STANDING COMMITTEE ON PUBLIC ACCOUNTS

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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Mr. Don McMorris, Deputy Chair
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Estevan

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Melfort

Ms. Lisa Lambert
Saskatoon Churchill-Wildwood

Mr. Warren Michelson
Moose Jaw North

Ms. Vicki Mowat
Saskatoon Fairview

Mr. Randy Weekes
Biggar-Sask Valley

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[The committee met at 09:02.]

The Chair: — Okay. Good morning folks. We'll convene the Standing Committee on Public Accounts here today. I'll introduce members around the table: Deputy Chair Mr. McMorris, Mr. Goudy, Ms. Lambert, Mr. Weekes, Mr. Michelson, Ms. Mowat. And do we have a substitution for . . . No substitutions here. Okay.

We have the following items to table: PAC 64-28, Ministry of Agriculture: Responses to questions raised at October 4th, 2018 meeting; PAC 65-28, Ministry of Education: Report of public losses, September 1st, 2018 to November 30th, 2018; PAC 66-28, Ministry of Finance: Report of public losses, October 1st, 2018 to December 31st, 2018; PAC 67-28, Ministry of Advanced Education: Report of public losses, October 1st, 2018 to December 31st, 2018; PAC 68-28, Ministry of Health: Report of public losses, October 1st, 2018 to December 31st, 2018.

I'd like to introduce the officials that have joined us here today from the Provincial Comptroller's office: Terry Paton, Provincial Comptroller; Chris Bayda, executive director of the financial services branch. I'd like to introduce and welcome Judy Ferguson and her officials that I know will be introduced by our Provincial Auditor with each of the respective chapters. And at this point I think we'll turn our attention to the Saskatchewan Cancer Agency and the reports: 2016 report volume 1, chapter 14; and the 2018 report volume 2, chapter 38.

I'd like to welcome officials from the Ministry of Health and the Cancer Agency for their attendance here today and for their work. Maybe I'll turn it over real quick for an introduction of the officials that are with us here today. I'd ask us not to get into the chapters just now because I'll pull it back to the Provincial Auditor and then turn it back for a subsequent response and then questioning of committee members. Thank you so much for being here today.

Health

Mr. Wyatt: — Good morning and thank you on behalf of the Ministry of Health. I'd like to thank everyone for the opportunity to discuss the 2015, 2016, 2017, and 2018 Provincial Auditor reports. My name is Mark Wyatt; I'm assistant deputy minister. And several ministry and health partner staff are joining with us today to assist in answering specific questions regarding the report. From the ministry, we have Billie-Jo Morrissette, assistant deputy minister; Kimberly Kratzig, assistant deputy minister; Deborah Jordan, executive director of connected care services; Linda Restau from continuing care; Bev Hungle from finance branch; and to my right, Kayla Edgerton, manager of contracts and CBO [community-based organization] review with financial services branch.

We also have a number of officials from both the Cancer Agency, the Saskatchewan Health Authority, and eHealth Saskatchewan, including Dr. Jon Tonita from the Cancer Agency along with Linda Weir from the Cancer Agency; Robbie Peters, vice president with the Saskatchewan Health Authority; Corey Miller, vice-president of provincial programs with the SHA [Saskatchewan Health Authority]; Andrew McLetchie, also vice-president with the SHA; Sharon Garratt, vice-president with the SHA; Terri Carlson, executive director from the SHA; Leanne Ashdown, chief audit officer from the SHA; Davin Church from eHealth; and Lisa Thomson from Saskatchewan Health Authority. We will ask officials to introduce themselves should they come to the microphone to address the committee.

Mr. Chairperson, the Provincial Auditor plays a vital role in ensuring the 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. The ministry, Saskatchewan Health Authority, and the other health agencies are committed to the responsible, efficient, and effective management and delivery of health care. Knowing that the Provincial Auditor also shares this goal, we welcome this report and appreciate the effort and detail that was put into the various reviews.

Progress has been made on a number of the auditor's recommendations and work continues in many areas, both at 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 look forward to answering the committee's questions. Thank you.

The Chair: — Thank you so very much, Assistant Deputy Minister Wyatt. And we have some serious health horsepower in the room here today. Thanks to everybody for the work that they do across the province for people.

I'll turn it over now to the Provincial Auditor to address chapters 14 and 38, and we'll go from there.

Ms. Ferguson: — Thank you very much, Mr. Chair, Deputy Chair, members, and officials. We're pleased to be here this morning and actually to discuss the bulk of the work that we've done in the last few years in the health sector. This morning we're going to present the two items on the agenda for Cancer Agency together. And you'll find that there's various ones today that we'll be grouping wherever we can.

Before we launch into that, I'm going to introduce Ms. Tara Clemett who's the deputy provincial auditor responsible for the health division and has led the bulk of the work that's presented today. And behind her is Kim Lowe. Kim is actually here with double duty today; she's got two hats. She's our PAC [Public Accounts Committee] liaison, but she's also an integral member of the health division team too and has led a good chunk of the work that's on the agenda today. Tara will be making the bulk of the presentations today too, so you won't have to listen to my raspy voice.

Before we launch into the presentation, we do want to take a moment to thank the officials at the Cancer Agency for the co-operation extended to us during the course of this work. Tara.

Ms. Clemett: — Chapter 14 of our 2016 report volume 1, on pages 163 to 180, reports the results of our audit of Saskatchewan Cancer Agency's processes to deliver its systematic population-based screening program for breast cancer. The program suggests women over 50 years of age have a mammogram every two years. In 2014-15, Cancer Agency spent

about $3.8 million on its screening program. The agency recognized the participation rates in the screening program were low.

We concluded that for the period of March 1st, 2015 to February 29th, 2016, Cancer Agency had — other than reflected in our recommendations — effective processes to deliver its screening program for breast cancer. We made five recommendations. I'm going to focus my presentation on those five recommendations.

Our first recommendation on page 170: we recommend that the Saskatchewan Cancer Agency evaluate the success of its screening program for breast cancer promotional activities against expectations. The Cancer Agency educates the public about its screening program through various promotional activities. Each year it spent about $43,000 on its promotional activities. Two staff were responsible for organizing these activities. We found the agency had not established how to determine the success of its promotional activities. For example, it did not determine the expected percentage increase in participation rates for a particular promotional activity for a targeted region or group. Rather the agency informally evaluated its promotional activities on an annual basis. It discussed what worked well, what it needed to improve. It did not keep record of these discussions or decisions.

By August 2018, as reported in our chapter 38 of our 2018 report volume 2, although the agency had developed tools to begin evaluating its promotional activities, it wasn't using them consistently. The agency continued to rely on verbal feedback from staff rather than post-event evaluations to gauge success formally. Without consistently measuring success, the Cancer Agency cannot know whether the time and money spent on its promotional activities are effective in educating the public. It also limits the Cancer Agency's ability to assess whether it has the optimal mix of promotional activities in place.

In our second recommendation on page 170, we recommend that the Saskatchewan Cancer Agency develop a strategy to engage physicians in initiatives to increase the awareness of its screening program for breast cancer. While the Cancer Agency participated in several events for health care providers, including physicians, each year, it did not have an ongoing relationship with physicians outside of these events. We found it didn't have a strategy to engage physicians in promotional initiatives to increase the rate of participation of eligible women in its screening program. Not having a strategy to engage physicians in promoting breast cancer screening increases the risk the Cancer Agency is missing opportunities to increase its participation rates in its screening program and reduces the opportunity for early detection of breast cancer. By August 2018 we are pleased to report the Cancer Agency had addressed this recommendation. It had developed strategies to engage physicians in initiatives to increase awareness of its screening program.

In our third recommendation on page 172, we recommend that the Saskatchewan Cancer Agency analyze information on difficult-to-screen populations for its screening program for breast cancer to assess whether sufficient strategies are in place to reach these individuals for screening. We found the Cancer Agency had developed several targeted strategies to reach difficult-to-screen populations. The agency's primary strategy to reach women in rural and remote areas is to make screening more accessible through using a mobile mammography bus and using ads to make individuals aware of the timing of visits to their community.

However we found the agency did not use the information it had already collected, for example the geographic information, to determine or assess participation rates of those difficult-to-screen populations, so those living in rural or remote areas. As a result, it didn't know whether its targeted strategies were actually increasing participation of difficult-to-screen populations in its screening program. By August 2018 we found the Cancer Agency had implemented this recommendation. It was analyzing its information. In addition it undertook new strategies to educate and reach difficult-to-screen populations.

In our fourth recommendation on page 177, we recommend that the Saskatchewan Cancer Agency broaden the use of its key quality indicators relevant to Saskatchewan to regularly analyze the performance of its screening program for breast cancer. We found that while the Cancer Agency did some monitoring of its programs, the information it used wasn't current to enable the agency to monitor whether its screening program is effective, so whether breast cancer is correctly identified through the screening test, and to monitor the performance of its individual radiologists.

[09:15]

The agency was trying to use national results published by a national body called Canadian Partnership Against Cancer, also known as CPAC. CPAC periodically published national results against established targets on 13 quality indicators. You will see in exhibit 5.0, starting on page 178, a list of those 13 indicators; for example, one indicator measures the number of invasive breast cancers found 12 months after a normal screening. However, information in CPAC reports is outdated; for example, the CPAC report for 2015 was based on data from January 2009 to December 2010. Its 2015 review about indicators related to radiologists was based on 2012 data. Without regular, timely tracking of key quality indicators in the performance of radiologists, the Cancer Agency's ability to analyze performance information and take timely action to address areas that fall short of established benchmarks is limited.

By August 2018 the Cancer Agency had made limited progress in broadening its use of key quality indicators. Management noted its current IT [information technology] system limited its ability to track information on all key quality indicators. Management indicated it expected to implement a new IT system over the next two or three years.

In our last recommendation, on page 178, we recommend the Saskatchewan Cancer Agency periodically report to senior management, the board, and the public on key performance information for its screening program for breast cancer.

Each quarter the Cancer Agency reports participation rates and wait times to senior management and the board. It publishes participation rates and volume information, so the total number of screening tests performed, in its annual report. However, it does not include information on a number of key quality indicators necessary to show that the breast cancer screening program works as intended, like whether it helps to identify

breast cancer early. As just described, the agency did not compile or analyze information on key quality indicators, like the number of invasive cancers detected and the number of invasive breast cancers found within 12 months after a normal breast cancer screen.

By August 2018 the agency had made some progress on improving its future reporting. The agency has identified additional key quality indicators such as retention rates, so the percentage of women who return for screening after 30 months of their previous screen, and interval cancer rates, the number of invasive breast cancers found after a normal screen within 0 to 24 months of the screen date. The agency hopes to expand its reporting on its key quality indicators by replacing its IT system.

That concludes my overview of these chapters. Thank you.

The Chair: — Thank you for the presentation and the focus of the work. I'll turn it back over to ADM [Assistant Deputy Minister] Wyatt, if he has some additional comments with respect to these recommendations. Otherwise we'll open it up for questions shortly.

Mr. Wyatt: — I can offer comments on all of the recommendations in one group or move through them individually, at the committee's request.

The Chair: — I'm happy for you to address them. We also have the status update, and thank you as well for that because that demonstrates the work and some of the progress that's been taken on. So, happy to have you respond to the recommendations, and then we can open it up for questions.

Mr. Wyatt: — Thank you. So speaking to recommendation no. 1, an evaluation tool, and we would consider that recommendation to be partially implemented. An evaluation tool was developed to assess the success of the screening program's promotional activities. The tool is to be filled out by the program coordinators and includes questions regarding how many participants have attended, was the target audience reached, what needs to be changed, and did the organizers want the agency to return to future events.

The agency has set out how often and for which type of event the coordinators should complete the evaluation. Coordinators completed evaluation forms in December 2018, and a master evaluation summary was completed in December of 2018.

Moving to recommendation no. 2. As noted by the auditor, this one has been implemented. Recommendation no. 3, also considered implemented.

Recommendation no. 4, we would consider partially implemented. In 2016-17 the Cancer Agency broadened the use and reporting of three new quality indicators: participation by age group, wait time for abnormal mammogram to definitive diagnosis, and proportion of clients receiving an abnormal screen result who waited within target time frames for diagnosis. Also of note, the Cancer Agency has embarked on the redesign of its program in relation to participation rates and follow-up procedures.

A new information technology system is expected to be implemented in two to three years. The system will allow further development of key indicators and the ability to extract and share data. Once the IT system is replaced, the agency will report on the following key indicators: participation rate per geographic areas of the province, participation rate per geographic area of the province and age group, retention rate, interval cancer rate, and wait time for abnormal mammogram to definitive diagnosis. This recommendation is expected to be implemented by 2021.

Recommendation no. 5, also partially implemented. In 2016 the agency broadened the use and reporting of three new quality indicators. They are participation by age group, wait time for abnormal mammogram to definitive diagnosis, and proportion of clients receiving an abnormal screen result who waited within target time frame for diagnosis. This information is reported annually to the senior leadership. In addition, participation rates and appointment wait times continue to be shared with the board, senior management, and executive. The public has access to volumetrics through the agency's annual report.

The agency continues to look at audiences and relative performance measures that can be extracted from current data. The new IT system previously mentioned will allow further development of key indicators and the ability to extract and share the data with senior management, the board, government, and the public. The new IT system will also allow the agency to better assess the effectiveness of its screening program. Finally, the agency in the spring of '19 will have a new website that is mobile friendly and easier to navigate. That concludes my comments on these chapters.

The Chair: — Thank you very much for that presentation. We'll be tabling the status updates going forward for all ministries, so I think you're the first, as a bit of a new process around this table. And as such, I'll table PAC 69-28, Ministry of Health: Status update February 26th, 2019. Thanks for the work that went into that as well. I'll open it up now to committee members for questions. Ms. Mowat.

Ms. Mowat: — Thank you, Mr. Chair. Thank you to the auditor and the ADM for the presentations. And it's also very useful to have the status update and to see what progress has been made. So I'll just ask some additional questions about some data that isn't necessarily available in the Provincial Auditor's report, and also about some of the actions that have been taken since the report.

We know from chapter 14 on page 166 that the breast cancer screening program in Saskatchewan, there was 3.8 million spent on this program in 2014-2015. Can you comment on what the spending has been like in the program since that point?

Mr. Tonita: — Hi. So I'll assist Mark with some of the answers. So I'm Jon Tonita and I'm the CEO [chief executive officer] of the Cancer Agency. I feel really small in here. This chair is . . . Is that by design or something?

Yes, so the budget for the screening program is pretty much the same. It hasn't changed very much since that time. Yes, I would say it's probably still 3.8. I think it's 3.89 still.

Ms. Mowat: — Thank you. And on the following page there's figure 3, the participation rates in the screening program for

breast cancer and the number of mammograms. This table tracks 2012-2013 to 2014-2015. It shows a declining trend in participation in the program. I'm wondering if you can comment on what explains this trend.

Mr. Tonita: — We are able to do around 38,000 mammograms a year, and that's almost our capacity with the staff we have at our facilities. Over the last 15 years, as you know, the population of our province has aged. We screen women 50 to 74 years of age. I think over the last 15 years that population has grown by 20 per cent, so there's just that many more women available for screening. But our capacity to do that many more is not really there, so that results in participation falling. But if you actually look at the number of mammograms, they're actually pretty stable. And even today they would be right around the same numbers, around 38,000 per year that are done.

Ms. Mowat: — Thank you. Do we have the numbers available for 2015-2016, and onward as well?

Mr. Tonita: — Yes.

Ms. Mowat: — Okay. That's sounds good. And in terms of capacity, is there any plan to expand capacity then?

Mr. Tonita: — Yes. So as Mark had mentioned, one of the responses, and it relates to one of the other recommendations about how we use our indicators, it was really the indicators that told us that we needed to do something different in how we're providing the service. So in our current five-year strategic plan of the Cancer Agency, redesign of the breast screening program is actually one of our initiatives. So we started that work.

The goal of that is really two primary goals. One is to increase participation. And the other is to ensure that the follow-up of women who have an abnormal screen, that the quality of that follow-up is more consistent around the province because our indicators have told us that there is inconsistency.

So we've created a provincial committee. There was about 50 people that attended our first meeting — people from the RHA [regional health authority], private radiology groups, our own team — looking at how we will redesign and make use of facilities that are available outside of our own capacity so that we can increase participation.

Ms. Mowat: — Thank you. I see that about 8,000 scans have taken place on a mobile bus. Was STC [Saskatchewan Transportation Company] utilized in any way for the screening program?

Mr. Tonita: — Like in terms of using their bus system to do the screens? No, we have our own. We have our own mobile unit that we use.

Ms. Mowat: — There's talk about an accreditation review in 2016 on page 173. It says its Regina facility received accreditation in 2015. It's due for another review in 2018. Can you speak to the results of these reviews?

Mr. Tonita: — I'll just refer it to Linda Weir. Yes, they were done, yes. Yes, so we received CAR accreditation in 2018. Canadian Association of Radiologists, that's what we use.

Ms. Mowat: — Thank you. In reference to, we've been talking a lot about participation rates in reference to wait times. There's some discussion about wait times on page 177, the time between when there's client contact with the SCA [Saskatchewan Cancer Agency] and when the mammogram is received. What have been the trends for wait times over the last several years? I don't know what the most recent data you have available is.

Mr. Tonita: — Those trends are fairly level. Like, they're not going up or down.

Ms. Mowat: — Okay. And what would be, what would be an average wait time?

Mr. Tonita: — Women who have . . . like after they respond to our invite, we're booking appointments within a month.

Ms. Mowat: — So I'm moving on to chapter 38 here. On page 259 there's reference to the process of replacing an IT system in the hopes that it will be used to track and report more key quality indicators. What is the status of this replacement?

[09:30]

Mr. Tonita: — So we've completed a requirements document of what our needs are, going forward. In April of this year we will have a business analyst dedicated to that work. It's probably going to take two years before a solution is implemented. Our current system is quite old. It's 16 years old. And I mean it's very difficult making any changes to our current system. It's very difficult getting information out of it, so it's not meeting our needs any longer. So by probably spring of 2021 we should have a new system in place, and it will certainly enable us to do a lot more.

Ms. Mowat: — Thanks. Yes, I can appreciate how much has changed in that period of time. On page 263 it says, "In 2017, the Agency signed a memorandum of understanding with the Northern Inter-Tribal Health Authority." Is there an update on this agreement?

