region and make any remarks on these 10 recommendations, that would be very helpful.

Mr. Wyatt: — Thank you. I would like to introduce Roberta Wiwcharuk who is vice-president of health services with Sunrise Health Region. She joins me at the front table. And I guess I'll maybe test the will of the committee. I can go through speaking remarks that are pretty well consistent with what has been shared with the committee in advance. And because we have 10 recommendations and some of them are more detailed, I'll just ask whether you'd prefer that I speak to them or we can just move ahead with questions.

The Chair: — You know, Mr. Wyatt, we don't actually table this document, so if you wouldn't mind putting that on the record, that would be helpful.

Mr. Wyatt: — All right. We'll begin with recommendation 1. The region has, and I'll maybe preface my remarks by saying that with this 2014 audit, Sunrise Health Region has already complied with 8 of the 10 recommendations, and it's recommendations 5 and 10 which are identified as still in progress.

And so with that, recommendation no. 1 has been concluded. Sunrise has addressed this by developing and revising various policies and guidelines. These include long-term care outbreak checklist and management guidelines, hand hygiene, routine precautions, a glove pyramid, the additional precaution signage, and new regional dress code for integrated health services. As well the hand hygiene and influenza immunization rates and targets for 2014-15 have been developed. Hand hygiene auditing is completed monthly at all long-term care sites, and the target is to reach 100 per cent hand hygiene compliance by March of 2015. The board has approved all actions and targets, and the recommendation was implemented June 2014.

Moving to recommendation no. 2, the region has addressed this recommendation: infection, prevention, and control. Educational brochures were developed and distributed in October 2014. These resources, along with new additional precaution signage, were presented at the annual IPAC [infection, prevention, and control] workshop. And I should just clarify that IPAC is the infection, prevention, and control committee in the province. So IPAC education brochures were developed and distributed in October 2014. These resources, along with the new additional precaution signage, were presented at the IPAC workshop in October 2014. Brochures are shared with managers, supervisors, and front-line staff via email communication and at local IPAC committee meetings.

Standardized signage posters resources were developed for long-term care facilities. Signage at the front entrance encourages all visitors to use provided hand hygiene prior to visiting and upon exiting the facility. Annual hand hygiene promotion week included the development of the hand hygiene and respiratory etiquette guide. As well, the policies, procedures, and guidelines are available on the Sunrise Health Region intranet. This recommendation was implemented October 2014.

Moving to recommendation no. 3, this has been completed. The guideline for placement of alcohol-based hand rub was developed to assist facilities in placement of hand hygiene stations so that they would be readily accessible. The recommendation was implemented September 2014.

Recommendation no. 4: the region has addressed this recommendation through guidelines and policies that were developed in June 2014. The policy includes cleaning procedures for dining rooms, common areas, entranceways and hallways, meeting rooms, public washrooms, and smoking rooms. The procedures were emailed to long-term care facilities for posting on daily management walls. Operational support services managers will verify compliance in each of their facilities in February 2015. A regional audit will be conducted twice per year beginning April 2015. This recommendation was implemented September 2014.

Recommendation no. 5: the region has made progress in

implementing this recommendation. The region developed the department practice guidelines for required documentation policy to address this recommendation. Worksheets have been reviewed and updated to ensure they include the common areas stated in the department practice guidelines for common areas in long-term care policy. Operational support services managers will verify compliance in each facility by February 2015. A regional audit will be conducted twice per year beginning April 2015. Work is still required on standardized formatting, and this recommendation is expected to be fully implemented by March 2015.

In recommendation no. 6, the region has developed and revised the following policies and procedures: the soiled linen policy and procedure, and also a soiled linen collection job safety analysis. In addition, operational support services managers will verify compliance in each facility by February 2015, and a regional audit will be conducted twice per year beginning April 2015. The recommendation was implemented September 2014.

Recommendation no. 7: the region has addressed this recommendation by providing formal updates on changes to infection prevention and control practices, policies, and procedures on the Sunrise Health Region intranet as well as providing onsite training sessions and collaboration with clinical educators. Examples include hand hygiene and personal protective equipment. Training packages have been developed and available to all long-term care facilities to support ongoing training and annual refresher processes. IPAC staff participated in newly developed continuing care assistant educational training sessions via Telehealth in January 2015. As well, formal updates and changes are reviewed at facility wall walks. This recommendation was implemented effective January 2015.

Recommendation no. 8: the region has implemented this recommendation. Sunrise collects data on all new antibiotic-resistant organisms, reports all new clostridium difficile infections to the ministry, and shares all findings with the region. Targeted organisms are monitored, and all outbreaks are reported to the Ministry of Health. Infection prevention and control nurses share all types of infection information with the long-term care facility manager and staff, and appropriate management measures are put in place on a case-by-case basis. IPAC staff participate in monthly conference calls with Saskatchewan's IPAC provincial technical advisory group for ongoing support and direction in surveillance practices for long-term care. This recommendation was implemented December 2014.

Recommendation no. 9: the region has implemented this recommendation. All urinary tract infections have been identified provincially as a concern for long-term care residents. The region implemented the Saskatchewan UTI, urinary tract infection, provincial guideline by working collaboratively with the antimicrobial stewardship committee which includes nurse educators, pharmacists, labs, and the infection prevention and control team.

As well, educational sessions have been held across the region with physicians and front-line staff over the past year, that's 2014. All lab results for antibiotic-resistant organisms, clostridium difficile cases, or reportable diseases are input into the software program for ongoing surveillance. Individual cases are followed up by IPAC nursing staff to ensure appropriate measures are in place and to provide guidance to managers and staff as to best practices to follow for individual long-term care cases. This recommendation was implemented December 2014.

Recommendation no. 10: the region provides monthly hand hygiene rates to senior management. The rates are shared with the board at regional wall walks. An annual report on the number and type of outbreak was shared with the board in October or November. Outbreak communication, including the type and cause of the outbreak, is shared with the board as well as with all staff, physicians, public health, emergency medical services, and others. The long-term goal is to develop an annual infection prevention and control reporting process that could be then shared electronically on the Sunrise Health Region intranet as well as on the public website. The target date for completion will be determined in collaboration with the executive leadership team and board, targeted for March 2015.

Those conclude our summary.

The Chair: — Thank you, Mr. Wyatt. That's much appreciated. I'd like to open up the floor for questions. Mr. Nilson.

Mr. Nilson: — Thank you. Again I'm going to ask the Provincial Auditor how this particular health region was selected for this particular survey.

Ms. Ferguson: — Actually, it's the same response as beforehand. Again, we recognized that it was a subject matter that we should be looking at within regional health authorities. And again, looking across the landscape, we determined that it was Sunrise's turn, I guess.

[12:00]

Mr. Nilson: — Okay. Well thank you for that, and thank you for the report. Obviously a lot of work since the auditor's been there. And I assume the answer's the same that you got outside help to do this particular review as well. Is that correct?

Ms. Ferguson: — Yes we did. And in addition to that, I must admit we leveraged the work that was done by a couple of other audit offices too. If you notice, in the references we refer to work that was done in Ontario and — just a moment; off the top I need to refresh — Alberta. So it was also leveraging the work that was done by those other offices, and that greatly helped us make a more efficient audit.

Mr. Nilson: — Thank you. Then my question's for I guess the deputy minister or the representative from the regional health authority. Right at the very end, you talk about a public website reporting this kind of information. Are there any of the health regions in the province that report the infection reports, if I can put it? I'm not sure if that's the right term; I guess there'd be infection prevention and control reports now. Or is this something that's new?

Mr. Wyatt: — Right now the one area where we do have public provincial reporting is related to *clostridium difficile*, and the Ministry of Health website provides regional information around C. diff infection rates. That's the one area where we've,

I guess, led out in terms of provincial reporting, and it does have that RHA breakdown.

Mr. Nilson: — Okay, and so then what we're seeing here is a continual rollout of that type of information for the public, which I think is a positive thing for everybody. It's nice to know exactly where the problems are.

I was looking through the list of the facilities in Sunrise Health Region, and it doesn't look like any of them are the cottage-type facilities where you have people living, you know, eight or nine or ten people living in a house with sort of one or two people taking care of them. So I had a question around that particular issue, which then maybe should be answered by the deputy minister, which relates to experience of infection control in a situation where you have one staff taking care of both the food side and the care of the patients, and whether there's any significant increase in infectious issues in that type of a facility versus the traditional type facilities, which I think include all of the ones in Sunrise Health Region.

Mr. Wyatt: — I'll maybe just start by relaying the observation from Sunrise where they have not seen that correlation between different rates of outbreak or incidence of outbreak in smaller settings. From a provincial perspective, we do have tracking around infection control, the ability to, I guess if there was something identified, to be able to look at whether there is a trend or a concern around that.

The other observation would be, as some of the facilities are functioning in a pod kind of design, that really does replicate a smaller care setting. I guess the difference in those examples around the spread and the kind of outbreak you might have are, I guess, not dramatically different than what you would see in a smaller facility.

Mr. Nilson: — Okay. I guess the auditor, the . . . how this whole process went didn't, or did it . . . I guess maybe I should ask in a positive way. Did it include observation of activities that was more in the sort of light of spying on people? I know some of the traditional infection control kind of activities have involved people sitting somewhere and just observing quietly what happens or hiding out in the washroom to see whether people actually wash their hands, things like that. Did any of this auditing here include that type of an activity?

Mr. Wyatt: — Could I just clarify? Is that a question directed to the auditor or to the region?

Mr. Nilson: — Well, I mean, I guess it can go to both places. But one thing about monitoring infection control is, who does the observation of handwashing rates and things like that? I mean, it seems to be a basis for this report that there is some kind of observation of how staff are doing. It's not self-reported, if I can put it that way. So perhaps you can explain how it's done.

Ms. Wiwcharuk: — Good morning, everyone. My name is Roberta Wiwcharuk, and I'm vice-president of integrated health services for Sunrise Health Region. And in response to your question, what we do in Sunrise Health Region, we have been auditing our hand hygiene compliance for the past year. And we do have specific individuals that are doing that task, and they do have, it's called an iScrub. It's an application. They have a little device that they record the hand hygiene compliance.

And it's an interesting comment that you had because I think when we initially implemented that, staff I think were feeling, you know, are people going to be lurking and kind of maybe not letting them know what they were doing? And what we found is that we wanted to let staff know that someone will be coming into your facility to audit the hand hygiene compliance. And we had to work with the auditors because I think initially they felt a little bit the same. Maybe we should just, you know, stand back a little bit, observe, not really speak to the staff.

What we found was it was better when the staff introduced themselves, said, I'm going to be here for the day; this is what I'm here to do today. And also what we found is if the auditor was watching me and I am doing my care and I didn't do something 100 per cent correctly, that it was better to then have a conversation with me at the time to say, you're not 100 per cent compliant with your hand hygiene because of this. You know, did I have my nails painted? Do I have my rings on? So then we could improve that process. And we still do that same process. I think we have more managers now doing, you know, auditing when they are out and about. Just, you know, watching staff, what they're doing. But the big piece we're finding is that the staff need the feedback to know what they have done incorrectly. So they do know that the auditors are there, and I would say the staff have a pretty good working relationship with them and want the feedback.

Mr. Nilson: — Well thank you for that explanation. I think that this area is difficult to know how you report and clearly it's not self-reporting. You do have individuals going to check that out and obviously continue the monitoring of what happens, because there's no question that infection rates in health facilities are maybe one of the most expensive things that the whole health system deals with. So it's good to see you have professional staff doing the cleaning and you're monitoring it. Thank you. I have no further questions.

The Chair: — Are there any further questions? Just a quick one on recommendation no. 9. And I'm curious, in the comments in our status update around, all urinary tract infections have been identified provincially as a concern for long-term care residents and that there's a Saskatchewan UTI provincial guideline. I'm just curious. Mr. Wyatt, this is more specific for you, so why are UTIs — they're not a contagious illness — why would they be more prevalent in long-term care facilities?

Mr. Wyatt: — The particular concern in a long-term setting is that people, that population is more likely to be incontinent and catheterized and so it's a very prevalent concern with many of the residents in a special care facility.

The Chair: — Thank you. That is a simple answer. Thank you for that. Are there any further questions? Seeing none, what is the will of the committee with respect to these recommendations? Mr. Merriman.

Mr. Merriman: — Thank you very much, Madam Chair. Again we'll group them if that's okay with the committee. For the 2014 report volume 1, chapter 13 for recommendation 5 and 10, concur with the recommendation and note progress towards

compliance.

The Chair: — Thank you, Mr. Merriman. Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 1, chapter 13 for recommendations no. 5 and 10, that this committee concur with the recommendations and note progress to compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Merriman.

Mr. Merriman: — Thank you again, Madam Chair. The remaining recommendations for the 2014 report volume 1, chapter 13, recommendation no. 1, 2, 3, 4, 6, 7, 8, and 9, I would concur with the recommendation and note compliance.

The Chair: — Thank you. Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 1, chapter 13, for recommendations no. 1, 2, 3, 4, 6, 7, 8, and 9, that this committee concur with the recommendations and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Well thank you to the auditor and to everybody who is here today for your assistance in helping us get further information. And with that, this committee stands recessed until 1 o'clock this afternoon.

[The committee recessed from 12:13 until 13:04.]

The Chair: — Welcome back to Public Accounts this afternoon. Before we get started on our afternoon's agenda, we have one item of business that wasn't on the agenda, but if everyone's in agreement we will proceed with it. Is that fine with the committee? Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay. Mr. Merriman.

Estimates of the Office of the Provincial Auditor

Mr. Merriman: — Thank you very much, Madam Chair. In compliance with the freeze on wages for the 2015-2016 for all senior officers, I'd like to put the following motion forward:

> That the motion for the 2015-2016 estimates of the Provincial Auditor, vote 28, (PA01) adopted on January 14th, 2015 will be rescinded and the following substituted in its place:
>
> That the 2015-2016 estimates of the Office of the Provincial Auditor, vote 28, Provincial Auditor (PA01) be approved in the amount of $8,187,000 as follows: budgetary to be voted would be 7,961,000, and statutory would be 226,000.

I move the following motion.

The Chair: — Thank you, Mr. Merriman. Mr. Merriman has moved:

> That the motion for the 2015-2016 estimates of the Office of the Provincial Auditor, vote no. 28, (PA01) adopted on January 14th, 2015 be rescinded and the following substituted in its place:
>
> That the 2015-2016 estimates of the Office of the Provincial Auditor, vote 28, Provincial Auditor (PA01) be approved in the amount of $8,187,000 as follows: budgetary to be voted, $7,961,000; and statutory, $226,000.

Is there any discussion around this? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you. Mr. Merriman.

Mr. Merriman: — Thank you very much, Madam Chair. I'd also like to put the following motion forward:

> That the 2015-2016 estimates of the Office of the Provincial Auditor as adopted on February 12, 2015 be forwarded to the Speaker as Chair of the Board of Internal Economy, pursuant to section 10.1(4) of *The Provincial Auditor Act.*

I so move.