Mr. Tonita: — So that work was funded actually by CPAC. We received a grant through the Canadian Partnership Against Cancer to do that work and then . . . It was kind of a one-time project, and that funding has ran out.

Ms. Mowat: — Okay. Can you speak to what that project looks like? It says that there was a pilot to evaluate the cancer surveillance system in northern Saskatchewan. Was that related to or separate from the funding?

Mr. Tonita: — Yes, there was . . . So there was communities that were wanting to know what their participation was and how they would engage with the program. In the end though, when we went to the individual communities, really what they wanted to know was whether their members were being screened or not. We do not have access to the First Nation indicators in our database, so we're not able to tell them specifically, these people in your community were screened, or not, because we don't have that. And you know, we mostly work off addresses, but in those communities addresses are not a good indicator of who people are.

So that project actually morphed into some different work. It was more engagement work with NITHA [Northern Inter-Tribal Health Authority] and with those communities, and yes, it ended up not . . . It just wasn't possible. We tried. We were trying to get those First Nations indicators, and it just didn't work out.

Ms. Mowat: — Thank you. There's some discussion about how the agency began tracking new quality indicators, one of them being the wait time from an abnormal mammogram to a definitive diagnosis. Can you speak to what these waits are typically like for this indicator?

Mr. Tonita: — So this would be one of the areas where it can be quite variable in the province depending on where the women live, which is why we're looking at a redesign. Women in the cities, if they have an abnormal mammogram, through our program we have nurse navigators who help them with the next steps. So they'll often go to private radiology clinics and have subsequent tests done. Usually it's another mammogram or ultrasound. If biopsies are required, then it again depends on where they live. In Regina, radiologists do biopsies; in Saskatoon they're done by surgeons. So the times can be inconsistent.

And then the rural women face other issues because then they have to travel for some of those procedures. So that's actually a big part of the redesign of our program, is how do we tighten that up and make sure that it's more consistent in how the follow-up is done. But a lot of that follow-up is also not . . . I mean it's not in the Cancer Agency's control because diagnostics either occurs in the Health Authority at the hospitals or in private radiology clinics. But they're all on our team looking at how we redesign that.

Ms. Mowat: — Thank you. And just to go back to the status update briefly. On the first outstanding recommendation, that the Cancer Agency evaluate its success of the screening program, there's been some explanation of the actions that have been taken since the report and the fact that there was an evaluation done by the program coordinators and a master evaluation summary. It was unclear . . . Has this summary been completed? Because in the status report it says it will develop a summary by June 2019 so I was just curious about . . .

Mr. Tonita: — It's already done.

Ms. Mowat: — Oh okay, okay. And is that a document that is publicly available or can be made available to us?

Mr. Tonita: — It's just on our internal SharePoint site but it could be shared.

Ms. Mowat: — Okay. Can we ask that it be tabled back to the committee?

Mr. Tonita: — Yes, I don't see why not.

The Chair: — Just on that then, just to be consistent with undertakings to get documents back to the committee, the Committee Clerk's office will provide some instructions on how to do that. Thanks for that commitment.

Ms. Mowat: — Thank you. I have no further questions, Mr. Chair.

The Chair: — Any other questions with respect to chapters 14 and 38? Mr. Michelson.

Mr. Michelson: — In regards to chapter 14, I do believe there was a chart there showing the participation rates. Is there any way of increasing those participation rates that would be quite obvious that should be done? And I guess the next part of that would be, how do these rates compare to other provinces?

Mr. Tonita: — Yes. So first with other provinces, it's really variable across the country. We would be in kind of the middle of the pack. In terms of what we can do to increase participation, I think we have to make use of their private radiology clinics that are out there. I would say they are already doing screening. There is screening going on outside of our program, and part of our redesign is, how do we bring those screens that are happening in private radiology clinics into the program?

It doesn't mean we have to do the procedures, but we need to know who is actually being screened, and as long as we can get the data. I anticipate that in our province our participation is really probably more like 60, 65 per cent, and the target is 70. I suspect we're very close to that. It's just that it's happening in two different places. So part of that redesign work is how do we bring that together . . .

Mr. Michelson: — With them.

Mr. Tonita: — Yes. Actually they've been really good. They have been participating on our committee looking at our redesign, and they're really engaged in it.

Mr. Michelson: — That's encouraging. Thank you.

The Chair: — Mr. Deputy Chair McMorris.

Mr. McMorris: — Thank you. Just regarding the . . . You know, it was mentioned that some statistics from CPAC, and they were quite dated, probably not really all that effective. And I know it's always a struggle to manage data. I mean there is so much information to collect and to know what is most important.

Do you do much work out of province with the other provinces? I mean every province is going through this. You know, I mean there's a border between Alberta and Saskatchewan or Manitoba and Saskatchewan, but that's all it is. I mean what's happening in Alberta or in Manitoba, you know, for screening programs is probably not a whole lot different. Do we talk to other provinces to look at the effectiveness or efficacy of their programs and how they're measuring that?

Mr. Tonita: — So that CPAC group that puts all of the stats together, there's actually a national . . . It's called a breast cancer screening network, and every province attends that and we are members of that. So it's more than just bringing the data together. We actually . . . All of the program managers come together at that national table and then talk about . . . They update what's happening in each province. They update the different kinds of work that they're doing. Because we all have the same problems, right? We all have the same issues, and so we do try to learn from our partners across the country something that they might be doing that we'd say, oh jeez, you know that might work here. And so yes, we do participate and that's been going on for 10

years.

The Chair: — Thanks for the responses here today and thanks for the status update. I think it allows us to focus in on our motions here. Two of the recommendations have been addressed, appear to be fully implemented, so I'd welcome a motion that we concur and note compliance with respect to I think 2 and 3. Ms. Lambert. Moved by Ms. Lambert that we concur with recommendations 2 and 3 of chapter 14 of the 2016 *Report of the Provincial Auditor* volume 1 and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — So that's carried. The recommendations 1, 4, and 5 both have progress I guess. I'd welcome a motion. Mr. Goudy would move that we note that we concur and note progress with respect to recommendations 1, 4, and 5 of chapter 14. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — All right, that's carried. Okay, so that concludes consideration of chapter 14 and will also conclude considerations of chapter 38. There were no new recommendations within that chapter. So thank you so very much to the Saskatchewan Cancer Agency for their presence here today and of course for their important work across the province.

Mr. Tonita: — Thank you very much.

The Chair: — I believe we've had notice from a member that they'd like to address a matter and possibly make a motion. Ms. Mowat.

Ms. Mowat: — Yes, thank you, Mr. Chair. I would like to move a motion, but I'd like to speak briefly about that first if I can have the committee's indulgence. The motion is for the auditor to make a special assignment to fully examine the ongoing questions about eHealth. The rationale that I have is this is one of the first opportunities that the Public Accounts Committee has had to scrutinize some of the allegations of wrongdoing at eHealth. While the public concerns have been related almost exclusively to vendor-sponsored travel, some other concerns have been brought forward that are related to unfairly tendered contracts, expenses on goods and services that have never been utilized, and the misuse of public dollars. These issues I would say fall squarely within the mandate of the Public Accounts Committee.

Given the fact that eHealth is in the process of taking on the monumental task of IT amalgamation for the SHA, clearing the air is very important. We know the minister and the auditor have been hearing similar concerns and similar allegations, and there should be shared interest among committee members to get to the bottom of whatever these allegations are, considering the mandate of our committee.

I understand that the auditor is already doing some of this work. I would submit that the committee members should have no problem voting for this motion and getting this on the record, and that with a special investigation from Public Accounts, the auditor's report would come back to Public Accounts for review. And I would submit that this is the most appropriate committee for that to take place in.

So I'll move my motion. It reads:

> That pursuant to section 16 of *The Provincial Auditor Act*, the Standing Committee on Public Accounts requests the Provincial Auditor perform a special assignment to fully examine eHealth Saskatchewan's recent and current contract and tendering processes, including whether vendor-sponsored travel by eHealth employees led to misuse of public resources, violated appropriate policies and procedures, or resulted in a failure to negotiate in the best interests of taxpayers; and
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> That the special report shall be tabled with the Standing Committee on Public Accounts.

I so move, Mr. Chair.

The Chair: — Moved by Ms. Mowat. Any questions or comments from folks around the table before we'd get to a vote or something?

Mr. McMorris: — I would first . . . I would ask the auditor to comment on the work that she's doing in this area.

Ms. Ferguson: — Most definitely. Thank you. As the member indicated, we became aware of issues in this area, so we had a look in terms of what work we had under way at eHealth in addition to the annual integrated audit. And what we've decided to do — and actually have work under way that we plan to include in our next report to the Assembly, which wouldn't be until June, early June of 2019 here — is we are doing additional audit work where we're looking at eHealth's policies and processes to mitigate vendor influence and related conflicts of interest used during the period April 1, 2017 to January 31, 2019.

[09:45]

The lines of inquiry that we're going to use in this work is looking at, is the code of conduct and conflict-of-interest framework sound? Are the policies and procedures for vendor-sponsored travel and training appropriate to avoid vendor influence in procurement decisions? And do procurement policies and processes sufficiently promote vendor evaluations and contract decisions in a fair and unbiased manner?

We have discussed this work with the entity already, the eHealth and its board. And it's actually, the work is under way at this point in time, like as I indicated, with a target to include the results of that work in our next report to the Assembly.

The Chair: — Deputy Chair McMorris.

Mr. McMorris: — Thank you. So I would say that with the work that the auditor is going to be doing into the future covers off pretty much everything in this motion, as well as work that is done by the deputy minister to the Premier. Cam Swan has already looked into some of this. But certainly, you know, the auditor's authority and purview is welcome on this front, and we would welcome that. I don't think the need for a special report . . . It would come with any other report, as in June is timely

enough to say that, you know, I think members on this side are more than satisfied with the work that the auditor is doing and has done and will do on this front.

The Chair: — Any other comments or questions or wishes of committee members at this time? The motion's been placed. I'll read the motion:

> That pursuant to section 16 of *The Provincial Auditor Act*, the Standing Committee on Public Accounts requests that the Provincial Auditor perform a special assignment to fully examine eHealth Saskatchewan's recent and current contract and tendering processes, including whether vendor-sponsored travel by eHealth employees led to misuse of public resources, violated appropriate policies and procedures, or resulted in a failure to negotiate in the best interests of taxpayers; and
>
> That this special report shall be tabled with the Standing Committee on Public Accounts.

That's moved by Ms. Mowat. Those in agreement?

An Hon. Member: — Agreed.

The Chair: — Those opposed?

Some Hon. Members: — Opposed.

The Chair: — The motion is defeated. Moving matters along, we'll focus in our attention to the regional health authorities' chapters. We're going to deal with, I think, chapter 25 of the volume 2, 2016 report independently. Is that correct?

A Member: — Yes.

The Chair: — So I'll turn it over to the Provincial Auditor at this point to bring their report and recommendations with respect to chapter 25 of the 2016 volume 2 report.

And I see not a member of the committee but a participating member of the committee here today, MLA [Member of the Legislative Assembly] Ms. Chartier, for joining us here today.

Ms. Ferguson: — I'm going to turn it over to Ms. Clemett right away. I just wanted to bring to the attention that there is new recommendations in this chapter for the committee's consideration.

Ms. Clemett: — In 2016 at the time of our audit, Saskatchewan had 104 ground ambulance operators, with regional health authorities owning about one-half of them. Over half of all ambulance operators responded to less than one call per day, and less than one-tenth of them responded to less than one call per week.

Cypress RHA had ambulance services in 12 communities across its region, using a mix of RHA-owned ambulances and contracted ambulance service providers. The number of ambulance service operators in the region had remained the same since 2002.

Chapter 25 of our 2016 report volume 2, on pages 123 to 142, reports the results of our audit of the Cypress Regional Health Authority's processes for delivering accessible and responsive ambulance services. We concluded, for the 12-month period ended August 31, 2016, Cypress Regional Health Authority had, other than reflected in our recommendations, effective processes for delivering accessible and responsive ambulance services. We made seven recommendations. I'm going to focus my presentation on those seven recommendations.

Our first recommendation, on page 131, we recommend that the Ministry of Health, along with the regional health authorities, formally assess whether the distribution of ambulance services are optimal for responding to patient demand. We found Cypress monitored, on a limited basis, historical patient demand and overall response times relevant to ambulance operator location. Even though Cypress received response time and call volume information from the Ministry of Health, its analysis of it was limited.

So our analysis of the data determined the following: emergency responses made up about 39 per cent of Cypress RHA total calls. The number of calls varied significantly across its ambulance operators, with one operator having 21 calls per year and another having over 2,000. Six ambulance operators responded to less than one call per week on average. On average the costs of service calls across the region ranged from $476 to almost $7,000 per call, with the average cost per call at about $2,400.

We further noted that Cypress had four less ambulance operators than Heartland RHA, which was a region of comparable geographic size and population. Heartland had ambulance services located in 16 communities. Without a comprehensive review of patient demand relative to ambulance services, there's a risk the ministry and the Saskatchewan Health Authority are not making the best use of resources.

In our second recommendation, on page 133, we recommend that the Cypress Regional Health Authority update its contracts related to the provision of ground ambulance services to include service quality expectations and periodic reporting on them. Cypress used five contracted service providers to help provide ambulance coverage in the region. Cypress had written contracts with each of these contracted ambulance service providers. It established the contracts with four of these service providers over 20 years ago.

Our analysis of the contracts found it did not reflect good practice. None of the five contracts included service quality expectations. In addition they did not require the ambulance operators to share key information like completed incident reports with Cypress to enable it to monitor the operators' ambulance service delivery.

Incorporating service quality expectations into contracts would help contract ground ambulance service providers understand the service Cypress RHA expects of them. In addition, it would assist Cypress RHA to monitor the effectiveness of the ambulance services they deliver and hold them accountable for the quality of the service that they provide.

In our third recommendation, on page 134, we recommended that the Ministry of Health consider updating *The Ambulance Act* related to contracted ground ambulance service providers to align

with contract management best practices.

The Minister of Health is assigned responsibility for *The Ambulance Act*. The Act came into effect in 1989. The Legislative Assembly last changed provisions in the Act related to the contracts with ambulance service providers in 2009, 10 years ago. *The Ambulance Act* recognizes that the use of contracted ambulance service providers helps provide adequate ambulance coverage. The Act contained detailed provisions over the continuance, renewal, and terminations of contracts between ambulance service providers and regional health authorities; for example, under the Act these contracts automatically renew upon expiry.

Cypress found the legislative provisions made it difficult for them to update contract terms and change how they use ambulance service providers, like the number and location of operators. Having contract provisions in law is unique. Certain aspects of the legislative provisions are not consistent with good management practice. For example, good contract management requires timely planning for contract expiry and renewal based on performance. Consideration as to whether all provisions of *The Ambulance Act* remain relevant and contribute to effective contract management is needed.

In our fourth recommendation, on page 135, we recommend the Cypress Regional Health Authority confirm ground ambulance operators operating in the region hold current ambulance licences. *The Ambulance Act* requires an ambulance operator to hold a valid ambulance licence issued by the Minister of Health.

Cypress did not have a process to confirm that the ambulance operators, either under its employ or contracted by them, hold a current ambulance licence. For five of eight ambulance operators we tested in late July 2016, their licences had expired three months previous, so in April. Confirming ambulance operators hold current ambulance licences also confirms the ambulances are safe to drive and they have all the required equipment on board the ambulances.

In our fifth and sixth recommendations, on page 140, we recommend that Cypress Regional Health Authority monitor response times against targets for all ground ambulance operators on a regular basis, either monthly or quarterly.

We recommend that Cypress Regional Health Authority follow its established policy to obtain completed incident reports for instances when ground ambulance response times do not meet targets, so it can determine required actions.

Cypress RHA only monitored response times on a call-by-call basis. It did not formally monitor ambulance response time on a regional basis or on an overall ambulance operator basis, other than its highest volume operator, which was located in Swift Current. Swift Current made up 58 per cent of the total Cypress emergency service calls.

In 2015-16 Cypress ambulance operators responded to over 1,900 emergency service calls. Our analysis found response times for 13 per cent of them, so almost 250 calls, exceeded the provincial response targets. So the provincial response targets are eight minutes and 59 seconds in an urban centre and under 30 minutes in a rural area. Response times for 25 of those calls exceeded one hour.

Cypress did not analyze why responses took longer than expected. It did not have planned actions to improve the compliance rates of ambulance operators not achieving targets. In addition Cypress wasn't enforcing its incident reporting policy. This policy required the ambulance operators to complete an incident report when there is a delay in response time. Its contract with contracted ambulance service providers did not require them to submit incident reports. Without detailed analysis of response-time trends, Cypress does not know the extent of excessive response times that need addressing or the reasons for delays. Delays may contribute to negative patient outcomes.

Our final recommendation, on page 141, we recommend that the Cypress Regional Health Authority report to senior management, to the board, and the public actual results against key measures to assess the success of its ground ambulance services at least annually. While Cypress adopted the provincial targets for ambulance response times, senior management and the board did not receive periodic comparisons of actual response times against targets. Without measuring key performance results, Cypress RHA did not know if it was delivering timely and quality ground ambulance services.

That concludes my overview of this chapter.

The Chair: — Thanks for that presentation. We'll open it up to ADM Wyatt and officials for a brief response. Thanks as well for the status updates on this front, and then we'll turn to committee members' questions.

Mr. Wyatt: — Thank you. I'll begin with recommendation no. 1, which we consider to be implemented. In 2017 the ministry conducted comprehensive consultations with a broad range of EMS [emergency medical services] stakeholders to determine how ground EMS can adapt to improve service to patients. The consultation topics included patient care, coordination and integration and efficiency, better value for money, accountability, performance management, contract management, and finally EMS legislation.

The consultation identified the need for a performance-based contract template. The template would be foundational for future improvements and would provide the basis for clarity of service expectations, improved accountability, and consistency across the province. A collaborative working group involving the Saskatchewan Health Authority, Saskatchewan Emergency Medical Services Association, representatives of ambulance services, and the ministry completed work on the performance-based agreement template in March 2018.

Effectively meeting patients' needs in the most efficient manner possible must be the highest priorities as improvements to the ground EMS system moving forward. The ministry has identified implementation of the performance-based contract, including a provision that the closest available ambulance responds to an emergency call as a priority for the Saskatchewan Health Authority. The performance-based template will be implemented as new contracts are signed with EMS service providers over the next two to three years.

[10:00]

Moving to recommendation no. 2, we consider this to be partially implemented. The Ministry of Health worked with the Saskatchewan Health Authority and provincial stakeholders to develop this new performance-based ground ambulance contract template, and the SHA will work with the privately contracted services to sign the new agreements. Contracts will be migrated to the performance-based agreements as contracts come up for renewal over the next two to three years or when both parties agree to meet. New contracts were signed by Swift Current ambulance and Val Marie ambulance providers in 2016 and they will move over to the new contract template when their current contract expires.

Moving to recommendation no. 3, we consider this to be implemented. In 2017 the ministry conducted consultations with a broad range of EMS stakeholders that included consideration of possible changes to *The Ambulance Act*. Following the consultation process, a decision was taken to improve contract management practices and introduce a new performance-based contract through collaboration and in negotiation rather than through legislative amendment. In 2017 the EMS stakeholders were advised that legislative changes would not be tabled in the fall sitting of the Legislative Assembly. Working within the current legislation, Ministry of Health staff facilitated a collaborative process with the SHA and EMS industry stakeholders to improve the consistency and quality of services through the development of the new EMS performance-based contract template.

Work on the template development began in December 2017 with the goal of having a consistent provincial ground EMS contract template which will ensure the performance criteria required to improve service and performance measurement is implemented. This new standardized performance-based contract template is currently being used by the SHA to update and renew its contracts with contracted ambulance providers.

Moving to recommendation no. 4, this is considered implemented. All previous region-owned and -contracted ambulance services now submit licensing documentation to the SHA's director of home care and EMS. Reporting timelines for submitting licensing documentation have been established and communicated. The last audit, April 2018, confirmed that there have been no expired licences.

Recommendation no. 5 we consider to be partially implemented. The region manually collected and reported on load and offload times over a six-month period. It was found that all response time targets had been met. The Saskatchewan Health Authority is working with the Health Quality Council to determine emergency medical service performance metrics that will be used provincially and align with the new performance-based contracts with ambulance operators. The SHA will continue to monitor response times while work is done on the new metrics. The new data collections requirements are expected to be completed for the 2019 calendar year and this recommendation is expected to be fully implemented in 2019.

Recommendation no. 6 we consider to be implemented. Ambulance staff have been informed that an incident report must be completed each time a response-time target of 30 minutes is not met. Four out of five ambulance services within the region have representatives that sit on a quality committee, the EMS quality team. Incident reports are reviewed and required actions are discussed at that forum. An incident report template has been developed and implemented. Incident reports are reviewed by the SHA's director of home care therapies and EMS. Quarterly audits indicate that incident reporting is occurring when response times do not meet targets.

And recommendation no. 7 we consider that to be partially implemented. The reporting structure of the SHA is being developed and reporting on actual results against key measures will continue once the reporting channels are established. The SHA is working with the Health Quality Council to determine emergency medical service performance metrics that will be used provincially. These metrics will help determine the performance of the EMS system. The SHA will continue to monitor response times while work is done on the new metrics. The new data collections requirements are expected to be completed for the 2019 calendar year, and this recommendation is expected to be fully implemented in 2019. That concludes my comments on the chapters and recommendations.

The Chair: — Thank you. Thanks very much for the work and the presentation. I'll open it up to committee members for questions. Ms. Mowat.

Ms. Mowat: — Thank you and thank you for the status update as well. I think I heard this correctly but can you reiterate. Has there been any regulatory or legislative changes that have come out since the auditor's report?

Mr. Wyatt: — As mentioned in my remarks, we've not made any legislative changes in relation to the operations of the EMS system. We've proceeded through a process of developing the performance-based contracts, and the changes that we are pursuing in the EMS system are being addressed both through that performance-based contracts and some of the other activity that we've discussed more specific to the Health Authority.

Ms. Mowat: — Okay, so maybe I'll ask the Provincial Auditor if she can weigh in because I remember from her report there was a section about required legislative changes and how our way of dealing with contracts is out of step with other provinces. So can you shed some light on that please?

Ms. Ferguson: — The recommendation is actually the ministry consider making changes to the Act to make sure that it's . . . What we're really getting at is to make sure that the practice that's being followed aligns with good contract management practices. So I'll have a look to see if they were able to achieve the outcome that we're seeking there, as really it's we want them to make sure that there's good contract management processes, that the Act isn't used as an impediment to get to good contract management processes, which is what we were hearing.

The Chair: — Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair, and thank you to the officials. Mr. Wyatt, could you give us some rationale as to why you decided not to open up the Act? I know you've talked about consultations with stakeholders, and I've talked to some of those same stakeholders as well, who have varying opinions on whether or not the Act should have been opened up. So I'm just wondering the ministry's rationale for not opening up the Act.

Mr. Wyatt: — Once we had concluded the consultation process we had basically a decision to make around whether we would try to achieve some of the outcomes that are addressed both, and I would say both, in the Provincial Auditor's review of the Cypress region. As well, we were also looking at the report of the advisory panel that reviewed the health system and made the recommendations related to the . . . what led to the amalgamation of, or the formation of the Saskatchewan Health Authority and the alignment of all of the previous health authorities.

And so I think we had opportunities to create some of the alignment and the establishment of a more cohesive EMS system through the formation of the Saskatchewan Health Authority. It gave us some of the tools that we need to try to bring greater consistency to the services, establish provincial-level policies across that organization.

And then with respect to the question around legislation, I think the recommendation . . . I believe it's the second recommendation that addresses the concerns around the contract management process. As we examined that specific issue, I think we concluded that you could either pursue that through legislative amendment or you could pursue that through this establishment of a consistent template contract that would then be introduced across all of the privately contracted services. And some of elements that we would be looking for in terms of performance management reporting could also be consistently introduced across the health authority-operated services. So it was, I think, looking at the ability to accomplish the outcome that we were seeking, and I would say to do so more immediately, in a more timely way, by virtue of introducing this template contract, rather than going through the legislative process, which ultimately would have led to the need for this contracted process in any event.

The final comment I'll make would be that, I mean, you know, there's always the future ability to consider a legislative change should that be necessary. Through our discussions with SEMSA, the Saskatchewan Emergency Medical Services Association, we had strong support from SEMSA in moving . . . We had strong support from the SEMSA leadership that they would be prepared to move down this track of introducing the performance-based contracts. And we felt that there was an ability to, you know, negotiate that new contract with their member operators and that we would achieve success. And if not, that ability to revisit the issue around legislation is always available should we require it.

Ms. Chartier: — Have you set for yourself . . . I know the auditor goes back and does reviews as well, but have you set for yourself then — you're establishing this contract template — when you might assess whether or not it's working? Obviously you're establishing performance measures. So you're saying there is the possibility to open up *The Ambulance Act*, but at this point . . . I guess my question is, how will you and when will you know if these are working or not?

Mr. Wyatt: — The negotiations related to the first contracts are under way, and I know that the authority has been making progress and hopes to have some of those contracts completed shortly. Just by virtue of entering into that contract, it accomplishes many of the objectives that we are seeking and that the auditor has identified. I mean, in the past some of these contracts didn't have clear renewal dates. And there were some of the contracts where the renewal date had passed and there were no changes in successive contracts, and to the extent that there were, you know, wide variation in terms of what the performance expectations were in those contracts. So as we move to a standardized contract with clear terms of renewal, with the requirement for standardized performance reporting, it introduces many of the, you know, many of the qualities of performance management that we are seeking.

And so as we are, as the Health Authority is able to negotiate those contracts, with each contract it will bring over time these operators into that new relationship with the Health Authority and create both enhanced performance management and reporting, but also some of the consistency that was clearly lacking under the previous system with the various regions and, you know, a wide range of just terms and performance expectations in those previous contracts.

Ms. Chartier: — And what is the length of the template contract?

Mr. Miller: — Good morning. My name is Corey Miller. I'm vice-president of provincial programs for the Saskatchewan Health Authority and the EMS services falls within my portfolio.

So we have been working with the Ministry of Health on these performance-based agreements. The template that we did work out in the working group that Mark spoke of, which I was also a part of and so was Mark, the template does have a five-year term. However it is in negotiation with the service provider. But the templates that we've shared with the providers are five-year agreements.

Ms. Chartier: — And the only way in which at this point in time anyway, I don't know what the template has, but the only way to . . . contract is not reviewed. It has to be terminated with cause. So what would constitute cause in terminating a contract?

Mr. Miller: — So an example of that could and would be when they're not meeting the expectations in the agreement. So the agreement, as the auditor has pointed out, has service expectations for them to have service delivery. An example would be the reporting of incidents, the reporting of their service performance measures. If they're not meeting those, then we could go down the road of not meeting the contract requirements.

[10:15]

Mr. Wyatt: — I'd also add to that, there's also a process that's identified. I mean obviously with any operator, you know, you may have a particular concern, and so the contract identifies a resolution process that is expected. And so from my recollection of the contract, if an operator does not work with the authority, the contracted partner in that contract, then that would also failure to comply, and to work with the authority around a concerned resolution process would also take the form of cause.

The Chair: — Ms. Mowat.

Ms. Chartier: — Thank you.

Ms. Mowat: — Thank you very much. Just getting into some of the meat of the contracts a little bit, do they represent a significant departure from what the existing contracts look like? I'm just thinking if there is a template that is being provided that it has to represent some type of gold standard. You say that there's an expectation that it's going to meet many of the consultation topics. So just wondering if you can provide some examples of ways that you see this template being able to fix some of these concerns.

Mr. Miller: — So the new performance-based agreements — even though we're speaking specifically about the Cypress Health Region and the audit that happened there — the recommendations that the Provincial Auditor's office has made is really relevant to the new Saskatchewan Health Authority, and us doing a better job of managing our contracts with our EMS providers. But not just the contracts, managing the reporting expectation, so that we can have better provincial metrics and monitoring of how we're meeting the needs of all people in all areas, and response times. So by having these provincial agreements, these common agreements with common metrics and common language, we're able to do a better comparison. But it's going to take us a number of years to get there.

I want to point out though that we will hold ourselves to the same standards within this performance agreement that we will hold our contracted private providers to. So as the Provincial Auditor pointed out, there were 104 operators. We were about half, and half were private. I will point out that a number of them are starting to amalgamate, meaning the same owner owned a number of services. And through the performance agreements we're working with those providers to amalgamate those into single contracts so that they themselves can have a better process and a better team to report our expectations for performance.

So these agreements allow the new Saskatchewan Health Authority a much better vehicle to hold ourselves and our operators at a higher standard. I think it's important to also point out that a number of the private providers are small, which were pointed out, small community-based organizations that are frankly looking to get out of the business. They stepped up in a different time and started operations, but they're not equipped to properly manage reporting and metrics. That's not how they were set up. So the SHA is willing and is working with a number of those to consider options where we do own and operate about half of the operations. And we will amalgamate them within our own services, and we're even looking for ways in which we can amalgamate our own agreements and our own services to be larger, more manageable.

I think it's also important to point out that the new performance agreements align well with our new organizational structure that we have put in place for the SHA, where we will have provincial oversight over contracts and provincial oversight over metrics, and it won't be left at a geographic or regional area. It will be more provincial in basis.

Ms. Mowat: — Thank you. And I'm glad you brought up the fact that these concerns are province wide as well. And that was one of my questions, is we know that there has been ongoing ambulance review, ground ambulance review processes within the province for years and years. Can you speak to what other changes are expected or, you know, if this new contract model template is sort of the big change?

Mr. Wyatt: — So I would answer the question by saying that certainly the establishment of the performance-based contracts is considered to be foundational to a lot of the work that we are doing. It's the basis on which it allows us to work more consistently across the system. And so that, you know, that is most definitely one of the top priorities.

In terms of some of the other, you know, priority areas for EMS in the province and sort of following from that consultation process and ongoing discussions that we've had with the EMS community, there are a number of other priorities that I think we are working with the SHA and I guess the SHA, in its lead-service delivery role, is following through.

Among those would be continuing to develop community paramedicine. There are a number of sites, both rural and urban right now where community paramedicine is being introduced. And that's certainly a priority to continue with the rollout of looking at how we can both take advantage of the skills, abilities, and scope of paramedics and also supporting some of our other priorities in the system related to how we support patients in the community along with other providers in primary health care teams.

There are other priorities I'd mentioned. The one priority related to response times, and certainly we do have a concern around trying to more consistently meet the response times that have been established. The issue around first-call response — the service or the car that is closest to a particular call being in a position to respond to a call — is one of the things that we, the SHA, will be trying to advance with the service operators in the province. There are some issues both related to contract, but also related to the technology that is required, to fully be able to implement that. But that's another priority moving forward.

And I would say ensuring that there are supports available to paramedics when they are involved in a traumatic situation and, you know, the concern around what's known as the second victim when you have providers, first responders who are participating in traumatic events, providing care in traumatic events, and knowing that there are mental health and trauma impacts on those providers and wanting to make sure that we can continue to provide the support that's required for our first responders. Those are among the provincial level priorities that I know that we've discussed with the Health Authority. I'll maybe just ask Corey if there's anything he would like to add to that.

Mr. Miller: — Thanks, Mark. Maybe just in addition to that, I would point out that the process for us through the performance-based agreements and the amalgamation of many of our service areas, we're able to look for more efficient ways to utilize our staff to better serve those local communities.

And I think there's an example that has happened more recently in the area of audit of Cypress, where in smaller communities where we lose access to a hard-to-recruit specialist, say like a combined lab and X-ray tech, we can use our community paramedics or our paramedics in new ways to do the phlebotomy, say, side of the testing required for that community. And we have examples of that in many communities where then the paramedics or the paramedic team are then able to do the

phlebotomy at a local site and deliver it to a neighbouring site that is able to do the testing for that local community. So we're looking for those ways to utilize staff in new ways to best serve those rural and remote communities.

Ms. Mowat: — Thank you. We'll get to Cypress specifically here, and I've got a couple of questions. On page 129 of the auditor's report it talks about the fact that Cypress has ambulance services in 12 communities, using a mix of RHA-owned ambulances and contracted ambulance service providers. Is this still the case in terms of the number of providers?

Mr. Miller: — There's been no change in that area.

Ms. Mowat: — Okay. And how many medical first responders are there in the Cypress region?

Mr. Miller: — That's a statistic that I don't have.

Ms. Mowat: — Do you know if there have been any challenges in terms of staffing or if there have been any changes there?

Mr. Miller: — There have been challenges. So we don't have the specific number of paramedics and EMS workers within the Cypress with us. I think I would point out that we have more in our EMS service than just our paramedics as well. I want to make sure that we acknowledge there are first responders. And when we do give the response time for EMS to be on scene, that is a statistic that's overlooked, that we have 1,100 volunteer first responders in our province that serve our communities every day. And they're important people to point out and acknowledge, so I would like to do that.

Certainly like all professional areas, we do have struggles from time to time with people leaving and having to be replaced, but nothing that I could specifically speak of today about the Cypress area.

The Chair: — Ms. Mowat, the Provincial Auditor has a little bit of a response as well.

Ms. Ferguson: — If you notice on page 136 of our report, at the time that we were doing the work we did note that in 2015 they had trained 158 people within the region for really the medical first responder certification. So that provides you with a little bit of insight in terms of the numbers for that particular area.

Ms. Mowat: — Thank you. We know that there are still problems with ambulance service that persist in the area. Can you speak to some of the specific challenges in Cypress and if there are particular communities that prove to be more challenging to serve?

[10:30]

Mr. Miller: — So to respond to the question, I think to just give a general answer, many of our small . . . As you pointed out, the Provincial Auditor pointed out, and some of the previous questions have pointed out, in low-volume sites with a small service area, it is often challenging — when you have a single ambulance service with a single ambulance and you have sick time or unexpected illness — to provide coverage. And we do the best we can with neighbouring providers that do provide that coverage, whether that be through unexpected illness or that that service is out on a call or a transfer to a larger site. So there is a lot of collaboration through our provincial infrastructure for that.

I think one of the other points that I spoke of earlier is finding ways to use our paramedics in a different way. And that's something that the SHA has been doing in that, if we have a vacancy in home care and we have a part-time EMS worker, is there a way in which we can have our EMS work in the community paramedicine way where, you know, it's easier for us to staff a service with full-time employees. So if we can find ways to utilize EMS workers in the community paramedicine way so that we can build up that staffing complement, that is a direction that we're moving, which will certainly help us in smaller, more remote areas like what we have in the southwest corner in Cypress.

Ms. Mowat: — Thank you. In terms of on page 141, there's a discussion about performance reporting, and there's a figure from the Alberta Health Services EMS talking about measures that they have reported on. One of them is talking about offload delays, which are a huge issue for us here as well. Has there been consideration or what consideration has been made to better public disclosure as in the case of Alberta?

Mr. Wyatt: — As mentioned previously, we are in the process of doing work, or I'll say the authority is in the process of doing work with the Health Quality Council related to identifying what the specific consistent measures would be. And so that work will obviously progress and lead to the establishment of what those consistent reporting measures will be on an ongoing basis.

In terms of the public reporting of measures, we do have a lot of, you know, a lot of different service areas across the health system. We report on certain areas, like you'll find things like surgical wait times, diagnostic wait times, reported publicly. We haven't moved to reporting all of our data in that same way, and so it's just a process of determining where the specific priorities are for public reporting of performance data.

The Chair: — Ms. Chartier.

Ms. Chartier: — Thank you. Just on that, in terms of . . . So you've got the Health Quality Council developing some new metrics for you, but you had said earlier that you were working with existing metrics. So I'm thinking, is it still the 8-59 in urban areas and 30 minutes in rural? And do we have compliance rates, not just for Cypress but beyond, like for all of SHA?

Mr. Miller: — I would say we have performance metrics on that in a broad number of our service delivery areas, but maybe not all of them. But that is something we're working on as part of the performance measures. But there were many RHAs that were previously tracking that on a monthly basis.

Mr. Wyatt: — I can add to that. Based on the existing reporting that we have had in place with the regional health authorities and now I guess with the Saskatchewan Health Authority, we do continue to receive reports around the response times. And province wide the urban response time meeting that 8 minutes and 59 seconds timeline is at 80 per cent, and the rural response time at 30 minutes is at 76 per cent. So obviously meeting those timelines in, you know, a large majority of cases, but clearly

some additional work that's required.