The Chair: — Thank you, Mr. Merriman. Mr. Merriman has moved:

> That the 2015-2016 estimates of the Office of the Provincial Auditor as adopted on February 12, 2015 be forwarded to the Speaker as Chair of the Board of Internal Economy, pursuant to section 10.1(4) of *The Provincial Auditor Act.*

Is there any further discussion around this? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Thank you. Moving on to our first item of business, or second item of business I guess for the afternoon, the Provincial Auditor's reports. We'll be looking at Agriculture and Health, regulating meat safety. We'll be looking at, initially at the 2012 Provincial Auditor report volume 2, chapter 33, and the 2014 Provincial Auditor report volume 2, chapter 41.

Welcome to the officials who have arrived this afternoon. Ms. Ferguson, the Acting Provincial Auditor will make some remarks and then we will pass it off to you to introduce, the ADMs [assistant deputy minister] to introduce themselves, or the DMs [deputy minister] to introduce themselves and any officials. And when you're speaking to any of the questions, if you could just identify yourself, that would be very helpful. So, thank you. With that, I will pass it off to Ms. Ferguson.

Agriculture and Health

Ms. Ferguson: — Thank you very much, Madam Chair, members and officials. First of all this afternoon I'm just going to introduce Rosemarie Volk has joined me, and behind her is Ms. Jennifer Robertson. And Kim Lowe is once again attending the committee as a liaison. Rosemarie is leading the work in the agriculture-related field and Jennifer is providing assistance in that front.

Before we present the seven chapters this afternoon, I just want to just pause and sort of give you a road map in terms of how we're going to do these presentations. The first one, part one is going to focus on the results of our 2012 audit of the processes to regulate the safety of meat and the related follow-up of chapter 33 from our 2012 report volume 2, and chapter 41 of our 2014 report volume 2. If you notice that that first chapter is a joint chapter between the Ministry of Health and the Ministry of Agriculture, hence we've got officials from both ministries at the tables this afternoon.

Then we'll be moving on to part two, which is the next two chapters listed on the agenda: chapter 3 of our 2013 report volume 2 and chapter 2 of our 2014 report volume 2. And those chapters set out the results of our annual integrated audits of the Ministry of Agriculture along with its related funds and selected agencies.

And then we'll just continue moving down the agenda. Part three will be chapter 21 of our 2013 report volume 2 and chapter 20 of our 2014 report volume 2, and those chapters are setting out the annual results of our integrated audit of the Saskatchewan Crop Insurance Corporation.

And then finally part four will be the recommendations that we made in the 2011 audit related to processes to maintain irrigation infrastructure at Lake Diefenbaker, and that's in chapter 16 from our 2014 report volume 1.

So before we embark on our presentations, I just want to pause and thank the officials both in Health and Agriculture, and the co-operation that we received in the course of the engagements before you, along with the officials from Crop Insurance too. Thank you very much. Just turning it over to Rosemarie.

Ms. Volk: — Thank you, Ms. Ferguson. Chapter 33 of our 2012 report volume 2 reports the results of our audit of processes to regulate the production of meat that is safe for human consumption when it is handled by slaughter plants within Saskatchewan. We made 10 recommendations.

Chapter 41 of our 2014 report volume 2 reports on the status of the implementation of those recommendations at September 2014. I will briefly describe each recommendation, explain why we made the recommendation, and provide you with the status as at September 2014.

On page 284 of our 2012 report volume 2, we recommend that the Government of Saskatchewan formally assess the risks related to uninspected meat and consider updating its regulation for the production of meat that is safe for human consumption.

First, a bit of background. Saskatchewan has about 90 slaughter plants that produce meat for human consumption. The federal government regulates meats sold interprovincially or internationally. About three Saskatchewan slaughter plants are subject to federal legislation. In Saskatchewan, two ministries are responsible for regulating the safety of meat sold in the province: the Ministry of Health and the Ministry of Agriculture.

Other than meat from farm gate, commercially sold meat in Saskatchewan must be from a licensed and/or inspected slaughter plant. Not all meat is inspected before sale in Saskatchewan.

Health regulates whether slaughter plants are sanitary. Through regional health authorities, it licenses and inspects them. It does not inspect animals, carcasses, or meat. About 76 slaughter plants are subject to these annual mandatory inspections.

Agriculture regulates slaughter plants who voluntarily agree to participate in a provincial inspection program. Plants who volunteer do not need a Ministry of Health inspection. Inspections under this program are more comprehensive and include looking at animals, carcasses, and meat. Agriculture hired Canadian Food Inspection Agency to carry out these inspections. During our audit, about 11 plants participated in this program.

As reflected in figure 3 on page 284 of our 2012 report volume 2, Saskatchewan's structure and regulation of meat differs from most other provinces. Only Saskatchewan uses two ministries to regulate meat safety and is one of three provinces who do not inspect all commercially sold meat before sale. Having two ministries responsible increases the risk that the government will not know how much meat enters the Saskatchewan food chain without being inspected or if inspections are conducted to the same standard. Effective regulation of meat and meat processing facilities is essential to protect consumers from buying meat that is not safe for consumption.

As indicated on page 334 of our 2004 report, the ministries have partially implemented this recommendation. By September 2014 they have consulted with one another and have created a list of inspection-related risks to examine further. They are working to enhance the provincial inspection program.

On page 279 of our 2012 report volume 2, we concluded that for the year ended August 31st, 2012 the Government of Saskatchewan, the Ministry of Agriculture, and the Ministry of Health needed to strengthen their processes to help keep meat safe in Saskatchewan. We made nine recommendations.

On pages 287 to 289, we made three recommendations related to the Ministry of Agriculture. We recommended that the Ministry of Agriculture review its standards for regulating meat production and formally approve them, that the Ministry of Agriculture update its public website to include a list of all the slaughter plants registered in the Saskatchewan domestic meat inspection program, and that the Ministry of Agriculture provide a report quarterly to its senior management on the causes of sanitation problems in slaughter plants and actions taken to enforce *The Regulations Governing the Inspection of Meat in Domestic Abattoirs 1968*.

We made these three recommendations because first, agricultural standards for inspection were over 10 years old, and with Canadian Food Inspection Agency's December 2013 decision to no longer do Saskatchewan inspections, it was a logical time to revisit and update standards prior to engaging a different agency to carry out the inspections; second, Agriculture did not make public the results of inspections of slaughter plants in the ministry's inspection program; and third, Agriculture did not provide senior management with reports on reasons for problems noted in its inspections of slaughter plants. By September 2014, as indicated on pages 335 and 336 of our 2014 report, the ministry had implemented each of these recommendations.

[13:15]

On page 290, we recommended the Ministry of Health, consulting with the Ministry of Agriculture and regional health authorities, develop and approve detailed sanitation standards for slaughter plan operations.

We made this recommendation because unlike Agriculture, Health does not give slaughter plants specific written standards for meat processing. Not having clear standards makes it difficult for slaughter plants to produce meat that is safe and for regional health inspectors to effectively inspect slaughter plants.

As indicated on page 336 of our 2014 report, the ministry has partially implemented this recommendation. By September 2014, Health was working on new slaughter plant provisions to be incorporated into the food safety regulations and was creating standards to accompany the revised regulations.

On pages 291 and 293, we made three related recommendations. We recommend that the Ministry of Health obtain more information to help it assess risks to meat safety, including the number of animals slaughtered in slaughter plants licensed under *The Sanitation Regulations, 1964*; and that the Ministry of Health confirm that regional health authorities take appropriate action to ensure that high- and medium-risk slaughter plants correct identified problems that could reduce the safety of the meat produced; and that the Ministry of Health analyze regional trends in public complaints about slaughter plants and/or contaminated meat.

We made these recommendations for the following reasons: we note that Health uses an ad hoc and informal process to oversee inspections and enforcements carried out by the regional health authorities. It did not request or have current information on various risk factors such as the number and types of animals being slaughtered and the location of meat sales. It did not have a process to know which slaughter plants regional health authorities assessed as presenting greater risks of processing unsafe meat or whether regional health authorities enforce regulations sufficiently and consistently within and between regions.