You'll never, you know, achieve 100 per cent with these kinds of targets because there are a limited number of cars in any service. And as soon as you have more calls or transfers that exceed the number of available cars, it does introduce challenges, whether you're in Saskatchewan or anywhere, for meeting those response times. But I think we want to continue to elevate those as best we can, and the work that we're doing through, you know, the work with the operators both public and private I think is aimed at trying to increase the existing performance.

Ms. Chartier: — Would you happen to have the Saskatoon response times in any of your binders there right now?

Mr. Wyatt: — I don't have Saskatoon-specific. I just made a point of bringing the province-wide numbers.

Ms. Chartier: — So province-wide. Would it be possible to get where you've had regions who've had those performing measures in the past? Would it be possible to get that, the most recent times maybe, for the . . . I don't know how you . . . They get reported out every month, is that correct?

Mr. Wyatt: — The data that we generate province wide is gathered through the ambulance service database. We've typically done it on a semi-annual basis there. And we can go back and find out what the most recent time that we would have for a complete reporting period for Saskatoon and respond to that in terms of, you know . . . And that would be how the ministry has identified what the response times look like. The Health Authority, with new processes and new reporting practices, may be looking at that on a more frequent basis. But in terms of sort of a broader province-wide assessment we can go back and look at whether it's by region or, in the case of Saskatoon, the Medavie service.

Ms. Chartier: — That would be very appreciated if we could have that data tabled.

The Chair: — Yes, so just a follow-up and make sure folks are clear here. There's an undertaking then to provide one of the more recent reports that's fulsome, that scans the province with whatever information you have around response times, and to table that back to this committee. Is that the undertaking?

Mr. Wyatt: — Can I just understand . . . I think the specific question was related to Saskatoon, so I just want to . . .

Ms. Chartier: — I'm happy to broaden it but I don't want to just . . . Like I don't want a province-wide number. I appreciate the 80 per cent response time provincially and the 76 per cent, like meeting those targets, but I'd like to see where we're not meeting those targets. So if that's possible that would be great.

Mr. Wyatt: — We'll make that undertaking to bring back what we have available for a breakdown of that provincial data.

The Chair: — Thanks for that undertaking. We'll make sure the Clerk's office supplies information on how to share that information back. Is it reasonable to have a report provided within a month's time? Is that reasonable?

Mr. Wyatt: — I believe it's reasonable. We can endeavour to try and meet a one-month time frame. Sure.

Ms. Chartier: — Thank you. Is there an area where concerns are being flagged? For example, in the former Saskatoon Health Region, is the SHA hearing those kinds of concerns coming out of Saskatoon in terms of response time?

Mr. Miller: — From the provider?

Ms. Chartier: — Well from provider, from users. Just in general, who is all flagging . . . Are those concerns being flagged, and from whom are you hearing that?

Mr. Miller: — Just so that people understand the linkage between response time and offload delays. There's a linkage there just because we have so many cars on the street, and it's a good indication in my job. I can just walk the back hallway of emergency, and if we have offload delays we typically are at a higher risk of having response delays. So you know, we know the days of the week and the times of the day that are higher risk just by knowing the backload delays. And as much as I want to say it's important that we share with you the Saskatoon data because, you know, certainly RUH [Royal University Hospital] is a backload delay risk to us, but it's a risk all over the province. And it's important that we find resolution to improve response times across the entire province for all people.

So you know, do we get complaints from time to time from our customers and/or from our service providers? Because everybody wants to do their best work and it's the system sometimes that causes them not to be able to because of offload delays, etc. So yes, we hear of it and we track and monitor that. And we'll provide that response back to table, back to the committee, just so that everyone is clear in understanding where our challenges are.

Ms. Chartier: — Thank you, I appreciate that, Mr. Miller. Obviously understanding that we want good service throughout Saskatchewan, but I know that the problems are quite acute in Saskatoon. In terms of working on those offload delays, what kind of work is being done to ensure that there are ambulances available at all times? Because that's not the case right now in Saskatoon. There are times of day where there is no ambulance available for people in Saskatoon.

Mr. Miller: — So just so that I . . . It's a complex issue that you're asking because it comes down to — and some of my colleagues here may be able to respond better — but the issue of offload delays is a cascade of challenges with system flow or bed flow. So when our emergencies get backed up and there are not emergency spots or beds or stretcher bays, whatever you want to call them, there aren't emergency spots for those patients to be moved from an ambulance into emergency, it's a cause and effect because there aren't enough open beds upstairs to move admitted patients out of emerg to an admitted place in the hospital. And that's where the backload . . . So it sounds like an EMS problem but it's not an EMS problem; it's a system flow, bed capacity challenge.

And there are a lot of initiatives happening right now across the province in all of our tertiary centres to improve patient flow so that we can remove the barrier of what we call BC4, or bed called

for, in emergency so that we always have beds available in our emergency department so that ambulances can offload their patients to the emergency where they've brought them for care. So it's a complex issue that starts up on the medical wards or up on our units, not only medical but on our hospital units, that turn into offload delays which turn into response-time challenges in our community.

Ms. Chartier: — For sure. And like you said, it's a complex problem that requires lots of different strategies for getting people out of hospital beds and into appropriate care in community, all those kinds of things. But I think the rubber hits the road where someone is waiting for an ambulance for, actually I spoke with someone who waited for three hours.

I'm wondering — in the short term obviously there's huge systemic stuff that has to happen and big change — but in the immediate time, are there measures being taken to try to address that offloading, recognizing that it is part of a much bigger picture? But how do you ease the pressure in making sure that people have access to first responders, paramedics, when they need them?

[10:45]

Mr. Miller: — So just to respond to your question, certainly we have ongoing communication and dialogue with all of our ambulance operators as our partners in delivery of this service. So we are aware of our providers and when they're having challenges and when we are having challenges in the system.

I think one important point that I want to make in response to your comment though, just so that people understand, when there are response delays there is a triaging and prioritization process through our 911 call centre. Just so that people understand, the most urgent people are the first to be responded on, which can lead to some of the response time delays when we are tight on cars. Just so that people understand, you know, 39 per cent of our calls are emergencies that get the first-tiered response from our EMS providers across the province.

And that's important for us to know, but certainly we know that offload delays cause, as I said, the response delay time. So you know, we have open communications with all of our operators to ensure that we are aware of the problems and challenges and we're working with them to resolve them.

Ms. Chartier: — Thank you, Mr. Miller. Just in terms of call-out language in the . . . So I appreciated your comments of a few minutes ago where you talked about part-time EMS and ways to allocate staff, and maybe there's paramedicine positions because it's much easier to fill a full-time position than a part-time position. I'm wondering, in terms of the contract template, does it include call-out language — or, pardon me, on-call language?

Mr. Miller: — To make sure I understand, you mean the performance . . .

Ms. Chartier: — So one of the challenges that I've heard from people in rural Saskatchewan who are paramedics is that when you're working on call, you get paid a minimum amount of money and sit there and can't take another job. And you may or may not get called out, and then you might get called out for 30 hours. So in this contract template, is there a way to better address those who are on call? Particularly it's an issue in rural Saskatchewan.

The Chair: — I might just . . . These are good questions. I think questions that get to, is there a better way to go about something, fit into the policy field area. The question around, is there language of such in contracts, is within the mandate, I think, of this committee. So if the question remains, you know, is there language of such in a contract, then that's within this committee. If we start looking at is there better ways or different policies to go at things, I would urge that to a policy field committee.

Ms. Chartier: — I'm asking if there's contract language.

The Chair: — Perfect.

Ms. Chartier: — On being called out.

The Chair: — Perfect.

Ms. Chartier: — Or on call. Pardon me.

Mr. Miller: — So the performance-based agreements that we have been working with our partners, through SEMSA with our partners at the ministry, the performance-based agreements have the hours of service of the service provider. But it doesn't go down into the specific levels of how we're going to call back employees. So the agreement, the performance agreements touch on the service provided by the provider, but not down to the local employee provider and how that call-back process will be made. So that's not in that agreement.

Ms. Chartier: — And so just to clarify, the contract template, or the performance-based contract template, is simply a template, and there's some . . . Is there a little bit of flexibility? Did I hear that in a comment a little bit earlier, that you've got a template from which to work but it's a negotiation with the provider so there would be some flexibility in that template?

Mr. Miller: — Right. So within the performance-based agreement there are appendixes that break down the services because each of our service providers provide different services for us depending on . . . Some of them, you know, are even in addition. So community paramedicine would be an example of that, where they're expected to provide this many ambulances on the street with this type of provider, like an advanced care paramedic and a community paramedic. So there is some flexibility in what we negotiate based on the service requirements for that area.

Ms. Chartier: — Thank you. And you had also mentioned that there are new metrics coming, that the Health Quality Council is working on those. I'm sure you did say the date, but I missed that, when those will be in place.

Mr. Miller: — I don't think we have any . . . There's work that's ongoing between our EMS leadership team. Aspects of our providers are at that table too. And we're looking and working with HQC [Health Quality Council] to provide those metrics and to work with us to build those metrics. But I don't think we have a set date for when that work will be complete at this time.

Ms. Chartier: — So with the contract template, then what kind of metrics are included in that template? Or will that contract template change when the Health Quality Council, when you've got a final set?

Mr. Miller: — No, I think that the data that's required from the service providers, that data will be used with the process being developed with the HQC. So I don't see the template changing. That's been agreed to, as Mark pointed out, with the working group. SEMSA has shared that with their legal counsel and given direction to the other service providers. So I don't see the template itself changing, but certainly if providers are willing to look at new and different metrics, as SHA we're interested in, you know, working with our providers to develop metrics that are meaningful to the front-line workers and to the patients they serve.

Ms. Chartier: — And just to clarify, two contracts have been signed with the new template thus far?

Mr. Miller: — So we have targets that . . . Our expectation of our team, so our EMS team, that's part of my portfolio. We have eight that are due to be signed before March 31st, and we still believe they're on track. We have given notification to 18 other providers, through better contract management, we've given notification that we do not plan to renew their agreements, their existing agreements in the '19-20 year. So we have a target to have eight signed before the end of March this year and 18 signed in the '19-20 year. And then as they come up with their existing agreements, we're giving them notification that we will not be renewing their previous agreement and we are moving towards the performance-based agreements.

Ms. Chartier: — Thank you very much for that. No further questions.

The Chair: — Any other questions from committee members at this time?

Mr. McMorris: — I just have two quick questions. The first one is to the auditor. And I should probably know this, but how do you choose Cypress out of the 12?

Ms. Ferguson: — So what we do from when we had an array of regional health authorities, what we were doing as an audit office was looking to make sure that our performance audit work was distributed across the province. And so from a Cypress perspective, quite frankly it was their turn from that coverage perspective. It wasn't like we selected them because we thought there was problems in that area.

Mr. McMorris: — Right, it was random. Random.

Ms. Ferguson: — I'm not going to say random. It was very thoughtful in that what we're doing is we actually track the coverage of work that we do across the province. And we took a very systematic approach to trying to make sure that we have coverage across the piece over time.

Mr. McMorris: — Okay. And one last comment and question to the ministry: congratulations on compliance with four. This is a huge file and a very tough one to bring together. Just a quick comment if you could on the benefit of a single health authority compared to the way it was when you've got 12 different health authorities managing however many contracts, compared to the way . . . You know it seems like there's a really strong grasp on quality control and compliance and all of that as we move forward because this is all relatively new, but maybe if you could just give a quick word on the benefit of a single health authority compared to, I hate to say disjointed, but perhaps a bit disjointed system that we had before?

Mr. Wyatt: — I'll provide an initial response and then ask Corey for his thoughts as well. I think, as an example, just the process of developing the model contract, the template contract, whereas in the past we would have been trying to implement that with not only the large number of contracted operators — which obviously brings, you know, a range of different perspectives from the operator side — but in the past we would've been working with the 12 regional health authorities. And believe it or not, there are times when those authorities or RHAs didn't all see eye to eye on every issue.

And so just that process of being able to work with the Health Authority, to work with Corey and a few members of his team representing the authority, as we're looking at trying to eliminate or reduce some of the variation that we see around policies, the ability to work with one entity rather than across those various RHAs, I think, has been very visible to many of us as we are working in this space. Corey, other thoughts?

Mr. Miller: — I completely agree. I think that this is a really good example with managing our EMS service. And moving down the path of the performance-based agreements, doing this with a single entity, we're talking about a bunch of relationships and trust. And if we have 12 different RHAs that have different relationships with different providers, now with a single, we have strong relationships with some that come on board early and bring along a lot of other providers who they have relationships with, and they're able to also work with a single entity much easier. Some of our providers had agreements in two and three health regions, so they were themselves arranging agreements with multiple different organizations. And this certainly allows us to look at better amalgamation, even of our own.

We operated 50-some services, and now we're able to look at, should we have one SHA owned-and-operated and not have a large number operated like one business. So you know, certainly those people who made that recommendation to our government for accepting those recommendations to go to a single health authority, certainly this is a good example. But we could have a whole day meeting talking about those benefits.

Mr. McMorris: — Thank you.

The Chair: — Thanks for the questions. To all, thanks for all the work and the responses from officials here today as well. I think there's four recommendations — 1, 3, 4, and 6 — that have been noted have been implemented. So I'd welcome a motion to concur and note compliance. Mr. Michelson.

Mr. Michelson: — Mr. Chair, I would note compliance on recommendations 1, 3, 4, and 6.

The Chair: — So that we would concur and note compliance with recommendations 1, 3, 4, and 6, moved by Mr. Michelson.

Agreed?

Some Hon. Members: — Agreed.

The Chair: — So carried. With respect to 2, 5, and 7, there's timelines that have been laid out towards implementation. Would we note . . .

[11:00]

Mr. Michelson: — Mr. Chair, I would note progress to compliance, note progress on 2, 5, and 7.

The Chair: — That we would concur and note progress with respect to 2, 5 and 7 moved by Mr. Michelson. Agreed?

Some Hon. Members: — Agreed.

The Chair: — So moved. We're going to take a five-minute health break, and then we'll move ahead with chapter 9.

[The committee recessed for a period of time.]

[11:15]

The Chair: — All right. Order, order. We're going to reconvene the Standing Committee on Public Accounts, and we'll focus our attention now on chapter 19 of the 2017 report volume 1. I'll turn it over to the auditor to address the report.

Ms. Clemett: — Immunization programs help prevent, control, or eliminate vaccine-preventable diseases. Provincial and territorial governments and local public health authorities such as Mamawetan Churchill River Regional Health Authority undertake the planning and delivery of immunization programming for residents living off-reserve. The federal government is responsible for the planning and delivery of the immunization programming for residents living on-reserve. Mamawetan delivers provincially funded immunization services to about 3,000 children under the age of 17 living off-reserve in the region. It had six public health nurse positions that deliver immunizations.

Chapter 9 of our 2017 report volume 1 on pages 115 to 132 reports the results of our audit of the processes of the former Mamawetan Churchill River Regional Health Authority used to deliver provincially funded childhood immunizations. This chapter contains five new recommendations for the committee's consideration.

We concluded for the 12-month period ended January 31, 2017 Mamawetan had, other than reflected in our five recommendations, effective processes to deliver provincially funded childhood immunizations. Given the government's announcement to consolidate the 12 regional health authorities into the Saskatchewan Health Authority in January 2017, we directed our recommendations to the provincial Health Authority.

I'm now going to focus on the five recommendations that we made.

Our first recommendation, on page 123. We recommend that the provincial Health Authority periodically formally analyze and report childhood immunization coverage rates by community. Mamawetan had set an immunization target rate of 95 per cent for infections such as pertussis and measles. Its actual coverage rates for two-year-old population was below this rate, at closer to 65 per cent in 2016. Actual coverage rates by community varied significantly from 42 per cent to 100 per cent of two-year-old children immunized.

Mamawetan did not formally analyze actual coverage rates by community, rather relied on the knowledge of its public health nurses and their use of immunization overdue lists. Public health nurses work closely with residents in their assigned communities. We found them to be knowledgeable about their communities and worked to accommodate their clients' needs, like do home visits. However we found that they weren't familiar with the actual immunization rates of their communities. Formally analyzing immunization coverage rates by community would help Mamawetan know whether it is putting the right amount of effort into the right communities. It may help decide where to adjust its immunization strategies to increase coverage.

In our second recommendation, on page 125 we recommend the provincial Health Authority properly store vaccines as required by the *Saskatchewan Immunization Manual*. During the audit we tested the storage of vaccines in three locations against expected storage procedures. We found for all three locations staff did not consistently fill out the temperature logs twice a day. For two locations, Mamawetan did not use the continuous temperature recorder, and for two locations Mamawetan did not regularly maintain the storage fridges.

Not following the recommended storage procedures could result in Mamawetan having to cancel immunization clinics due to loss of vaccines, resulting in lost opportunities to immunize. It could also increase the risk that Mamawetan is unknowingly giving recipients ineffective vaccines which would increase the recipients' susceptibility of acquiring an infection.

In our third recommendation, on page 125 we recommend that the provincial Health Authority regularly reconcile its on-hand vaccine inventory to quantities recorded in its records. Although the public health nurses physically count the vaccines in the storage fridges each month, no one compared the quantity counted to the quantity recorded in the records. Not reconciling the amount counted on hand to the amount expected increases the risk that vaccines could go missing without notice.

In our fourth recommendation, on page 126 we recommend that the provincial Health Authority document and make staff aware of emergency-event recovery plans as required by the *Saskatchewan Immunization Manual*. We found that the Mamawetan staff was not aware of the requirements for handling emergency events related to vaccines and did not have an emergency-event recovery plan as required. Not having a complete emergency-event recovery plan and staff fully aware of the plan increases the risk the vaccines are not properly protected. It also increases the risk of Mamawetan incurring monetary losses in the event of emergency through loss of vaccine inventory.

In our last recommendation, on page 125 we recommend that the provincial Health Authority periodically give its board coverage

information as it relates to provincially funded childhood immunizations. The board received limited information on how well it delivered its immunization services within Mamawetan. While the board received information about overdue clients by community with some trends identified, it did not receive analysis on these trends. In addition, the board did not receive any information on the immunization coverage rates by the region or by community or whether Mamawetan's immunization coverage rates met targets. Without adequate reporting, the board cannot determine if it is providing the right level of immunization services in the right locations.

That concludes my presentation.

The Chair: — Thank you for the presentation and the focus of the work, certainly important work. I'll flip it over to the ADM of Health, Mr. Wyatt, to respond along with officials.