Also we noted that Health referred complaints about slaughter plants to regional health authorities and did not know how or whether the complaints were appropriately handled. As indicated on pages 337 and 338 of our 2014 report, by September 2014 the ministry had partially implemented each of these recommendations.

In 2012 Health, using a survey, collected data on a number of risk factors from slaughter plants it licenses. It analyzed and reported this data to management. Health was considering revising its regulations to require slaughter plants to provide it with similar information on an annual basis.

Health expected to implement a new database in spring 2015. It plans to use this database to track information on deficiencies found in the inspections, enforcement actions taken by the regional health authorities, and public complaints about slaughter plants or meat safety. This information should help it provide its oversight of its provincial inspection programs.

On pages 293 and 294 we make two related recommendations. We recommend that the Ministry of Health update its public website to include the inspection results of all slaughter plants licensed under *The Sanitation Regulations, 1964* and that the Ministry of Health provide a summary report quarterly to its senior management on the causes of sanitation problems arising at slaughter plants and the actions taken to enforce *The Sanitation Regulations, 1964*.

We made these recommendations because inspection results were not readily accessible to the public. It relied solely on operators of slaughter plants posting their current licence to show that they had passed a regional health authority inspection. Also similar to Agriculture, Health did not provide its senior management with reports on reasons for problems noted in inspections of slaughter plants. Written reports are essential for senior management to make informed decisions that impact inspection and regulation of slaughter plants and provide a permanent record of the history of inspection results.

As indicated on page 339 of our 2014 report, by September 2014 the ministry had partially implemented these recommendations. The ministry has posted a listing of all the Health-licensed slaughter plants and their facility operators on its website. The ministry is considering changes to the law to provide for public disclosure of slaughter plant inspections that is not currently provided for under *The Public Health Act, 1994*.

In 2014 Health provided a report to senior management covering its 2013 activities. The report provided inspection statistics, indicated there were no reported incidents of food-borne illnesses, described common deficiencies found during inspections, and compared those findings to historical trends. With the implementation of its database in 2015, Health will be able to report on the actions taken by regional health authorities to enforce *The Sanitation Regulations, 1964*.

In summary, by September 30, 2014, the Ministry of Agriculture had implemented all three related recommendations, with the remaining seven being partially implemented. Madam Chair, that concludes my overview on these chapters.

The Chair: — Thank you, Ms. Volk. And I will pass it off. We've got Alanna Koch, the deputy minister of Agriculture, and Mark Wyatt, the assistant deputy minister with Health here today. I'm not quite sure how you handle that. There's obviously recommendations that apply to Health and Agriculture, so I don't know if . . . Whomever wants to go first, be my guest. But if you could outline what's happened with

each recommendation, and timelines, where you're at with each one, that would be very helpful.

Mr. Wyatt: — I might begin by introducing our official and maybe ask Agriculture to do the same. So joining me today is Tim Macaulay who is the director of environmental health in the population health branch.

Ms. Koch: — And with me today I have Tom Schwartz who is the executive director of the livestock branch. And also with us today with regards to this section of what we're going to be talking about today, we have with us Chris Smith. He's our food safety specialist in our animal health unit, which is in livestock branch.

Mr. Wyatt: — So what I will do is provide a response to recommendation 1 and then recommendations 5 through 10, and just to begin by saying with each one of these recommendations we would classify them as making . . . concurring with the recommendation and making progress towards compliance. So with that, by way of introduction, I'll briefly walk through each of the specific responses.

With regard to recommendation 1, the Ministry of Health has consulted with the Ministry of Agriculture and created a list of inspection-related risks to examine further. This list includes reviewing inspection standards, determining the amount of meat consumed in the province that has not been inspected, and tracking any communicable diseases as a result of contaminated meat.

The Ministry of Health is working to enhance the provincial public health inspection program including enhanced food safety guidelines and includes the procurement of a new electronic data management system, the amendment of *The Food Safety Regulations*, and the development of new slaughter plant standards. Collectively these enhancements will enable the Ministry of Health to analyze a variety of operational information from the slaughter plant industry and monitor regional health authority inspection statistics and non-compliance issues related to Health-licensed slaughter plants. These enhancements are expected to be in place in 2015.

Now moving to recommendation no. 5, the Ministry of Health maintains . . . and this is the recommendation that the ministry analyze regional trends and public complaints.

All right. Now we've got this as recommendation no. 2 from chapter 41, page 336: ". . . that the Ministry of Health, consulting with . . . Agriculture and regional health authorities, develop and approve detailed sanitation standards for slaughter plant operations." Okay. That is the correct one. The response: the development of new slaughter plant standards is expected to be completed in 2015 in consultation with the Ministry of Agriculture, slaughter plant operators, and regional health authorities. The new standards will assist the industry in meeting the regulation requirements of *The Food Safety Regulations*.

Moving to recommendation no. 3, page 337, the planned amendments of *The Food Safety Regulations* to include provisions related to the operation of slaughter plants will enable the Ministry of Health to capture a variety of information for the purpose of assessing meat safety risks. These amendments are expected to be completed in 2015.

Moving now to recommendation no. 4, page 337, chapter 41, the implementation of a new electronic data management system will enable the Ministry of Health to improve the re-inspection oversight at both the regional health authority and Ministry of Health level. The new data management system is expected to be implemented in 2015.

It is important to note that a slaughter plant with a high or moderate re-inspection priority does not mean that meat originating from the facility is unsafe. Re-inspection priorities are used to determine when the facility should be next inspected. If the plant is considered to be unsafe the public health inspectors will take enforcement actions such as suspension of an operating licence to address the issue.

Recommendation no. 5, page 338, the Ministry of Health maintains a registry of inquiries and complaints for program areas including food safety and slaughter plants. With the implementation of a new data management system, the ministry will be able to conduct more in-depth analysis of complaints at a regional health authority level to determine if additional changes in the meat safety program are needed. The new data management system is expected to be implemented in 2015.

And recommendation no. 6, page 339, an amendment to *The Public Health Act* of 1994 will be necessary to allow for the disclosure of slaughter plant inspection results on a public website. The Ministry of Health will look at the potential for a proposed amendment during a future call for legislation.

And recommendation no. 7, page 339, senior management reporting will be enhanced in 2015 with the implementation of a new data management system, the amendments to *The Food Safety Regulations*, and the development of slaughter plant standards. Future reports will include information on inspection statistics and non-compliance issues related to the Health-licensed facilities. And those conclude my remarks.

The Chair: — Thank you. Ms. Koch.

Ms. Koch: — Thank you very much. So we'll go through the three recommendations for the Ministry of Agriculture. So recommendation no. 1 on page 334 from in 2012, it was new and was partially . . . Oh, I'm sorry. Sorry. In 2012 it was a new recommendation — sorry, page 335 — and so the recommendation was to recommend ". . . that the Ministry of Agriculture review its standards for regulating meat production and formally approve them." That recommendation has been fully implemented. The ministry reviewed and approved its standards for regulating meat production, and this was in place and approved on July 30, 2014.

Recommendation no. 3 on page 335, the recommendation was ". . . that the Ministry of Agriculture update its public website to include a list of all the slaughter plants registered in the Saskatchewan Domestic Meat Inspection Program." This recommendation has been fully implemented. The ministry posts the names of the licensed companies on our public website. This is ongoing of course, as companies may be added or removed.

Recommendation no. 4 on page 336 was ". . . that the Ministry of Agriculture provide a report quarterly to its senior management on the causes of sanitation problems in slaughter plants and actions taken to enforce *The Regulations Governing the Inspection of Meat in Domestic Abattoirs, 1968*." So this recommendation has been fully implemented. The ministry provides a report on a quarterly basis to senior management, and of course this will be an ongoing measure. So that concludes my report.