Mr. Wyatt: — Thank you. With respect to the first recommendation, we consider it to be implemented. In 2017-18 an analysis of childhood immunization coverage rates by community was completed for the region and shared with the Mamawetan Churchill River board, chair, and vice-president. Beginning June 2017, monthly reporting on immunization coverage for pertussis and measles, along with the target of 90 per cent coverage, were shared with the board. In addition, a public health nurse was hired for the Sandy Bay community to provide enhanced public health programming, including childhood immunizations.

On the second recommendation, we consider it to be implemented. The Saskatchewan Health Authority has implemented improvements related to the management of vaccine inventory, such as reviewing vaccine storage requirements and policies with all staff. Routine maintenance checks on vaccine storage equipment have been completed and will continue into the future. As well, ongoing maintenance contracts for outlying community health centres have been arranged.

Moving to the third recommendation, we also consider this to be implemented. Vaccine disposal reconciliation work standards were developed, and all staff have been trained on the new standards. A vaccine disposal reconciliation is now completed monthly.

On the fourth recommendation, also considered implemented, emergency-event recovery plans specific to each community health centre have been developed with applicable training completed. The plan includes updates for all staff on vaccine storage requirements and policies, including routine maintenance checks on vaccine storage equipment.

And with the fifth recommendation, we consider this to be partially implemented. An analysis of childhood immunization coverage rates by community has been completed for the region and shared with the former Mamawetan Churchill River Regional Health Authority board, Chair, and vice-president. Beginning in June 2017, monthly reporting on coverage rate information started to be shared with the board.

The Saskatchewan Health Authority's 2018-19 accountability letter, received from the Ministry of Health, includes an operational priority to meet or exceed the provincial immunization target by 2022 and the national vaccine coverage goals by 2025, and by March 31st, 2019 achieve one valid dose of pertussis by 91 days of age, and measles, one valid dose by two years of age and two valid doses by five years of age.

Reporting to the Saskatchewan Health Authority board on these measures will be done through the performance monitoring framework and as part of quarterly status reports provided by the senior medical health officer. This recommendation is expected to be fully implemented by March 2019. Those conclude my comments.

The Chair: — Thanks for the comments and all the work on this front. I'll open it up to the committee. Ms. Mowat.

Ms. Mowat: — Thank you very much. With regards to the status update, you mentioned that your first recommendation in the actions that have been taken is that in 2017-2018 an analysis of immunization coverage rates by community was completed for the region. I'm just wondering if you can speak to what the 2017-2018 coverage rates were, and whether it was just Mamawetan or if it's available by former health region as well.

Ms. Morrissette: — Good morning. It's Billie-Jo Morrissette, assistant deputy minister with the Ministry of Health, and I do . . . So just to your question around the rates for Mamawetan, I don't have the community-specific work that was done with me, but I do have updated rates for Mamawetan that I can kind of give you. So if you look at the report on page 122, there was rates there listed for the 2016 rates. I can maybe just provide you with some updated rates.

And just before I go into the rates, just generally speaking what we have seen through some of the efforts that my colleague could probably speak to, we have seen the rates start to improve. And so I'll just maybe list them to you, if that's of interest.

So in the age group for the two-year-old population, the pertussis coverage rate at the time of the report was 66.2 per cent, and as of December '18 it is now at 84.3 per cent. For measles in the two-year-old population, the coverage rate at the time of the report was 64.1 per cent, and as of December 2018 is 86.2 per cent. For meningococcal coverage, at the time of the report was 86.7, and December 2018 was 97.5. In the seven-year-old population, at the time of the report it was 71 per cent, and in December 2018 it's sitting at 73 per cent.

For measles in the seven-year-old population, it was 89.5 and now has moved to 95.4 as of December 2018. And then the last one, meningococcal for the seven-year-old population was sitting at 93.1 and is now, as of December 2018, 96.9.

With respect to your more broad question around immunization rates more broadly in the province, we do on our website publish that data for previous regions, for each of the previous regions as well as provincial rates. And so that can be certainly either tabled with this committee, or we can at least refer you to that public document.

Ms. Mowat: — Thank you. If it's publicly available, I think that's fine with me if it's not tabled. It's certainly encouraging to hear about these improvements. What do you attribute the

improvements, to what actions would you say have led to this?

Ms. Morrissette: — If I might let Andrew speak to that, as he's a little bit more intimate with the actions of the region.

Mr. McLetchie: — So I'm Andrew McLetchie. I'm the vice-president, integrated northern health for the Saskatchewan Health Authority.

I think there's a number of things that Mamawetan did in response to this audit. One was working with the teams on the ground, making sure that we had nurses in each of the communities that could do the vaccination. Another was working with the medical health officers to ensure that they were working with our staff on the ground to look at the rates, and if a community was not up to a certain level, to kind of ensure that we have a strategy to get more resources on the ground to support that community to increase the rates.

And the other was, in a sense the MHOs [medical health officer] working with our First Nation partners. About 50 per cent of the services in public health in Mamawetan are delivered by the First Nation partners up there, and so a collaborative approach to reach those immunization rates had to be looked at.

Ms. Mowat: — Thank you. And you made some reference to appropriate nurses staffing. Has the complement of nurses grown?

Mr. McLetchie: — The complement hasn't grown, but there was a note in the report there that a nurse was put into Sandy Bay, which is one of our higher risk communities. And that definitely helped that community in terms of increasing its rates of immunization.

[11:30]

Ms. Mowat: — Thank you. There's some discussion on page 118 about how the process will be changed with the amalgamation into a single SHA assuming responsibility overall for delivering provincially funded immunizations. How has this transition impacted operations for immunization delivery in the former health region?

Ms. Morrissette: — Thanks, it's Billie-Jo again. I do want to just comment. Prior to the consolidation of the health authorities, this is an area that we had really strong oversight of. Immunizations is something that is, you know, nationally driven. We sit on a lot of national tables, a lot of expert national tables who provide advice on what kinds of things should the population be immunized for, what those rates are nationally, what we're learning from each other in terms of who's really doing well on their immunization rates. And so we had strong processes in place to kind of monitor this type of activity. And similarly we had strong processes with our health authority partners, certainly to share and disseminate that information.

You know, we share very regularly updates — I think maybe even quarterly — around immunization rates in a number of different categories. And so I think with the consolidation of the Health Authority, those processes have been maintained. It's certainly an area of oversight that the ministry still has a role in, but Andy might be able to speak a little bit about how that works in his organization from a management perspective.

Mr. McLetchie: — I think probably the changes there, as was mentioned, there's been those connections. I think it's just now we're looking at things more from a provincial level. The MHO is all part of one organization. And being able to compare, you know, the different parts of the province, where they're at, and be able to look and say what are the best practices, what can we learn more from each other, it's reduced the barriers to some of those improvement activities in terms of meeting some of these targets on immunizations.

Ms. Mowat: — Thank you. I have no further questions, Mr. Chair.

The Chair: — Any other questions from committee members on this chapter? Ms. Lambert.

Ms. Lambert: — Well this is maybe outside of this time period, but there was a challenge with whooping cough in rural Saskatchewan recently. I know that because we were welcoming a new grandbaby into our family, and I actually had to go and get an updated pertussis vaccination before that baby arrived, even though I don't know if whooping cough had moved into Saskatoon. So I just wondered if you could give a quick update on where we're at with that in the province?

Ms. Morrissette: — Thank you for that question. Yes, so whooping cough is of course one of the things that we monitor very closely. You'll recall in the auditor's report there is . . . We spoke to a 90 per cent coverage rate target that we have. Whooping cough is included in that target, and so that's certainly one of the measures that we look at often.

When that outbreak occurred we did look at some of our policies around immunization, especially for expectant mothers and for people who work with small children. And so that was really just an extra measure because our pertussis rates weren't at ideal herd immunity rates. And so we're, I think, through those measures and our continued action around some of the immunization work that we've been talking about today, you know, we're seeing some progress in those areas. And so we're pleased with that.

Ms. Lambert: — Has it moved into the main urban centres, the whooping cough?

Ms. Morrissette: — No, we do not have any of those this year.

The Chair: — Ms. Chartier.

Ms. Chartier: — So there were some cases of pertussis in Saskatoon last year?

Ms. Morrissette: — Sorry, yes. Just let me check one second and see if I have that with me. I'm not seeing it in my binder, so maybe that's something that we could endeavour to return with for you, or table with the committee.

Ms. Chartier: — Thank you.

The Chair: — Thank you for that. We'll make sure the Clerk's office connects so that you have the instructions on how to make sure that's tabled with us in a timely way. Is within a couple of

weeks all right on that piece of information? Thank you very much. And thanks for all the good work.

I believe we have four of these important recommendations that have been implemented, and the fifth one that has a timeline, very soon actually, where it'll be implemented. So I'd entertain a motion with respect to the first four recommendations. Mr. Michelson.

Mr. Michelson: — I will so move that we concur with the recommendations and note compliance.

The Chair: — With respect to recommendations 1, 2, 3, and 4. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — All right. That's carried. And with respect to recommendation no. 5, I'd welcome a motion. Ms. Lambert.

Ms. Lambert: — Note progress towards compliance.

The Chair: — That we would concur and note progress towards compliance. Thank you, Ms. Lambert. And is that agreed?

Some Hon. Members: — Agreed.

The Chair: — All right, that's carried. We'll conclude consideration of chapter 9, and we'll move along to the 2017 report volume 1, chapter 12. I'll turn it over . . . While the officials adjust their chairs, I'll turn it over to the Provincial Auditor's office to make their presentation.

Ms. Clemett: — Saskatoon Regional Health Authority provided special-care home services to about 2,200 individuals living in 30 homes located throughout the region. In 2015-16 it had contracts with 20 special-care home operators located in eight communities, for a total cost of $106.9 million. The contract with special-care homes had a combined 1,598 long-term care beds and eight respite beds. Chapter 12 of our 2017 report volume 1, on pages 161 to 180, reports the results of our audit of the effectiveness of the former Saskatoon Regional Health Authority used to oversee contracted special-care homes' compliance with the Ministry of Health's program guidelines for special-care homes.

This chapter contains six new recommendations for the committee's consideration. We concluded for the 12-month period ended December 31, 2016, Saskatoon RHA had, other than reflected in our six recommendations, effective processes to oversee contracted special-care homes' compliance with the Ministry of Health's program guidelines for special-care homes. Given the government's announcement to consolidate the 12 regional health authorities into the Saskatchewan Health Authority in January 2017, we directed our recommendations to the new provincial Health Authority.

I'll now focus on the six recommendations we made. Our first recommendation on page 167 and our second recommendation on page 168, respectively, we recommend that the provincial Health Authority work with the Ministry of Health to clarify the accountability relationship between the authority, the special-care homes, and the Ministry of Health. We also recommend the provincial Health Authority enter into contracts with special-care homes that clearly set out expected accountability relationships between the authority of the special-care homes and the Ministry of Health.

We found the accountability relationship between the ministry, Saskatoon, and each special-care home was unclear. The agreements in place between Saskatoon and each of the special-care homes did not reflect monitoring of care homes by the Ministry of Health. We found in practice, although the ministry is not party to the contracts with the care homes, it was directly involved in overseeing the care that contracted special-care homes provide; for example, it directly monitored the performance of each home as compared to the ministry's seven performance-measure targets. Where the performance of a care home was below that of any of the performance-measure targets, the ministry, not Saskatoon RHA, required care homes to submit planned actions to improve performance.

This direct involvement of the ministry with homes added complexity to the relationship. It made it confusing as to Saskatoon's monitoring role and responsibilities. In addition, the ministry's direct monitoring of homes resulted in Saskatoon performing limited analysis of performance data collected from the homes.

Unclear accountability relations can cause confusion and frustration for home operators. Home operators may take direction or provide reports to the wrong agency. In addition, it may cause the ministry or Saskatoon to duplicate monitoring efforts or, conversely, not sufficiently monitor if they think the other party's doing it.

In our third recommendation, on page 170, we recommend that the provincial Health Authority work with the Ministry of Health to confirm performance measures that it requires contracted special-care homes to report on to help them assess each of the home's compliance with the Ministry of Health's program guidelines for special-care homes and improve the quality of resident care.

Management of special-care homes did not understand how Saskatoon or the management or the ministry used certain performance information about the residents and operations of the homes that they were required by contract to track and report. They reported the specified information to the ministry and to Saskatoon. They referred to this information as measures. Homes found some of these measures contradictory; for example, they felt reducing the use of physical restraints may result in increased resident falls.

Our review of the measures found that many of the measures do not provide insight into the quality of care practices each special-care home used, like feeding methods, mobility and safety, hygiene practices, or medication reviews. Saskatoon was unable to explain the linkage between the measures and quality of care. In addition it was unable to explain how it used this information to monitor the performance of homes and their compliance with the guidelines. Having measures that clearly link to key aspects of quality of care would help homes better understand the quality of care expected of them. In addition it would assist Saskatoon and the ministry to determine whether homes meet the quality of care the guidelines expect.

In our fourth recommendation, on page 171, we recommend that the provincial Health Authority clearly defines service expectations related to quality of care and include targets for related key performance measures and all key reporting requirements in its contracts with special-care homes.

Our review of the contracts with special-care homes found, in general, contracts included most but not all general expectations. They did not include clear service expectations, performance targets, or reporting requirements. Not including clear, defined service expectations in a contract makes it difficult for homes to know what level of care they should provide to residents. It makes it difficult for Saskatoon to measure the performance of the home and to hold them to account.

In our next recommendation, on page 176, we recommend the provincial Health Authority periodically inspect special-care homes to assess if they comply with the key areas of the Ministry of Health's program guidelines for special-care homes. We found that Saskatoon was not doing enough to confirm the accuracy of information used to monitor special-care homes' compliance with the ministry guidelines.

Both Saskatoon and the ministry primarily use data that special-care homes self-reported on the ministry's seven performance measures. Through its annual check, Saskatoon was aware there was about one-third of this information that the care homes self-reported each quarter was not accurate. A June 2016 ministry survey of the homes on their compliance with the guidelines reported the homes were complying with 92 per cent of the key guidelines. However neither the ministry or Saskatoon checked the accuracy of this information.

In addition, the results of our visits to four homes suggested inaccuracies in the information reported. We found various instances of non-compliance. Self-reported information is not always accurate. Without directly assessing whether homes comply with the guidelines, Saskatoon does not know whether the residents at the contracted special-care homes are receiving the level of care it expects or the homes are meeting the ministry's guidelines.

In our last recommendation, on page 177, we recommend the provincial Health Authority take prompt action when it finds non-compliance with key measures that assess the special-care homes' compliance with the Ministry of Health's program guidelines for special-care homes.

Despite the use of a collaborative and co-operative approach to address identified areas of concern, our analysis found each contracted home did not meet at least one of the ministry's seven performance targets, some for extended periods of time. For example, 14 special-care homes did not meet the ministry target in 2014 and '16 for residents whose bladder worsened.

Not addressing underlying reasons promptly can result in residents receiving poor quality of care for a long period. Poor quality of care may negatively impact the quality of lives of the residents in these special-care homes. That concludes my presentation.

[11:45]

The Chair: — Thank you for the presentation, and again the very important focus of your work. I'll turn it over to the ministry officials to respond, then open it up for questions.

Mr. Wyatt: — Thank you. With respect to the first recommendation we consider that implemented. Representatives from the Saskatchewan Health Authority and Ministry of Health work together to clarify accountabilities. The clarified accountability relationship, roles, and responsibilities will help guide the approach to new contracts with affiliate special-care homes.

On recommendation no. 2, we consider that partially implemented. A working group whose membership includes Ministry of Health, Saskatchewan Health Authority, and affiliate representation has been established to oversee language in a new affiliate agreement or contract that clearly outlines the accountability relationship. The recommendation is expected to be fully implemented by June 30th of 2019.

On the third recommendation, we consider that to be partially implemented. Work on a new affiliate principles and services agreement provides an opportunity for clarity on performance measurement. A review of the program guidelines for special-care homes is also under way, to ensure the guidelines are clear, ensure a high quality of care, and meet the needs of residents, families, and the continuing care sector. This work will inform the identification of clear reporting requirements that align with performance measurements and accountability. The recommendation is expected to be fully implemented by June 30th, 2019.

On the fourth recommendation, we consider this to be not implemented. Determination and finalization of key performance measures and targets that define service expectations related to quality of care will be articulated in the new principles and services agreement schedules, and the recommendation is expected to be fully implemented by June 30th, 2019.

On recommendation no. 5, we consider that to be partially implemented. Annual site visits are performed by the Saskatchewan Health Authority's executive leadership and senior leaders to hear from residents and staff of special-care homes about what is going well and opportunities for improvement. In addition, resident and family surveys of all long-term care homes provide an opportunity to hear directly from individuals and their families. The SHA and ministry will continue to work together to ensure a clear process exists to measure compliance with key areas of the program guidelines for special-care homes. The recommendation is expected to be fully implemented by June 30th, 2019.

And on recommendation no. 6, we report that is not implemented. The Saskatchewan Health Authority will draft a proposed framework for non-compliance with key measures agreed upon in the principle and services agreement or contract. The recommendation is expected to be fully implemented by June 30th of 2019. Thank you.

The Chair: — Committee members that would have questions. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair, and thank you to the

officials here again today. And it sounds like these recommendations are very close to all being implemented so that's always good news. Just starting with the first recommendation with respect to the accountability document, can you tell us a little bit about what that document looks like, what is in it?

Mr. Wyatt: — The overarching accountability document is one that was developed between the ministry and the Saskatchewan Health Authority. It identifies high level, I'll say high-level assignment of roles, responsibilities between the two organizations. There were many areas where those roles and responsibilities are shared and so it's certainly not a document that assigns exclusive responsibility in the various areas. And that document is one that we use as a general guideline for the relationships. Obviously when it comes to specific issues and processes we use that, as I said, as the guideline, and then working from that look at each situation based on where the appropriate balance is between ministry and SHA involvement.

Ms. Chartier: — Thank you. And with respect to recommendation no. 2, earlier we were just talking around EMS and a contract template. So will this be in fact the document that's . . . The principles and services agreements, will that be basically a template for a contract with special-care homes?

Ms. Garratt: — I'm Sharon Garratt, and I'm vice-president, integrated urban health and chief nursing officer with the Health Authority. So I've been the executive sponsor of the working group that's working on the principles and services agreement.