The Chair: — Thank you very much for that. I would like to open up the floor for questions. Mr. Nilson.

Mr. Nilson: — Good afternoon, and thanks for being here to answer some questions. I know something about the health, and actually I used to have cattle myself, so I know about the marketing of cattle and the sale of cattle.

And so I guess my first comment is, good job for the two of you to work together to try to sort out what the federal government kind of left you, is what I see in the sense of basically changing the whole system of how meat has been inspected. So I appreciate that this is a work in progress.

One of my questions was, given the fact that it's, you know, quite complicated to report it to us, can you compare with another province, whether it's BC [British Columbia] or Alberta or Ontario, where they have a single provincial sort of meat inspection plant? Or is that not the case? But I seem to get a hint in here that we're one of the few provinces which has a joint system, so I would like to have a bit of an explanation of how that works.

[13:30]

Mr. Schwartz: — Tom Schwartz, Ministry of Agriculture. Saskatchewan is the only province, certainly in Western Canada anyway, that allows uninspected meat to be sold. The rest of the provinces have inspections so they are under one set of legislation. So we still are able to . . . You know, we've had a long-standing history I think in the province here, and a lot of these are custom slaughter plants, these uninspected ones, where people are taking their animal in, getting it slaughtered, taking the meat back again. But there is I think some sale from them as well, and that's something that's gone on in the province for quite some time.

Mr. Nilson: — So I guess to understand then, if you're in Alberta, is this all done under the Agriculture department or under the Health department or Health ministry? Who handles that? That's my question. It seems to be quite complicated here.

Mr. Schwartz: — It's under Agriculture.

Mr. Nilson: — It's under Agriculture? And then federally though it was, when it used . . . Are there still any federally regulated plants?

Mr. Schwartz: — There still are federal plants that can sell interprovincial and export meat. Those are all federally inspected plants and they exist in all provinces. And CFIA [Canadian Food Inspection Agency] at the time of this audit was also auditing our provincial plants as well or doing the inspection at those plants.

Mr. Nilson: — Okay. On a contract basis.

Mr. Schwartz: — On a contract basis.

Mr. Nilson: — Okay. Yes. Okay. So then I mean ideally we'd get this sorted out as to how it should work. I mean I guess it's not necessarily a bad process to have this double eyes or triple or quadruple eyes looking at the same thing, but I just have to say, trying to read this and then hear your report, it's a bit complicated how it's done. So then like how many people are involved in this process from the Health side and the Agriculture side? Because you have, I think you said 90 plants that are involved here. There are 90 slaughter plants?

Mr. Wyatt: — So on the Health side of the inspection, there are 85 people involved in inspections through the regional inspection system, and that would include both inspectors but also some management supervisory positions.

Mr. Schwartz: — In the ministry there's 12 full-time and part-time staff that do the inspection on a contract basis with a third-party contract to carry out the inspections in the provincially registered plants.

Mr. Nilson: — And so does that include the CFIA as well?

Mr. Schwartz: — The CFIA no longer does it.

Mr. Nilson: — Oh, okay.

Mr. Schwartz: — That's another thing that they've stopped doing. So we've got a contract with the Food Centre, and they've got inspectors that were trained both by ourselves and through the CFIA inspectors; CFIA providing most of the inspection that have now been hired to do the inspection in these plants.

Mr. Wyatt: — If I could just clarify my earlier answer, just to be clear that the 85 individuals, that's not their sole responsibility. They would have other inspection-related responsibilities in the public health.

Mr. Nilson: — So then practically you have, if I read and hear the reports correctly here, Health inspects the facilities but not the meat part. And then Agriculture inspects the process but not every, you know, every animal that goes through the system. Is that correct?

Mr. Schwartz: — No, every animal is inspected.

Mr. Nilson: — Every animal is inspected. Okay. But there are some plants that you don't inspect, is that right?

Mr. Schwartz: — There's 11. It's a voluntary process, and all the plants that are signed up to be on the provincial meat regulations are all inspected.

Mr. Nilson: — So that's 11 that are inspected like that.

Mr. Schwartz: — Correct.

Mr. Nilson: — So there's another 79 that are, basically the facilities are inspected by Health, but not the animals.

Ms. Koch: — That's right.

Mr. Macaulay: — Tim Macaulay, director of the environmental health. Just to answer the question, at the time of the audit there were 76 Health-licensed facilities. And at those 76 facilities there is no meat inspection. There is a health inspection that is performed that looks at the facility and the equipment and the handling of the meat, but there's no carcass inspection.

Mr. Nilson: — Thank you. You know, I appreciate that. That's what I was just trying to figure out, how that works. And I think, you know, we all have contacts in smaller communities and that's how it operates: basically you also rely on the reputation of the butcher. So it's a combination of a number of things. I don't have any more questions.

The Chair: — Thank you, Mr. Nilson. Are there any further questions? Mr. Michelson.

Mr. Michelson: — I'm just wondering if there's any more efficiencies that can be . . . I mean, to have the two ministries working together is great. Is there efficiencies that could be obtained if it only went through one? I'm just thinking of the price of oil. That's where we're always looking for efficiencies.

Ms. Koch: — I can let Health certainly answer. I think, from our perspective, we're not seeing duplication of work. So we always need to be examining opportunities for efficiencies, no question, and so we'll continue to do that. I think it's fair to say, you know, we're working closer than ever with the Ministry of Health on the topic of meat inspection. And so that relationship will continue, and I think in that discussion and conversation, we'll always be seeking opportunities for efficiencies.

But I think it's fair to say our work is quite different, and so I'm not really sure that at this point there'd be any duplication. That would be my comment.

Mr. Wyatt: — Just one other idea around the issue of efficiency is from the Health perspective. Because these inspectors would have various areas of responsibility, they may be going out to a community and inspecting a slaughter facility. While they're there, they may also be inspecting other public health areas. And so it does combine and give those inspectors, as they're travelling around rural communities, the ability to combine some of their roles in public health inspection.

The Chair: — Mr. Hart.

Mr. Hart: — Thank you, Madam Chair. Just for clarification on this whole area, you say there is 11 processing plants where the animals are inspected. So those would be the larger ones, I would guess, something like Harvest Meats in Yorkton and Drake Meats. And the smaller ones where the facilities are inspected but the animals aren't, they would be the smaller abattoirs, local abattoirs and that sort of thing. Would that be a fair summary of what's happening in meat inspection in our province?

Mr. Schwartz: — Generally that would be correct. Harvest Meats is actually federally inspected because they sell interprovincially. But Drake would be an example of one. They are all listed as required on the website, the ones that are inspected.

Mr. Hart: — So if I want to know, go to the website and they're all listed there, the ones that are where the animals are inspected, the ones that you're inspecting. But how about the small ones that Health is inspecting? Are they also listed?

Mr. Macaulay: — So just to respond, the Health-licensed ones in general are providing a service to local farmers who are wanting to have an animal slaughtered and dressed, and so that is their business. So you know, the volume or the level of risk in our minds is less; you don't have this mass production that is going on like you do in the larger facilities. And you know, we have done a risk assessment in terms of communicable diseases to see if we would see any connection between reportable diseases linked to meat that has come from one of these types of plants, and we don't see a correlation.

But I do caution that statement with the fact that there are some illnesses that go unreported. So food-borne illnesses can be associated with the flu sometimes, and there could be some situations like that. But certainly we haven't had a large outbreak, like XL Foods or a facility like that.