So the recommendations are very interrelated and they're helping us, actually. I would say they've been very helpful in guiding us through that process. So we're working together with the affiliates, with the committee that's co-chaired with affiliate representation and SHA to look at a template contract and ensure that all of the components are there. There's legislated components that have to be in the contract, that are dictated through legislation, so there's certain pieces that are there and we know what they need to be. It isn't as simple as a template contract because it speaks to the relationship that we have with the affiliates and what that relationship means.

And so there's a lot of work to do in terms of what supports does the SHA provide to the affiliates, what are the service expectations, the funding agreements, and other things. So there's a lot of work tied up in the working group, but we're doing it together with the affiliates and representation from the SHA.

Ms. Chartier: — So will the principles and services agreement just be a part of each contract then?

Ms. Garratt: — No, the principles and services agreement is the contract with the special-care home.

Ms. Chartier: — Okay, so just a clarification then. So there are things that will exist in every contract, but like the EMS contracts there will be some flexibility, depending upon their relationship with the affiliate.

Ms. Garratt: — Different affiliates will provide different services. When you think about long-term care, some could be regular long-term care beds. Some may provide a dementia unit. Some may provide respite services or day support. So there'll be flexibility in the services that are provided, and the interactions.

Ms. Chartier: — And this will be, is expected to be done by or implemented by the end of June 2019. So how many . . . Just noticing on page 171, so I just want to . . . Bear with me here. In terms of the numbers of those who have signed contracts, there was an issue around length of time and passing. So I'm just curious. Where are we at with respect to the 20 homes in Saskatoon and how this new principles and services agreement will roll out in terms of their existing contracts?

Ms. Garratt: — So I think how I would answer that is that the current situation is similar to when the auditor was there, so the contracts are rolling over or continuing with the care homes. The opportunity that we've had with becoming an SHA is that we're looking at it from a provincial perspective and looking at the consistency across the province because one of the considerable concerns of the homes was the variation in how they were treated by previous regional health authorities.

So there's a lot of hard work to get agreement on what the consistent approach is. And from here with our contract management and others and similar to Mr. Miller's responses on the EMS contracts, we'll be able in the future, from the basis of this template, be able to have a timely response and work in a more timely way with the affiliates. But there's upfront work before we can get to there in the current relationship.

Ms. Chartier: — Is there a base funding formula for . . . Obviously principles and services agreement is the contract. Is there a base funding formula for all the special-care homes?

Ms. Garratt: — There has not been to date, which is one of the affiliate and the health care organizations that provide service, one of their concerns. So one of the schedules in the principles and services agreement speaks to services and funding and some of the work we're doing is conversations about what that looks like consistently across the province.

Ms. Chartier: — So the goal is to move to a consistent funding formula depending on if you're providing a dementia unit or if you're . . .

Ms. Garratt: — Our goal is consistency and transparency and then a plan for how we get there, because we're not going to get there overnight with everyone.

Ms. Chartier: — Thank you for that. In terms of the third recommendation on care homes reporting . . . Just in your status update you talked about how this work will pave the way for identification of clear reporting requirements that align with performance measures and accountability. Can you tell us a little bit about how that work will pave the way to identify clear reporting?

Ms. Garratt: — So I think it comes back to what's the role of the ministry and what's the role of the SHA, which is some of the work we've done. So it's really clear that the ministry has responsibility and accountability for the special-care home guidelines, to set that policy. And similar to the ambulance services, the SHA has owned and operated long-term care

facilities and has contracted services. The same requirements apply to all and that framework is overall.

What's been clear in how we work through this is the SHA is accountable to the ministry regarding the special-care home guidelines. And as we work with our contracted agencies, they are accountable to us in terms of the reporting structure. So I think the work on the special-care home guidelines is led by ministry. The work of how that integrates into a contracted relationship is between the SHA and the affiliated agency. So I think that helps some of the clarity in terms of what we saw in the auditor . . .

Ms. Chartier: — And with respect to the program guidelines, so they're relatively new, like the last five or six years. Was it 2011 or '12?

Ms. Garratt: — The special-care home guidelines are from 2013.

Ms. Chartier: — 2013. Okay. I know it wasn't in the too-distant past. So they're currently being reviewed right now? I know one of the things that the Ombudsman had flagged here, if memory serves me correctly, a way to operationalize these . . . The guidelines, the program guidelines are great and sort of aspirational but how, as a special-care home, do you put those guidelines into practice?

So I'm wondering how that work has happened. And it all ties in with the review of the program guidelines. So I'm just wondering how, to date, have you managed to operationalize those guidelines. And obviously you're in the process of reviewing too.

Ms. Kratzig: — Hi. I'm Kimberly Kratzig, an assistant deputy minister with the Ministry of Health. I think we've had discussions in the past. As you mentioned, the Ombudsman's report was sort of one of the big signals to us that there was work to be done around how do you measure and operationalize the special-care home guidelines.

So a lot of work was done over the past several years with the former regional health authorities, and working with some of the affiliates as well, in terms of putting in place consistent implementation of those guidelines, clarifying the guidelines that were difficult to measure. And that's sort of some of the ongoing work around the review that was talked about: how can we ensure that those guidelines maintain a high quality of care, people know what they need to deliver on, and that they can be easily measured? So that's the work that's under way.

[12:00]

I think the Provincial Auditor's report talks about some of the audit tools that are in place. That's been one of the main ways we have been measuring. We have used the quality indicators to provide a link back to some of the guidelines as well. And I just wanted to talk a bit about those quality indicators. There are seven quality indicators that have been talked about in the auditor's report and previously, and they still are, I think, being reported to the ministry. And again, as we transition into the Saskatchewan Health Authority, I think we need to look at how best and to whom those are reported to.

Those quality indicators are not defined in the special-care home guidelines. They are, I would say, nationally accepted outcome measures that are reported by most provinces, collected by CIHI, the Canadian Institute of Health Information. So they're a slightly different kettle of fish, as you might say. I think overall though they are also a key piece of information that tells us how our homes are operating. And I don't envision a scenario where we're not collecting that information as well, even though it's not within the special-care home guidelines.

Ms. Chartier: — And so you see new measures being added. And I noticed, and the auditor points this out, that some special-care homes have pointed out that some measures seem contradictory, like using restraints versus falls. So how do you reconcile that?

Ms. Kratzig: — I wouldn't say that I would expect new measures to be added. I would just say that right now Saskatchewan collects information on seven quality indicators, and I would envision that continuing. Across the country it's accepted that this is one of the ways to measure how your long-term care system is functioning. And it's not about individual resident care but overall how are our homes functioning.

I think that in terms of the commentary about, I think it was restraints and antipsychotic drug usage and whether they are sort of in alignment or misalignment, I think they tell two different stories. I think that measuring restraints again tells us something that's happening in long-term care, and we have targets around what is an acceptable restraint usage and what is the national average, provincial average. And I think we've discussed that before and we have that information again with us today, if you're interested.

I think that antipsychotic use for people who don't need it might be measuring something else and may or may not have . . . any of those might have an impact on falls or not. But again I think you have to look at them overall. They're not necessarily one linked to the other linked to the other, but overall they provide you with a fairly wholesome, I guess, sense of what's happening within that long-term care home.

Ms. Chartier: — So what kind of story do you think then? Like, looking at figure 4, the number of Saskatoon-contracted special-care homes meeting and not meeting ministry's seven performance targets for July to September 2016, there were a number that weren't meeting their targets. So what story do you think that that tells?

Ms. Kratzig: — I think that with all of the quality indicators — whether it be in the Saskatoon affiliate homes or across the province in SHA homes or other affiliates — I think we set stretch targets to continue to drive improvement. And so in areas where those goals aren't being met, we have in the past asked for individual homes to provide, we call them corrective action plans so that we can look at what's happening within the home and try to continue to drive change.

So I think we look at the long-term trends and how the provincial average is. And then within the former regional health authorities and now the Saskatchewan Health Authority, if there are some ongoing issues they would continue to work with that home as

they would with their own homes as well.

Ms. Chartier: — With respect to those, to figure 4 and figure 5 then, would it be possible to have the most recent information tabled with the committee?

Ms. Kratzig: — I don't think we have the home information with us today, but we could certainly get that and table it with the committee. Definitely.

Ms. Chartier: — That would be great. The most updated for . . .

The Chair: — Just for consistency, the Clerk will engage with instructions within a couple of weeks. Is that reasonable, two weeks to have that information supplied back?

Ms. Kratzig: — Yes, absolutely.

The Chair: — Thank you.

Ms. Chartier: — I'm asking for the Saskatoon information, but do you have . . . It's collected provincially for all homes?

Ms. Kratzig: — It's actually on a website. So on the CIHI website they have all of the quality indicators for, I believe now it's probably all of the homes or the bulk of the homes in Saskatchewan. And it's actually an interactive website where you can do comparisons of homes in Saskatchewan against other provinces, etc. So again this has become very much the trend in quality reporting within long-term care.

Ms. Chartier: — And when would be the last sample of reporting? Is it quarterly that it reports out?

Ms. Kratzig: — On CIHI it might be annual. I think the ministry would have more recent though in terms of quarterly reporting that we could also table with the committee.

Ms. Chartier: — I think that that's what I would prefer, please. You had mentioned a little bit about if folks aren't meeting these measures then you'd work with them. One of the recommendations, no. 6, deals with non-compliance, and I know you've said that it'll be implemented by June 2019. But at this point in time what happens when a special-care home isn't in compliance with these measures, not just over a short period of time but seen to over a long period of time?

Ms. Garratt: — I think what we've talked about is these are quality measures. So when we look at quality work, we look at quality improvement. So when a home, when we see that the metrics are not being met, we have some support staff within the Health Authority, quality improvement staff and others, that will help the homes dig into what's the root cause of the problem and what are some things they can try to make a difference in terms of a change, you know.

So it's that definite, that work of understanding why the metric is showing where it's at. What are the reasons for that, and what can the home try to make an impact on that metric? And then that's reporting back in the quality measures. So those corrective action plans are an ongoing work but they're not just . . . They're the home's, each individual home's responsibility, but we provide support to help them work through the process.

Ms. Chartier: — And how often, if there's a corrective action that's required, the minister responsible for the special-care home guidelines, how often does the ministry follow up?

Ms. Garratt: — So I think we've been clear in the relationships that the relationship with the homes is the SHA responsibility. So that's some of the clarity we're trying to achieve here in terms of the going forward. So the SHA is working with the care homes, and if we aren't now, we will be as we move forward, working with them on the corrective action plan.

Ms. Chartier: — Thank you for that. Recommendation no. 5 talks about periodically inspecting. And I know the auditor pointed out that sometimes self-reporting isn't quite . . . For example, the ministry surveyed homes on compliance. And homes said they were compliant 92 per cent of the time, and then neither the ministry nor the SHA or the region checked, Saskatoon didn't check for accuracy.

And I know one of the things that I have heard in the past is that as the Health critic, or the former Health critic, that with the CEO tours — that's a hard thing to say all at once — one of the concerns that both residents and employees have shared with me is that they feel like it's the affiliate's best foot that gets put forward on that occasion. It's like, you know, someone's coming over so you clean your house. We all do that. So I know that there's been concern that what we see on the surface isn't necessarily what is happening.

So we've got the CEO tours, and I know with that recommendation as well that the working group is doing some work on the transparent process. What do you think that that's going to look like?

Ms. Kratzig: — I'll let Sharon respond to what the process might look like going forward because I think that heavy lifting's happening now. But I also want to flag that we also do have the resident and family surveys as well, which are another very key piece of information that tell us a lot about how families and residents are perceiving their care and their entire experience. This is their home and we're really interested in understanding how they perceive all elements — care, environment, etc.

Ms. Chartier: — I did have a question about that too. The family and resident surveys, how often do those happen?

Ms. Kratzig: — The first one was done in '15-16. And at that point we committed that we would be doing them — pardon me, in '16-17 — and going forward they will be done biannually. And we are currently . . . By the end of March we'll have completed the '18-19 survey, so we'll actually have some comparable data. You might recall we released the first report in '17-18. So we're looking forward to those results, by mid-year probably.

Ms. Chartier: — Okay. Because I'd asked in written questions about that in the fall. But the challenge with the family and residents survey too, it's a . . . And I was invited as a guest to a family and resident meeting. And I mean, people say nice things about the people who work in their building, and people love their staff for sure, but I know I was also at a meeting where they passed a motion to ask for more staff because that was this resident and family council's request. In looking at the document that was compiled by the ministry, it didn't exactly reflect what

residents were saying at that particular meeting. So I think it's a really important piece.

But I'm wondering. So we've got what used to be called the CEO tours and resident and family surveys, but back to that point about all people always put their best foot forward when we know we're being inspected, are there going to be any other ways to monitor what is happening in special-care homes?

Ms. Garratt: — Yes. What I would say at this point is that's a work in progress because as we're working through the recommendations in the principles and services agreement, we will get to what is the governance and how we monitor the quality. I don't have the answer to that yet because we're going to build that answer with the affiliates. So I just don't have that answer for you today.

I think it is important that there's CEO tours. There's the quality indicators. There's the survey. There's also Accreditation Canada. So the long-term care, all of our affiliates and others participate in accreditation, and each one of those things gives us another piece of information about how things are going and what the situation is. Because you're right: there's good things about some of the information that we get and there's drawbacks. So we're trying to look at a range of ways of getting the appropriate information.

Ms. Chartier: — Thank you. This all sort of blends together, but when can we expect the next public reporting of the CEO tours?

Ms. Kratzig: — That information, I believe, was posted about two weeks ago. So that information is now public.

Ms. Chartier: — And that's for the 2018 . . .

Ms. Kratzig: — 2018 calendar year.

Ms. Chartier: — Calendar year. Okay. And then you said, by the end of March we should have the collated results of the family and resident surveys?

Ms. Kratzig: — Close. We have a deadline that all homes will have completed the surveys by the end of March. And then we will, as we have in the past, provide that in a collated way publicly.

Ms. Chartier: — And when do you think that would be made public?

Ms. Kratzig: — Mid-year. A couple of months probably to do the analysis and bring it together. I don't have the status on what we have so far. If we're getting it sort of batched or brought in one at a time, I'm just not sure.

Ms. Chartier: — Okay. Well thank you. I think that those are all my questions for today. Thank you so much.

The Chair: — No more, Ms. Chartier?

Ms. Chartier: — Well probably, but they're probably not in order in this committee.

The Chair: — Any other committee members have any other questions? I do want to clarify one point. I believe in the presentation, the recommendation no. 4, ADM Wyatt stated that it wasn't implemented. I know that there's some actions that have been laid out and a timeline there. On the assessment we received here, the template states that there's some . . . that it's partially implemented. Certainly I appreciate the actions that are committed to and the timeline that's there. I just want to get clarity from your perspective whether or not there's progress.

Mr. Wyatt: — Thank you for the opportunity to clarify that. Just the materials, we had that presented in two different ways and the appropriate presentation of that should be partially implemented. I believe there were two different recommendations where I said not implemented and would like to, I guess, make the change to reflect those as partially implemented.

[12:15]

The Chair: — Thank you very much for that information, that clarification. Thanks for all the work by all the officials and all partners on this front as well, very important work. With respect to recommendation 1, I think that one's been implemented. I'd entertain a motion to that effect — Ms. Lambert — that we concur and note compliance with recommendation no. 1. Agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. Progress for recommendations 2, 3, 4, and 5. I'd entertain a motion — Mr. McMorris — that we concur and note progress for recommendations 2, 3, 4, and 5. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — So moved. And with respect to recommendation no. 6, I'd entertain a motion, maybe simply that we concur with the recommendation.

Mr. Michelson: — Mr. Chair, I'll move that we concur with the recommendation.

The Chair: — Moved by Mr. Michelson. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay, and so moved. At this point we'll conclude consideration of chapter no. 12. We'll recess till 1 o'clock and reconvene at that point with our focus set on chapter 32 and 40 together from the 2016 and the 2018 reports.

[The committee recessed from 12:17 until 13:02.]

The Chair: — We'll reconvene the Standing Committee on Public Accounts this afternoon, and we'll focus our attention on chapters from the 2016 report, report volume 1, chapter 32. And at the same time we'll consider from the 2018 report, volume 2, chapter 40. At this time I'll turn it over to the Provincial Auditor's office.

Ms. Clemett: — These chapters report the results of our first and second follow-up of the status of the implementation of recommendations we originally made in our 2013 audit, related

to the effectiveness of Saskatoon Regional Health Authority's processes to triage patients in the three city of Saskatoon hospital emergency departments.

Chapter 32 of our 2016 report volume 1, on pages 293 to 298, reports our first follow-up, up to March 2016; and chapter 40 of our 2018 report volume 2 reports our second follow-up, up to August 2018.

By August 2018 Saskatoon had implemented four of the eight recommendations. By March 2016 Saskatoon gave emergency department staff real-time access to bed availability information and started measuring the total wait time from when a patient arrives in an emergency department.

By August 2018 the authority assessed its triage process monthly to confirm it was appropriately prioritizing patients. It improved its signage in Saskatoon emergency departments to enable patients to more easily find assessment areas.

In 2016 we also determined one recommendation was no longer relevant as Saskatoon changed a previous goal.

As of August 2018 Saskatoon still needed to: develop alternative care models to provide specialist physician care for less-urgent patients outside of emergency departments — specialists' use of emergency rooms can cause significant bottlenecks with emergency departments; document triage captains' reassessment of medical conditions of patients in emergency wait rooms — not doing so increases the risks of not identifying deterioration in a patient's condition in a timely matter; put processes in place to ensure emergency department patients see physicians within established time goals.

We found, on average, patients categorized as urgent waited more than two times longer than the CTAS [Canadian triage and acuity scale] goal of 20 minutes to see a physician in both 2017-18 and '16-17. Seeing a physician in a timely manner reduces the risk that a patient is not properly cared for. That concludes my presentation.

The Chair: — Thank you. Thank you for the presentation. I'll note to folks as well that might be tuning in that these recommendations have been considered by this table before and discussed and reported on. Thanks to officials for providing the status of where implementation is. I'll flip it to the assistant deputy minister and officials to respond briefly and then open it up for questions.