Mr. Hart: — Certainly. And I'm very familiar with at least one or two of those small plants; in the past, I've utilized their services. And no, I totally agree with the comments that were made. If there is, you know, thought that there may be a problem with a plant, that word gets out to the people that are customers of those plants very quickly. And I know people are very cautious, and nobody wants to see, you know, people getting sick from the meat that they're taking home and that sort of thing.

I think up until, at least up until this point, the system that we have in place has been working quite well. The big change, as noted earlier, is when the CFIA backed away from inspecting the animals in some of our plants, but the feds are still doing Harvest Meats. That's the only one in Saskatchewan that's being inspected federally?

Mr. Schwartz: — Thunder Creek would be another example, in Moose Jaw, where they have a slaughter plant, the hog slaughter plant there.

The Chair: — Are there any further questions on these two particular chapters? Seeing none, I'm wondering what the will of the committee is with respect to these recommendations for chapter 33. Mr. Merriman.

Mr. Merriman: — Thank you very much, Madam Chair. Again we'll group these together. For the 2012 report volume 2, chapter 33, for recommendations 2, 3, and 4, concur with the recommendation and note compliance.

The Chair: — Thank you. Mr. Merriman has moved that for the 2012 Provincial Auditor report volume 2, chapter 33, that this committee concur with recommendations 2, 3, and 4, and note compliance. Is there any further discussion? Seeing none,

is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Merriman.

Mr. Merriman: — Thank you again, Madam Chair. And again for the 2012 report volume 2, chapter 33, the remaining recommendations of 1, recommendation 5, 6, 7, 8, 9, and 10, I put the motion forward to concur with the recommendation and note progress towards compliance.

The Chair: — Thank you. Mr. Merriman has moved that for the 2012 Provincial Auditor report volume 2, chapter 33, that this committee concur with recommendations 1, 5, 6, 7, 8, 9, and 10, and note progress to compliance. Any further discussion? Seeing none, is that carried, or is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on to the 2014 Provincial Auditor report volume 2, chapter 41. As there are no new recommendations in that, and we've just discussed the previous recommendations or the recommendations in the previous chapter, is there a will to conclude considerations? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I put a motion forward that we conclude considerations on the 2014 report volume 2, chapter 41.

The Chair: — Thank you. Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 2, chapter 41, that this committee conclude considerations of those recommendations. Any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Well I guess we will be saying goodbye to the Health officials. Mr. Wyatt, thank you, and to all your officials, we appreciate your time this afternoon. And we'll just give you a moment for the Agriculture officials to be organized for the next few chapters.

Mr. Wyatt: — Thank you to the committee, and I also want to pass on my appreciation to the staff, both from the ministry, eHealth, and regional health authorities that supported our work today.

The Chair: — Thank you. We will be moving on to the next two chapters. The auditor will talk about how she will approach it from her perspective, but I think we'll be looking at the 2013 Provincial Auditor report volume 2, chapter 3 and the 2014 Provincial Auditor report volume 2, chapter 2. I will pass it off to Ms. Ferguson for her presentation.

[13:45]

Agriculture

Ms. Ferguson: — And I'm going to continue to pass it along the table to Ms. Volk.

Ms. Volk: — Thank you, Ms. Ferguson. Chapter 3 of our 2013 report volume 2 and chapter 2 of our 2014 report volume 2 provide the results of our 2013 and 2014 annual integrated audits for the Ministry of Agriculture and the funds and agencies listed in the background of each chapter. Our 2013 report does not contain any new recommendations. Our 2014 report contains three new recommendations for the committee's consideration, along with the status of two past recommendations. As a result, I will focus my comments on the 2014 report, chapter 2.

We report that in 2013 and 2014, financial statements for the ministry's funds and agencies were reliable, the ministry and its agencies had effective rules and procedures to safeguard public resources, and complied with authorities governing their activities other than the following matters. I will highlight the main recommendations first and I will briefly describe each, explain why we made the recommendation, and then I will provide an overview of the other recommendations.

On page 23 of our 2014 report volume 2, chapter 2 we recommended that the Ministry of Agriculture follow its established procedures to promptly remove unneeded user access to its computer systems and data. We made this recommendation because the ministry was not consistently following its established procedures for promptly removing user access to its computer systems and data. For example, we found that 6 out of 10 individuals we tested did not have their computer access removed promptly. The access was removed between 3 and 36 working days after their last date of employment. Not promptly removing user access of former employees increases the risk of inappropriate access to the ministry's systems and data.

On page 24 we made two recommendations related to authorizing transactions and making information public. We recommended that the Ministry of Agriculture obtain an order in council prior to entering into an animal products inspection administration agreement and an animal identification inspection administration agreement as required by law, and that the Ministry of Agriculture table all animal product inspection administration agreements and animal identification inspection administration agreements in the Legislative Assembly as required by law.

We made these recommendations because the ministry did not obtain an order in council before it entered into an agreement with Livestock Services of Saskatchewan covering both animal product inspection and animal identification inspection or table the agreement in the Legislative Assembly as required by law. As a result, the agreement was not properly authorized or made public as required by law. We note that subsequently Agriculture has obtained an order in council and has tabled the agreement in the Legislative Assembly.

Also in chapter 2 of our 2014 report volume 2, we note that Agriculture is making progress on obtaining assurances from the information technology division of the Ministry of Central Services on operating effectiveness of the technology division's controls over its client systems and data. The ministry needs this information in order to manage the risk of key computer systems and data not being available when needed.

We also report on the estimation process that the ministry uses for AgriStability program expenses. This committee discussed this recommendation and its status at its November 26, 2014 hearing. Madam Chair, that concludes my overview on these chapters.

The Chair: — Thank you, Ms. Volk. Ms. Koch, if you'd like to introduce the officials that are with you here today, that would be great. And just for when you . . . If you get asked a question, if you could just identify yourself, that would be very helpful. And I'll leave it to you, Ms. Koch, for your remarks.

Ms. Koch: — Good. Thank you very much, Madam Chair. So in addition to the officials that I already introduced in our previous appearance, I maybe will just list the remainder of the officials that are here to support us today. So with me is Jeff Morrow who is vice-president of operations from Saskatchewan Crop Insurance Corporation. Also from Saskatchewan Crop Insurance Corporation is Fred Retzlaff. He's the executive director of AgriStability. With me here today is also Ray Arscott, who is our executive director of our corporate services branch. And also with me is Karen Aulie, assistant deputy minister; Rick Burton, assistant deputy minister; and Jason Drury, who is the manager of our irrigation in our crops and irrigation branch. And of course I've already mentioned Tom Schwartz, our executive director of livestock.

So we have taken the recommendations that are in both for 2013 and 2014. Some of them are repeats, so it's a little bit sort of maybe a bit confusing. I'll try to make it unconfused. I'll try to say where this is a repeat so that we're all clear on what we're talking about.

So I am going to first of all speak about chapter 3 from the 2013 report. And so there was an outstanding recommendation, recommendation 1, which was the recommendation on page 34, and that was that we recommend the Ministry of Agriculture use the most current information when estimating program expenses. Now this recommendation was actually replaced, but I'll get to that in a moment. So we just indicate on this recommendation that the ministry has always been using the most current information available when estimating program expenses.

But then we'll go to the next recommendation, which was actually I think the replacement recommendation, and that was that we recommend that the Saskatchewan Crop Insurance Corporation work with the Ministry of Agriculture to develop processes to ensure that the annual fiscal year-end estimates for the AgriStability program benefits are reasonable, consistent, and current. And this recommendation has been fully implemented. The ministry and SCIC [Saskatchewan Crop Insurance Corporation] have developed processes to ensure that the annual fiscal year-end estimates for AgriStability program benefits are reasonable, consistent, and current. And both the ministry and SCIC will disclose the range provided by Agriculture and Agri-Food Canada to inform the public of the possible variability in estimating the AgriStability program benefits. And the Provincial Auditor has agreed in writing to this approach. Now this recommendation is also repeated in the 2014 report, which I'll get to in a moment.