Mr. Wyatt: — Thank you. As noted, the first recommendation is considered no longer relevant, so we'll move on from there. The second recommendation is considered partially implemented. Neurology and orthopedics are the two highest users of the emergency department for consultant care traffic. Consultant care for neurology less-important or non-urgent patients outside of the emergency department is fully implemented through redirecting care to outpatient or ambulatory departments. Consultant care for orthopedic less-urgent and non-urgent care is partially implemented as standard work is being completed and submitted to orthopedics, and the Saskatchewan Health Authority is now working towards improving compliance with the orthopedic team.

In December 2018 the Saskatchewan Health Authority hired a new position in Saskatoon: the director of ambulatory care services. One of the accountabilities for this role will be in assisting with work to redirect non-urgent consult visits from the emergency room to a more appropriate area for care. The long-term plan is for this to be sustained which will help to reduce volumes in the emergency departments. The recommendation is expected to be fully implemented by December 31st, 2019.

Moving to recommendation no. 3, it's noted that this has been implemented as with recommendation no. 4. Recommendation no. 5, the triage captain, is partially implemented. The triage captain role has been developed and utilized at both the Royal University and St. Paul's hospitals. Functions of this role include meeting and initiating communication with patients as soon as they arrive in emergency departments, providing an initial assessment and reassessing patients if delays occur.

The Saskatchewan Health Authority is currently working with triage captains to identify a solution to efficiently document the reassessment of patients' conditions when they are not seen within the specified goal times. The SHA is also working with eHealth to improve the documentation process for the reassessment of patients in electronic health records, and this recommendation is expected to be fully implemented by March 31st of 2019.

Recommendation 6 is considered implemented. And moving on to recommendation 7, reducing emergency department wait, and this is partially implemented. Reducing emergency department wait times has been one of the health system's highest priorities. Wait times to see a physician in emergency are a function of many different factors. These include the efficiency of the emergency department itself but also importantly the patient flow through the hospital, the availability of care options in the community, and the prevention of, I'll say unnecessary emergency visits.

Physician initial assessment times are meeting targets for most emergent care required in CTAS 1 and 2 patients; however physician initial assessment targets for non-emergent care and the CTAS 3, 4, and 5 patients have not been achieved. As a result an additional four-hour physician coverage has been added in June 2018 which provides two physicians in the Royal University Hospital emergency department 24-7. The Saskatoon City Hospital has an additional four hours of physician coverage based on patient volumes as of December 2017. Fluency Direct, a dictation system, has improved physician performance by allowing physicians to dictate the clinical encounter instead of typing it, and as a result it frees up time for direct patient care.

Individual physician performance is being monitored with coaching from the department head, and significant investments are being made in the community to support our connected care strategy, with the goal of reducing pressure on our hospitals. Market Mall Community Health Centre opened last year and we are also planning other enhancements in primary care in west Saskatoon communities. Investments in mental health, the police action crisis teams, and community paramedicine are other examples of community-based investments aimed at making a shift from hospitals to community. And with respect to recommendation no. 8, that has been implemented.

The Chair: — Thanks for the report, but thanks for all the work that's been undertaken. I'll open it up for questions. Ms. Mowat.

Ms. Mowat: — Thank you. I only have a couple of questions on chapter 32, and then I'll focus my questions more in chapter 40. In terms of the recommendation that's deemed no longer relevant because of the change in goals or moving away from the goals, it talks about reducing the wait time, the target being to reduce waits by 60 per cent from the March 2015 levels. Can you confirm that that is now a 35 per cent target, that that number has changed? And also what were the March 2015 levels exactly? It's not indicated on page 294. The baseline . . .

Mr. Wyatt: — Sure. So the provincial target was changed from a 60 per cent to a 35 per cent target to reduce emergency department wait times. We've typically assessed that against four different measures of ED [emergency department] performance, and again measures of ED performance but highly influenced by other factors outside of the ED itself. Those would be physician initial assessment, average length of stay for admitted patients, average length of stay for non-admitted patients, and the time waiting for an in-patient bed. In terms of the 2015-specific measures, I would have to do a little bit of digging to find what the actual measured times were.

Ms. Mowat: — Okay. Is that something that could be provided to us, though?

Mr. Wyatt: — Yes, it could be.

Ms. Mowat: — Okay. What are the most current, up-to-date waits for each category, then?

Mr. Wyatt: — Are you . . . Is it related to Saskatoon?

Ms. Mowat: — Yes, we can do Saskatoon and then the whole province.

Mr. Wyatt: — So for Saskatoon, the time from the . . . so the physician initial assessment, which is measured from the time of registration or triage to the physician assessment . . . And this is at the 90th percentile. It's just important to note that we're not talking about the average or the mean but at the high end in terms of those waits. For Saskatoon our time is 169 minutes.

The emergency department length of stay for non-admitted patients, Saskatoon is 8.7 hours. Emergency department length of stay for . . . Sorry, we've also broken it down by CTAS [Canadian triage and acuity scale] by the urgency for the patient. The number I just gave you was for CTAS 1, 2, and 3, and that was 8.7 hours for Saskatoon. And CTAS 4 and 5 is 6.3 hours. The emergency department length of stay for admitted patients in 2018-19 is 40.7 hours. And the time waiting for an in-patient bed — again all at the 90th percentile — Saskatoon in '18-19 were showing as 32.7 hours.

Ms. Mowat: — So have those . . . Oh sorry, go ahead.

Mr. Wyatt: — And I'm just looking . . . So the data that I've given you, I have a note on this that shows that it is up-to-date as of February 6th. And so this is not for the complete fiscal year but year-to-date as of early February.

Ms. Mowat: — Thank you. And so have we realized any reduction in waits in any of those measures in Saskatoon?

Mr. Wyatt: — For the most part, I think we're showing either similar or higher wait times. When you do year-to-year comparisons you will find — so for the physician initial assessment, for example — there is improvement over the last couple of years. If you look at the PIA [physician initial assessment] in 2016-17, it was at 197 minutes and it's come down over the last couple of years to 176 and then to 169.

[13:15]

So we have seen some recent improvement there on the CTAS 1's, 2's, and 3's. It's basically consistent over the last couple of years. Same with the CTAS 4's and 5's, basically comparable. There's been a bit of an increase in the admitted patient length of stay as well as the time waiting for an in-patient bed.

Ms. Mowat: — So what would you think accounts for the inability to see a reduction in waits then?

Mr. Wyatt: — That's a really challenging question that I think our health system and many others are contending with. And I would say, you know, there are a number of factors that contribute to the problem that we do have with wait times in our emergency departments. We are seeing, you know, certainly over the last decade we've had very large growth in the population in Saskatoon and the catchment area that's relying on the Saskatoon emergency departments. So you can look at population factors. You can also look at the acuity of the patients who are coming in. So there are certainly external population- and demographic-based considerations, and then beyond that, you're looking at a lot of issues related that take you outside of the emergency department.

I think, you know, our main strategy is around trying to create community-based, home- and community-based capacity outside of the hospital that will both relieve some of the . . . Well I would say, provide a more appropriate location for patients to receive care for non-urgent medical issues. And also by creating that capacity in the community to be able to reduce the length of stay in in-patient beds which will then allow for better flow, as we were discussing earlier, out of the emergency department and also free up the physicians to begin seeing more patients more rapidly rather than caring for a lot of those patients who are awaiting that admission. And so, you know, there's a lot of the broader issue relates to achieving more highly effective patient flow through the facility and into the community.

Ms. Garratt: — I could add to that.

Mr. Wyatt: — Sure.

Ms. Garratt: — I just might add to that. It's been a focus since we started the SHA in terms of the challenges that we have at Saskatoon. So we've done a lot of work to dig down into the root cause. We worked with the Health Quality Council on some modelling to help us understand if we did certain things, what were the things that would have the biggest impact on the emergency department in freeing up the space. And it was to move the patients waiting for an in-patient bed through the system, that had the biggest impact on freeing up the emergency

department to function as an emergency department. Adding staff didn't help. Actually removing the non-urgent didn't help because they don't have a place to be seen because of the people sitting in there waiting for a bed. So the modelling showed us the biggest impact is on the alternative level of care.

So we have processes in place now with specific targets and a number of projects that we're looking at. How are we impacting on that group? How are we pulling people back home into the community and providing care? How are we keeping people in the community so that they're not deteriorating to the point where they need to present to hospital? And why do we think that might have an effect? It's because we've seen an impact from those kinds of solutions in Regina.

So that's some of our learning, is from the work that was done in Regina where we've seen some impact through those processes. So there's a lot of work under way right now that's very much focused on fixing the root cause of the challenge that we have.

Ms. Chartier: — I think I've got two questions. I want to get back to the root cause piece here but, Mr. Wyatt, you gave us the doctor initial assessment for 2016-17, '17-18, and '18-19. Would you mind giving us the measures, the numbers for the other three measures: the admitted patient length of stay, the non-admitted length of stay, and the time waiting for the in-patient bed? Those three measures for the last three years, where we are in . . .

Mr. Wyatt: — For the last three years?

Ms. Chartier: — You gave those to us for the doc initial assessments, so I'm wondering if you could do that for the other three.

Mr. Wyatt: — Sure. So for the others?

Ms. Chartier: — Yes.

Mr. Wyatt: — So for emergency department length of stay, non-admitted CTAS 1, 2, and 3 for the last three years: 2016-17 was 8.8 hours; 2017-18 was 8.8 hours; 2018-19 was 8.7 hours. For the non-admitted CTAS 4's and 5's: '16-17 was 6.6 hours; '17-18 is 6.3 hours; '18-19 is 6.3 hours.

Moving to emergency length of stay for admitted patients — and again all this is at the 90th percentile — in Saskatoon in '16-17 that number was 39.8 hours, dropped in '17-18 to 35.9 hours, and then lifted back up in '18-19 to 40.7 hours.

On the time waiting for an in-patient bed, which is basically part of the timeline that we look at, an element of the overall admitted length of stay, for 2016-17 in Saskatoon that was 29.3 hours, dropped in '17-18 to 27.2, and increased in '18-19 to 32.7.

Ms. Chartier: — Any thoughts on what could have caused that increase in '18-19? What is the data or the modelling telling you?

Mr. Wyatt: — We can't say with absolute certainty what the factors are, but some of the things that we would expect have impacted those wait times would be, coming back to the issue around the acuity of the patients who are coming in, your CTAS 1's, 2's, and 3's require more time for diagnostic work. Those are the patients that you are waiting to get into in-patient beds. And so if you are seeing higher acuity, that will just put more pressure on both the department itself, but also on the in-patient bed capacity that you have. That would be probably one of the main considerations.

Ms. Chartier: — Thank you, and the first part of that was the conversation around root causes. You had said that there are some projects and some targets that have been set. I'm just wondering if you could tell us a little bit about that.

Ms. Garratt: — So if you think about the people that need alternative level of care, keeping people from presenting, so the community paramedicine program in Regina supports people to stay, you know, in a long-term care facility where they're at and get care. So if you don't present, you don't get admitted. There's been some enhancements to that program in Saskatoon in terms of the hours of service that it provides. And we're also looking at whether that team can help support people to transition back home in a more timely way with providing some supports.

We have, as people know, there's the health network model that started within Regina where services are co-located and working together to serve the needs of a community. And we found that model where we have, like home care, public health, working with physician partners and others, that we can be more responsive to the needs of individuals from a neighbourhood and bring them home.

So we have members of those teams going into the hospital to, say, see members from their community and what could they do to bring them home to community and provide service. And that's been a really important bridge because people in the hospital don't know what services can be provided in the community. So our teams in community are becoming a lot more responsive to the needs that they see in their area and starting to bridge those individuals home.

Those are just some examples. So we're looking at anything that would impact the length of stay, anything that could . . . if someone no longer needs acute care and could transition to an alternative level of care place, where are those options and how are we moving people through those systems as well.

Ms. Chartier: — Speak of the teams, are you speaking of Connected Care, so the pilots in Saskatoon and Regina? Is that what you're referring to?

Ms. Garratt: — It's broader than that. So when you think about the foundation for how we're forming the Health Authority, it's very much based on networks of health providers that work together, an integrated team co-located in the community. And it's pretty amazing when you have that team working together, and together closely with physicians, how they're able to support people so that they don't progress, and how they're able to bring people home and help support their needs in the community.

Ms. Chartier: — You had mentioned targets. You had mentioned you'd set some targets.

Ms. Garratt: — So teams when they're looking at a project, we talked earlier about the long-term care when we have QI [quality improvement] targets. So if you have a target that you know you're trying to impact, then you work on a quality improvement

project. You try something. Is it working? Yes. Good. Is that target not changing? Then you look at it again.

So for this instance we talked about the time waiting for in-patient beds or the number of people sitting in the emergency department waiting to go up. That's the focus of our work. And so anything that our teams are working on needs to be focused on impacting that, and they will have a specific target related to the work that they're doing.

And those adjust over time, and as we do the quality improvement work, we monitor the improvements. We see the changes. We don't see the changes, we work on something else.

Ms. Chartier: — Thank you.

The Chair: — Ms. Mowat.

Ms. Mowat: — Thank you. On page 295, there's a figure given: for March 2016, the Saskatoon RHA determined that 35 per cent of ED admissions were there to see a consultant. Do we have a percentage of this today?

Mr. Wyatt: — We don't have that data point with us, an updated number for you on that.

Ms. Mowat: — Is that something that you could endeavour to get back to the committee?

Mr. Wyatt: — We're not certain whether that is a regular measure that is collected as a regular matter of course. We can look into whether we have that data or not on an ongoing basis or whether it was a point in time that was identified. Not information we have here today.

Ms. Garratt: — So can you just clarify what was the number you were looking for? The percent of . . .

Ms. Mowat: — I just moved this page, but it's the percentage of folks that were in the emergency department to see a consultant. Yes. It was reported on page 295 of chapter 32.

Moving on to chapter 40, it's listed that there's 228 full-time equivalent positions in the SHA. Do we have comparable staffing levels today?

Mr. Wyatt: — Could you repeat the reference, the page number for that?

Ms. Mowat: — Sorry. Page 269, just at the bottom, it's talking about the emergency departments handled about 121,500 patients in 2017-2018. They employ about 228 FTE [full-time equivalent] positions. Just wondering if there's been any change to that.

[13:30]

Mr. Wyatt: — Again that's a number that we don't have here with us today, but we can see if that's something that can be returned.

Ms. Mowat: — Thank you. Moving on to page 271, there is a discussion about the challenges with reassessment. So at the bottom of the page it indicates that at August 2018, none of the Saskatoon emergency departments could show they routinely assess patients' conditions when patients did not see a physician within the authority's specified goal. Just wondering what the challenges are to reassessment. Are folks just too busy, or why do you see it not occurring?

Ms. Garratt: — That was one of the outstanding recommendations that we spoke about in terms of outstanding recommendation no. 5. And I think the challenge with the individuals, being the initial assessment and reassessment, are related to delays and how busy the ER [emergency room] is and the physician having a space to see the individual. So what we've done is, working on the triage captain, identifying that, you know, so we have processes in place so that if somebody is waiting for a long period of time that we are reassessing them.

And the work we've been doing is to ensure that we're documenting those reassessments so we know that they occurred and that we're not guessing, has somebody checked this person or that person. We do an assessment; we document it and know it's being done. And the work we've been doing is to try to work to a way to improve those processes so we know that, yes, we've assessed them; yes, we've checked on them; and now we have it documented and know with confidence that we're checking on those individuals.

Ms. Mowat: — I'm just wondering about . . . There's a figure on page 272 that shows a number of patients presenting at the three Saskatoon emergency departments and their levels. It says that the source is SHIPS, Saskatoon Regional Health Authority strategic health information and performance support. I'm just wondering . . . So this is obviously broken down by region right now. Is something comparable going to be available within the amalgamation of the SHA? Is that reporting still going to take place within the new structure?

Ms. Garratt: — I would say yes. So we have a number of factors, the number and volume of patients we've looked at in other regional health authorities, and have processes to collect that information and monitor the change. SHIPS, the reference to SHIPS is now . . . That's become part of the Saskatchewan Health Authority and we're looking at how they're supporting the province in terms of data collection.

Mr. Wyatt: — If I could just add to that. So Saskatoon in the past and Regina, Prince Albert, and some of the Prairie North sites feed their data into CIHI and then we can get back aggregated, you know, provincial-level data. So we have access to that data from emergency department data for sort of, you know, four of the previous health authorities with larger emergency departments. We have other sources for data in some of the smaller emergency departments and I think over time, you know, we would like to be able to get the same rigour in that data across at least the larger emergency departments to understand some of the performance issues we have.

The Chair: — Ms. Chartier.

Ms. Chartier: — Thank you. Just with respect to the mental health assessment unit, I know back in I think 2013 there was, on emergency department wait times in Saskatoon, there was a presentation from someone from Australia who had many ways

in which we could reduce wait times. And one of the things they have in Australia is the psychiatric emergency care centres and just a different way of triaging mental health patients. Has that been flagged as a concern? Obviously mental health patients presenting at the emerg is a challenge for the patients but also for staff, and with the closure of the mental health assessment unit and the move to the new emerg, how are we going to support mental health patients?

Ms. Garratt: — There's lots of history on the mental health assessment unit, as you say, and when it was put in place we were looking at a quieter and calmer environment for the psychiatric patients within the current emergency department, knowing that transitions were coming. So it has been an important and valued sort of environment for the patients and for the staff in terms of the interactions.

So what's happening now is that when a mental health patient presents to the ER, you don't always know that their situation is physical or mental or what their issues are. So triage is an important function when you come to the ER. So that triage function happens, and then we can direct patients to the appropriate care environments. At the moment there is . . .

Yes, concerns have come forward about that mental health assessment unit. People have valued it, so wondering kind of how we're going to function moving forward. We're reviewing that at the moment to determine what will happen when we transition to the Jim Pattison Children's Hospital.

Ms. Chartier: — When you say you're reviewing that, what are you thinking? That you may provide other supports for mental health patients presenting at the emerg? I know the children's hospital is virtually done so it's hard to shoehorn something else in there. But what are you reviewing exactly?

Ms. Garratt: — What we're reviewing is how we're providing the service to the mental health patients that are presenting and ensuring that we have an appropriate flow and what spaces and areas and treatment, what we have within the ER, how we're using those in the new ER and then what gaps or other needs we may have.

Ms. Chartier: — Just going back to 2013 and the presentation, it was about a quiet and calm space, when Australia established these. But it also is very much about the third-door option and a different way of patients, mental health patients, flowing into the system. Is there any will or interest in . . . I know there's the decanted space where the mental health assessment unit is, and the rest of the ED. Is there the thought of using that perhaps as not just an assessment unit but perhaps a short stay like a stabilization unit?