Now also in the 2013 report, an outstanding recommendation was that we recommend that the Ministry of Agriculture obtain assurance from the information technology office on the operating effectiveness of ITO's [information technology office] controls over its client systems and data and assess the impact of deficient control on the Ministry of Agriculture's operations. This recommendation is partially implemented. I would also note that it is repeated in the 2014 report, so I'll also speak to it there. The ministry has requested the report from the information technology division and, once received, the ministry will assess the impact of any deficient controls on the ministry's operations. And I would just indicate that information technology division has suggested that the report could be available in 2015.

So now I'll move on to the 2014 report. And so here we have recommendation 1 on page 23, and this is a new recommendation: "We recommend that the Ministry of Agriculture follow its established procedures to promptly remove unneeded user access to its computer systems and data," which really is kind of a repeat of the recommendation I mentioned that was in 2013. Or no. This one's not repeat. I'm sorry. This one has been fully implemented. The ministry has reminded all managers and supervisors to delete user access to computer systems and data on a timely basis, and we will continue to provide reminders to managers and supervisors on a regular basis to ensure compliance.

Recommendation no. 2 on page 24: "We recommend that the Ministry of Agriculture obtain an Order in Council prior to entering into an animal products inspection administration agreement and an animal identification inspection administration agreement as required by law." This has been fully implemented, as was noted. The OC [order in council] was approved by the Lieutenant Governor on November 13, 2014.

Recommendation 3 on page 24: "We recommend that the Ministry of Agriculture table all animal products inspection administration agreements and animal identification inspection administration agreements in the Legislative Assembly as required by law." This has been fully implemented and the agreement was tabled in the Legislative Assembly on December 4, 2014.

Then we move into the outstanding recommendations, recommendation no. 4 on page 24:

> We recommend that the Ministry of Agriculture obtain assurance from the Information Technology Division of the Ministry of Central Services on the operating effectiveness of the Information Technology Division's controls over its client systems and data and assess the impact of deficient controls on the Ministry of Agriculture's operations.

Of course, this is that repeat recommendation that I had mentioned coming from the 2013 report. And it's the same status, as I mentioned, from the 2013 report, which is partially implemented. So as soon as we get the report from the information technology division, which we hope to get in 2015, we will certainly at that time assess the impact of any deficient controls.

Then recommendation no. 5 on page 25 is an outstanding

recommendation. This is again a repeat recommendation. "We recommend that the Saskatchewan Crop Insurance Corporation work with the Ministry of Agriculture to develop processes to ensure that the annual fiscal year-end estimates for AgriStability program benefits are reasonable, consistent, and current." This is fully implemented and, as I had mentioned, this is where we will be disclosing the range provided by Agriculture and Agri-Food Canada to inform the public of the possible variability in estimating AgriStability benefits.

And I believe that concludes the report on the recommendations from both 2013 and 2014. Thank you.

The Chair: — Thank you for that, Ms. Koch. If I could open up the floor for questions. Mr. Nilson.

Mr. Nilson: — I think I just have one question, and that relates to the information technology division. How long is it since that division has moved out of Agriculture into the Central Services? How long ago did that happen?

Ms. Koch: — I think when ITO was formed was early 2007, as I recall. Oh, I'm thinking maybe before that. Prior to 2007, maybe 2006. I'm sorry. I'm not exact, but it's been quite some time.

Mr. Nilson: — That's what my recollection was. It was quite a while ago. And I was just trying to figure out if this was a problem with having some kind of centralized IT versus having one that's more controlled in your department, or if it's just the nature of the information that's being required which is quite difficult. I mean, that's maybe an opinion you don't need to give. But it looked to me, when I was looking at the information that you provided around the variability of the amounts that went into the programs, which is what you're trying to get your hands on . . . I'm not sure if I'm correct here.

Ms. Koch: — Okay. Maybe if I could just ask for clarification. Because I thought first of all you were referring to the information technology division's transition, but I think now you may be referencing AgriStability. I'm a little bit confused. I'm sorry.

Mr. Nilson: — Okay. Well this one relates to the information you get around the systems. Is that right? That's what it says here, I think.

Ms. Koch: — I'm sorry. Which recommendation is it that you're . . .

Mr. Nilson: — I'm looking at no. 4. And so it keeps saying, you know, you've requested a report from the ITD [information technology division].

Ms. Koch: — Oh, okay. So you are talking about ITD.

Mr. Nilson: — Yes. I'm just trying to figure out, well, you know, you can request a report and request a report. If you don't get it, then you can't comply with this. And so you don't really have much control over when the report comes is my sense, listening to you and reading this. So is there anything that the auditor can do to help you get reports faster?

Ms. Koch: — I might just generally comment, and then I might ask Mr. Arscott to further reflect. You know, far be it for me to comment kind of broadly on decisions that government makes as far as centralization or services that are in line ministries. You know, that decision was made quite some time ago. Of course there's always efficiencies that come with centralization which oftentimes drive decisions to centralize, and of course then the challenge is to ensure that client needs are dealt with in line ministry, you know, sort of service requirements.

So I think there's always this challenge of centralized agencies being able to provide what the client needs in the line ministries. I'm not sure that ITO centralization is any different than probably any other centralized agency. I think that's an ongoing question that always occurs in any organization, government or otherwise, so I don't really want to sort of question the value of that decision, because that was taken by government quite some time ago.

But I might just ask Ray to reflect on, you know, the request we put forward and maybe some of the challenges that we've been meeting and any further comment that he might be able to offer.

Mr. Arscott: — Thanks a lot. I'm Ray Arscott, executive director of corporate services. In 2013 the Provincial Auditor made this recommendation for seven ministries, and my understanding, they made recommendation for every ministry in 2014. So I think ITO is getting the message from everybody right now to get the reports done.

Mr. Nilson: — Well that answers my question then, because it's a general message that IT needs to have timely response to departments so you can do your job. Okay. I don't have any further questions then about that. And I recall actually those ones now, when you say it, from 2013. So practically you're making, like always, your best estimates around what you're doing based on the information that you have, and the auditor's here saying, we should have some better information. When you get it, you'll use it. But until you have it, you do your job. So thank you.

The Chair: — Are there any more questions on these two chapters? Seeing none, what is the will of the committee with respect to the 2014 Provincial Auditor report? Well actually no, we'll deal with no. 3. Sorry. The 2013 Provincial Auditor report volume 2, chapter 3, there's no new recommendations to that. Mr. Merriman.

[14:00]

Mr. Merriman: — Thank you, Madam Chair. If I could put a motion forward to conclude considerations on the 2013 report volume 2, chapter 3.

The Chair: — Mr. Merriman has moved that for the 2013 Provincial Auditor report volume 2, chapter 3 that this committee conclude considerations. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on now to the 2014 Provincial Auditor report volume 2, chapter 2 with respect to the three new

recommendations. What is the will of the committee? Mr. Merriman.

Mr. Merriman: — Thanks again, Madam Chair. In regards to the 2014 report volume 2, chapter 2 I would make a recommendation that we concur with the recommendation and note compliance on recommendation 1, 2, and 3.

The Chair: — Thank you. Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 2, chapter 2, that this committee concur with the three recommendations, 1, 2, and 3, and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. We will now move on to the next couple of chapters, but I will pass it off to the Provincial Auditor to let us know how she's grouped them.

Ms. Ferguson: — We're going to be presenting just the next two chapters on the agenda, and I'm going to turn it over Ms. Volk to do that presentation.

Ms. Volk: — Thank you, Ms. Ferguson. Chapter 20 of our 2013 report volume 2 and chapter 21 of our 2014 report volume 2 provides the results of our 2013 and 2014 annual integrated audits for the Saskatchewan Crop Insurance Corporation. Neither chapter includes any new recommendations for the committee's consideration. In each chapter we report that the corporation's financial statements were reliable and it complied with authorities governing its activities for the years ended March 31st, 2013 and 2014. In both chapters we report on the estimation process that the corporation uses for AgriStability program expenses. The committee discussed this recommendation and its status at its November 26th, 2014 hearing. Madam Chair, that concludes my overview.

The Chair: — Thank you, Ms. Volk. Ms. Koch.

Ms. Koch: — Thank you. I am going to report on the recommendation which was new in 2013 and outstanding in 2014, but you'll recognize it because it is exactly the same recommendation that you'll have seen in the ministry's recommendations. And so that is that ". . . Saskatchewan Crop Insurance Corporation work with the Ministry of Agriculture to develop processes to ensure that the annual fiscal year-end estimates for the AgriStability program benefits are reasonable, consistent, and current."

And as I indicated, we have fully implemented this recommendation. We have developed processes to ensure that program benefits estimates are reasonable, consistent, and current and, as noted, both the ministry and SCIC will disclose the range provided by Agriculture and Agri-Food Canada to inform the public of the possible variability in estimating AgriStability. The Provincial Auditor has agreed in writing to this approach, and the timeline for implementation is July 27, 2015. So thank you very much.

The Chair: — Thank you, Ms. Koch. If I could open up the floor for questions. Seeing none, what is the will of the committee with respect to both these chapters who have no new recommendations? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. In regards to the 2013 report volume 2, chapter 20, I would put a motion forward that we conclude considerations.

The Chair: — Mr. Merriman has moved that for the 2013 Provincial Auditor report volume 2, chapter 20 that this committee conclude considerations. Any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on. Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. Again for the 2014 report volume 2, chapter 21, I would put a motion forward that we conclude considerations.

The Chair: — Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 2, chapter 21 that this committee conclude considerations. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on to the last item, or last item on our agenda today, the 2014 Provincial Auditor report volume 1, chapter 16. And I will pass it off once again to our Acting Provincial Auditor.

Ms. Ferguson: — Thank you very much, Madam Chair, and officials. This one here, we are changing topic here. So now we're actually dealing with the irrigation infrastructure maintenance, and it is a follow-up with no new recommendations. So Ms. Volk is going to provide us with an update of the content of that report.

Ms. Volk: — Thank you, Ms. Ferguson. Chapter 16 of our 2014 report volume 1, starting on page 151, contains the results of our first follow-up on five recommendations relating to our 2011 audit of the Ministry of Agriculture's processes to maintain its irrigation infrastructure at Lake Diefenbaker.

By February 2014, the ministry had implemented three of five recommendations. The ministry had improved its processes to regularly assess the condition of its irrigation infrastructure, document its planning processes and its maintenance plan for irrigation infrastructure, and document its maintenance activities completed on irrigation infrastructure.

The ministry is making progress on implementing the remaining two recommendations. By February 2014, the ministry had drafted a provincial irrigation strategy which includes its long-term irrigation objectives that would be part of the 25-year Saskatchewan water security plan and was waiting for its approval. Long-term irrigation objectives would help the ministry select the right maintenance activities at the right time over the life of the irrigation infrastructure.

Also by February 2014, the ministry was beginning to collect information using its new computer system in preparation for the future operating seasons. As data is collected, it should be

able to prepare reports on its maintenance activities. Written reports are essential for senior management to make informed decisions that have a long-term impact on the condition of irrigation infrastructure. Madam Chair, that concludes my overview.

The Chair: — Thank you, Ms. Volk. Ms. Koch, if you'd like to make some comments.

Ms. Koch: — So we, the Provincial Auditors reported that Agriculture has implemented three of the five recommendations made in the 2011 report volume 2. And then the Provincial Auditor had two outstanding recommendations for the ministry, which I'm going to briefly outline.

So number one, the recommendation that ". . . the Ministry of Agriculture set long-term irrigation objectives and use them to guide maintenance plans and priorities for its irrigation infrastructure," this has been fully implemented. The ministry has published the irrigation strategy on our website, and the strategy is an action item under the Water Security Agency's 25-year Saskatchewan water security plan. This was released in July of 2014.

And then the second outstanding recommendation was that the Ministry of Agriculture require and review regular written reports on the results of its maintenance activities for irrigation infrastructure for review by senior management. This has been fully implemented. The Saskatchewan irrigation infrastructure management system has been implemented and its first annual report on the results of maintenance activities were provided to senior management on January 27 of '15. Reports are expected to be completed and submitted on an annual basis by the end of January, and then that reporting will be released annually. So that concludes my report.

The Chair: — Thank you, Ms. Koch. If I could open up the floor for questions. Mr. Nilson.

Mr. Nilson: — Yes, thank you for this report, and congratulations on getting all the work done. I just had an interesting question. Growing up, our family farm was right on the Saskatchewan River before the dam was built, and so one canal on the west side went by the upper side of the farm; the other one was across on the other side of river.

But just knowing the infrastructure fairly clearly from when it was built and then following it over the years, what's the intersection between what you're responsible for and what the Water Security Agency is responsible for? Because obviously, they have the dam and that kind of work, and then, you know, does it start right with the canals? Is that what you have to deal with, or with the pump, or with the river? Or you know, where's the interconnection?

Mr. Drury: — My name's Jason Drury. I'm the manager of the irrigation section for the ministry. You're correct. The dam is definitely Water Security Agency. And as of March of 2014 the East Side pump station and the M1 canal that supply water for the Broderick reservoir were actually transferred to the Water Security Agency from the Ministry of Agriculture. So there is an intersection there. Most of the infrastructure for the South Saskatchewan River irrigation district is still in the name of the ministry.

Mr. Nilson: — So then you have the West Side canal and then you have all the Riverhurst infrastructure? Would that be . . .

Mr. Drury: — That's correct.

Mr. Nilson: — And so then that possible big water user project on the east side is on the M1 canal, so you don't have to worry about that part anymore. Is that correct?

Mr. Drury: — That's correct.

Mr. Nilson: — Thank you. I have no further questions. These questions in some ways are asked for me but also for my mother who is following all of this very carefully. Thank you.

The Chair: — Are there any further questions on this particular chapter? Seeing none, what is the will of the committee with respect to the 2014 Provincial Auditor report volume 1, chapter 16? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. In regards to the 2014 report volume 2, chapter 16, I would put a motion forward that we conclude considerations.

The Chair: — Volume 1? Just a correction here. Could you repeat your motion again?

Mr. Merriman: — Absolutely. In regards to the 2014 report volume 1, chapter 16, I would put a motion forward that we conclude considerations.

The Chair: — Thank you. Mr. Merriman has moved that for the 2014 Provincial Auditor report volume 1, chapter 16, that we conclude considerations. Are there any further questions? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you to the ministry officials here today. I don't know if you want to make any remarks in closing.

Ms. Koch: — No, I would just comment, thank you very much to the committee for their attention and their questions and interest today. And I do want to say a thank you to the officials who put an enormous amount of work into ensuring that we can properly report to the committee. So thank you very much.

The Chair: — Thank you. I have to say thank you for the status updates that we received. This is the first time we're doing this in PAC, and I know it was incredibly helpful for me. And so we all recognize, I think, lots of work went into that, and I think it helps guide our discussion. So thank you for doing that so thoroughly. With that, could I have a motion to adjourn?

Mr. Michelson: — I so move.

The Chair: — Mr. Michelson. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned until

tomorrow at 9 o’clock.

[The committee adjourned at 14:11.]