Ms. Garratt: — What I would say is we're reviewing all of the needs and determining what we need to do moving forward. So I don't have a solution to say or do. We're reviewing what the needs are and, because we have a goal, to ensure that we're providing the appropriate care and in the appropriate place and appropriate environment for the patients we serve.

Ms. Chartier: — So with the opening of the new ER . . . Which will be when? Are we anticipating this year? At what point . . . I'm talking about emergency wait times . . . [inaudible interjection] . . . No, this is directly tied to emergency wait times. So do you have a sense of what is . . . So when it opens, do we know what will happen? When will we have a decision about what will happen with mental health patients? So timing for the children's hospital and what will happen with mental health patients that actually impact wait times and flow.

Mr. Wyatt: — So with respect to the Jim Pattison Children's Hospital, the target remains that it will be open in the fall, this fall, 2019. The assessment unit will continue to operate until the time of that transition. As mentioned previously, there is a review under way that's looking at whether there are any changes required to meet the need that's been identified and that's really kind of as much as we can say in terms of the process that's under way.

Ms. Chartier: — Just in terms of timeline then, just for clarity. So we've got the children's hospital opening in the fall. I'm just wondering when . . . I'm speaking with many people who have utilized the mental health assessment unit and they're wondering when there might be an answer around meeting their needs, which also ties very much into emergency department waits.

Ms. Garratt: — Can I just speak to that to some degree. We've always had the intention to meet the needs of the mental health patients presenting, so where those are. We have a plan in terms of the transition to the new site, how we would manage the mental health patient needs. So they're not forgotten about in that process. We have a plan in place for how we manage their needs and in the new ER and how that works. What we're reviewing is whether or not there's any need for the mental health assessment unit going forward, given the plan that we have. So there is a plan to continue to manage care for individuals. So I think that that's important for people to understand that it isn't that . . . The service is transitioning and will continue to support physically and mentally ill people in the emergency.

Ms. Chartier: — Thank you very much for that. With respect to the review for the mental health assessment unit, when can we expect that to be complete?

Mr. Wyatt: — We can't give you a time here today as to when that will be completed. Obviously the hospital is opening this fall and the assessment is taking place in the interim months. We can't tell you exactly when it will reach a conclusion.

Ms. Chartier: — Okay. Thank you.

The Chair: — Are there questions from committee members? Not seeing any, thanks for the work on this front. It's certainly an important area.

We'll conclude consideration as it relates to chapters 32 and 40 and we'll move along to the consideration of the 2017 report volume 1, chapter 29. And I'll turn it over to the Provincial Auditor's office.

Ms. Clemett: — Chapter 29 of our 2017 report volume 1, on pages 271 to 272, reports the results of our third follow-up of the recommendations originally made in our 2010 audit related to Saskatoon RHA's processes to protect its IT infrastructure. By March 31, 2017, Saskatoon RHA implemented all three outstanding recommendations. It improved its processes to

monitor security of its IT systems, patched its computer systems and network, and better restricted user access to its IT systems and data. That concludes my presentation.

The Chair: — Thank you very much. I'll turn it over to ADM Wyatt for a brief response, then open it up.

Mr. Wyatt: — Thank you. As noted, the first recommendation has been implemented, the second recommendation implemented, third recommendation implemented. I think that's all I have to say.

The Chair: — Just like that, eh? Good work. Any questions from committee members? Thanks for the work. Of course for anyone tuning in, this has been before the committee before. Thanks for all the work, certainly by the auditor's office but also officials as well. And we'll conclude consideration of chapter 29 at this time and we'll move along.

I'm just looking for my sheet here. Where are we headed next? We're going to do two of them, I think. So we're going to move ahead here with chapter 51, Kelsey Trail Regional Health Authority from the 2015 report, and chapter 28, the Sask Health Authority following up with Kelsey Trail, and that's from the 2018 report. And I'll turn it over to the Provincial Auditor's office.

Ms. Clemett: — Chapter 51 of our 2015 report volume 2, on pages 243 to 245, and chapter 28 of our 2018 report volume 1, pages 287 to 289, reports the results of our second and third follow-up of the recommendations originally made in our 2010 audit on Kelsey Trail's processes to maintain its medical equipment.

By December 2017 the former Kelsey Trail Regional Health Authority implemented two of three remaining recommendations. It properly updated its medical equipment listing and regularly gave senior management sufficient information to facilitate meaningful discussions about its equipment. As of December 2017, Kelsey Trail still needed to maintain all of its medical equipment in accordance with the required standards.

[13:45]

Our testing found that some items received maintenance six months after their scheduled dates. For example, one item was nine months past its scheduled maintenance date. We also found some equipment received annual maintenance when the manufacturers suggested . . . required semi-annual. Properly functioning medical equipment supports the health system in providing safe, patient-centred care. That concludes my presentation.

The Chair: — Thank you for the presentation. I'll turn it over to the ADM for Health, ADM Wyatt.

Mr. Wyatt: — Thank you. The first recommendation has been implemented, as noted by the auditor. With respect to recommendation no. 2, we consider this partially implemented. Scheduled preventative maintenance is scheduled and created by the computerized maintenance management software system for each individual piece of equipment. Further work is taking place to research and record the interval of each equipment's preventative maintenance as per the manufacturer's recommendation.

Preventative maintenance is completed annually. However, this process will be reviewed and all changes to the maintenance schedule will be documented. By March 31st, 2019, the standardization of medical equipment preventative maintenance frequency will be integrated into a provincial approach as clinical engineering services are consolidated into a provincial service line. And the third recommendation has been implemented.

The Chair: — Thanks for that report and the work. Committee members, any questions? Ms. Mowat.

Ms. Mowat: — Thank you very much. So just a couple of questions here. So in chapter 28, on page 287, the auditor's report talks about having adequate processes to maintain medical equipment. And I'm just wondering, are there different processes that are in place now, or are we waiting for this software change that has been identified?

Mr. Wyatt: — Once again, we'll introduce Corey Miller from the Health Authority and he can answer questions on this topic.

Mr. Miller: — I think this is a good example of . . . to Minister McMorris's point earlier today around the advantages of moving towards a single health authority for the province of Saskatchewan, and that we have the opportunity now to take best practices from one region and share and replicate across the province.

In this specific example around medical equipment, it crosses the boundaries of many of our portfolios. So this isn't specifically in my area, but many of my departments . . . Equipment maintenance, preventative maintenance is a big part in medical imaging and pharmacy and laboratory, and we have a varying practice in our province of some health authorities have gone with service contracts with vendors because they're unable to recruit and retain clinical engineering people in remote areas or maintain their training and staff, where now we can have a consolidated approach to this.

So I would say we have the opportunity with the new structure to have improved processes in place to allow us to look at all the models available, as well as to spread our teams to better cover the equipment that we have. And over time, through the process of standardizing our equipment — so we're not going to have different equipment in every different corner around the province — we'll have standardized purchasing. We'll have standardized training for our clinical engineering staff. But we'll also have standardized processes around where do we fix this equipment and maintain it ourselves and when do we contract it out.

I think another important factor in this auditor's report is also looking at, there are other processes that we're accountable to in maintaining equipment. Like many of our Accreditation Canada standards in many of the areas that I'm accountable for in imaging and lab, this is a required operating practice that we have planned, scheduled, make preventative maintenance for all of that type of equipment.

So I think to answer your question, it's the processes now . . . We

have the ability to look at this at provincial level with clinical engineering and our infrastructure partners, as well as with the clinical operations departments.

Ms. Mowat: — Thank you. So are you saying that there have been changes because of looking at best practices around the province? Or you're looking at changes? I'm just trying to determine sort of where we're at in the process.

Mr. Miller: — So I think there's best practices being considered, I think, in the response in clinical engineering. So the software specifically you were referencing is a clinical engineering software, but there's also processes being improved within clinical operations to ensure that their equipment is meeting the required operating practices of our accreditation standards. So it's sort of, on two folds, the answer is yes.

Ms. Mowat: — Thank you. That concludes my questions, Mr. Chair.

The Chair: — Any other questions? We'll conclude consideration with respect to chapter 51 in 28 and we'll move along to the 2015 report volume 2, chapter 55, as well as 2018 report volume 1, chapter 30. Turn it over to the Provincial Auditor.

Ms. Clemett: — Chapter 55 of our 2015 report volume 2 and chapter 30 of our 2018 report volume 1 reports the results of our first and second follow-ups of the recommendations originally made in our 2013 audit of the former Sun Country Regional Health Authority processes to manage and administer medications in its district hospitals. By September 30th, 2015 Sun Country had implemented four recommendations and had made limited progress on addressing the remaining one recommendation about consistently completing patient medication profiles by documenting patients' weights.

By December 2017 the Saskatchewan Health Authority had not addressed the recommendation of the two district hospitals. Of the 30 patient files we tested, 43 per cent of the medication profiles did not include documentation of the patients' weights. Documenting patients' weights reduces the risk of prescribing improper medication dosages to patients. That concludes my presentation.

The Chair: — Thank you for the presentation and for the work. I'll turn it over to ADM Wyatt.

Mr. Wyatt: — Thank you. Recommendations 1 and 2 have been implemented, recommendation 3 as well. With respect to recommendation 4, we can also consider that to be implemented. A process was developed in 2015 for recording patient weights — and I'll clarify that's w-e-i-g-h-t-s. We talk enough about patient waits around here. And monthly audits continue to be performed to ensure they are recorded appropriately in patient medication profiles. Audit results have found that the flagged site, Weyburn General Hospital, has demonstrated continued improvement, scoring 80 per cent or above consistently since January 2018. And with respect to recommendation 5, also implemented as per the Provincial Auditor.

The Chair: — Thanks for the report. Thanks for the work. I'll open it up for questions. Ms. Mowat.

Ms. Mowat: — Thank you. And just to sort of conceptualize what we're talking about here, is the pharmacy adjacent to the hospital? Is that where the concerns arose?

Mr. Miller: — The pharmacy is within our hospital, right? So we have pharmacies within our acute care facilities that distribute medications. In some of our rural sites we may get that service and support from a community pharmacy, but for the most part in our larger acute care centres we have pharmacies embedded into our hospital service.

Ms. Mowat: — Okay, good. So that's what I thought. So we're on the same page. On the issue of recording patient weight, it's good to see that these measures are in place now. What was the initial challenge in terms of why patient weights weren't being recorded?

Mr. Miller: — I think the challenge there is that the patient's weight needs to be continually documented in their care cycle, because patients lose and gain weight which impacts their dosage that they should be getting and it will impact their ongoing dosages. So I go back a little bit with the Cancer Agency and my time working there. This is a very big piece. And they had actually automated some of that in some of their outpatient clinic where it was an automated weight scale that put it into their electronic health record, because it's so important in their care.

So the patient, upon registration, is weighed. That is automatically put into the electronic health record because in their world it's that important to get their doses correct. And many of their patients lose weight quickly. So that's where I believe this warning or this risk was identified by our partners at the Provincial Auditor, because it is important for proper dosing for our patients.

So this isn't a pharmacy-held issue. This is jointly pharmacy and nursing and anyone who's entering into the . . . and charting into the patient's chart, I guess. Our Provincial Auditors are stressing that it's important that that information is documented, so that the next person in the checking is properly checking to make sure that they've taken into account the patient's weight when deciding what dose to put.

Ms. Mowat: — Thank you. That concludes my questions on this chapter, Mr. Chair.

The Chair: — Any other questions from committee members? We'll conclude consideration with respect to chapters 55 and 30 and we'll move right into consideration from the 2017 report, volume 2, chapter 25.

Ms. Clemett: — In Saskatchewan, health care costs are rising each year. Excessive absenteeism significantly increases costs of delivering these programs and providing service. In 2016-17 the former Heartland Regional Health Authority had the seventh highest amount of sick leave per FTE of the 12 Saskatchewan regional health authorities with 84.29 hours per FTE or about 10.5 sick-leave days per FTE.

Chapter 25 of our 2017 report volume 2 on pages 177 to 197 reports the results of our audit of Heartland Regional Health Authority's processes to minimize absenteeism. This chapter includes five new recommendations for the committee's

consideration. We concluded for the 12-month period ending June 30th, 2017, Heartland Regional Health Authority had, other than reflected in our recommendations, effective processes for minimizing employee absenteeism. We made five recommendations, and given the government's announcement to consolidate the 12 regional health authorities into the Saskatchewan Health Authority in January 2017, we directed our recommendations to the Saskatchewan Health Authority.

I'm going to focus now on the five recommendations. Our first recommendation, on page 187, we recommend that the Saskatchewan Health Authority reassess the role of human resources in promoting employee attendance to enable more timely resolution of issues causing employee absenteeism. We found that Heartland's attendance support program was not being used as intended and employee attendance was not improving. We noted the following: the former Heartland Regional Health Authority did not meet senior leadership team-approved sick leave targets since 2011-12; managers were not documenting their management of employees with excessive absenteeism as required; employees often remained in the first phase of the support program for extended periods, with only a few advancing to the next phase; and the use of its employee and family assistance program was lower than the authority expected.

Our analysis found supervising managers did not have the capacity to complete their day-to-day activities and give timely support to employees with excessive absenteeism, given the number of employees under their supervision with excessive absenteeism. About half of the 22 facilities had a single out-of-scope manager overseeing more than 80 employees. Almost 90 per cent of Heartland's 22 health care facilities had employees with excessive absenteeism.

Heartland was aware of these challenges, so in April 2017 it was piloting a slightly different attendance support program with managers at two facilities with a high amount of sick leave per FTE. In these facilities, HR [human resources] staff gave managers more support through the pilot. HR staff were more active in the day-to-day steps of the support program, and they worked more directly with employees with higher-than-regional-average sick leave. Involving human resources personnel differently is a way to reduce the workload for managers. This may promote completion of an absenteeism documentation to provide a basis for future decisions and provide more timely absenteeism management, particularly when you have a large amount of individual staff with excessive absenteeism.

[14:00]

In our second and third recommendations, on page 188, we recommend the Saskatchewan Health Authority implement standard detailed checklists to aid in conducting and documenting meetings with employees who have excessive absenteeism. We recommend that the Saskatchewan Health Authority monitor that those responsible for employee attendance management document discussions and actions taken with employees who have excessive absenteeism.

Heartland's employee attendance and managing absences guide did not have sufficient detail to promote robust discussions between busy supervising managers and employees with excessive absenteeism. In addition, it did not ease documenting these discussions. For example, the guide did not suggest discussing specific attendance management strategies, such as action plans, or providing ready access to available employee and family assistance programs. In addition, templates provided didn't prompt managers to record these aspects of their discussions.

Without proper records, managers cannot show if and how they are addressing the reasons for identified absences of employees with excessive absenteeism. Properly setting, documenting, and monitoring attendance action plans to reduce absenteeism provides evidence that the managers are applying appropriate attendance management strategies. Making standard, detailed templates available promotes documented and consistent attendance management.

Our fourth recommendation, on page 190, we recommend that the Saskatchewan Health Authority analyze significant causes of its employees' absenteeism and implement targeted strategies to address them. Heartland did not analyze significant causes for excessive sick leave. Reports that senior management received did not attempt to link excessive sick leave hours to sick leave causes or provide insight on how well existing strategies reduced excessive sick leave or suggest alternative actions or options.

For example, while Heartland's most common workplace injury to employees is strains to the back and shoulders, it did not show how much sick time is attributable to back and shoulder injuries or to workplace injuries in general. In addition, it didn't know if its training on transferring, lifting, and repositioning was reducing these types of injuries.

Analyzing causes of absences would assist in the development of actions to reduce employee absenteeism. Without sufficient analysis of absenteeism causes, the authority could not develop targeted attendance management strategies to address the causes identified or know whether its existing programs are sufficient.

In our last recommendation on page 190, we recommend the Saskatchewan Health Authority give the board periodic reports on the progress of attendance management strategies in reducing employee absenteeism and related costs. In 2017 Heartland had an average of about 10.5 sick leave days per FTE as compared to their absenteeism target of eight days. Reports to the board about absenteeism did not include reasons for not meeting the targets or information about whether its attendance support programs were making a difference. More information analysis would help the board understand why their actions and strategies effectively reduce employee absenteeism and whether changes are necessary. That concludes my presentation.

The Chair: — Thanks for the presentation. These are recommendations that are new to us as a committee here today. Thank you for the work. I'll turn it over to ADM Wyatt and officials to respond briefly and then open it up for questions.

Mr. Wyatt: — Thank you. The first recommendation is considered implemented. Beginning in April 2018 on a monthly basis, the ability management coordinator reports to all managers on employees whose sick time exceeds the regional average. Managers are expected to review and follow up on these reports. Letters created by the ability management coordinator are sent to

employees whose sick leave use exceeds the average to educate them on the attendance support program. The receipt of the letter sets the stage for the employee and manager to discuss ways to improve the employee's regular attendance at work.

Recommendation no. 2 is also considered implemented. Formal meeting guides that include standards, detailed checklists, and areas to document discussions and follow-up actions were rolled out to all managers in December 2017. As well, in February 2018 Saskatchewan Association of Health Organizations provided an education session to all managers on managing attendance support issues.

Recommendation 3, again considered implemented. Formal meeting guides that include standard detailed checklists and areas to document discussions and follow-up actions were rolled out to all managers in December 2017. Managers are required to provide copies of the formal meeting guides to the ability management coordinator as evidence of the meetings. The ability management coordinator reviews the completed guides and provides coaching to managers as required. Formal tracking of attendance support activities is reviewed monthly by the ability management coordinator and shared with management.

Recommendation 4 is considered partially implemented. Analysis to determine significant causes of employee absenteeism is ongoing and has resulted in the development of an attendance support brochure that promotes the Saskatchewan Health Authority's chronic disease management programs, including Pathway to Wellness, LiveWell, and collaborative team health care. The brochure is provided to every employee who receives a letter notifying them of their high sick leave use. Contact information for the chronic disease coordinator as well as details on the employment family assistance program are included in the brochure.

In addition the ability management coordinator is made aware of the nature of an employee's health issues and works closely with managers to intervene where sick leave use is associated with mental health. Management plans to implement more formalized tracking of absenteeism causes in the '19-20 fiscal year.

Recommendation 5, also considered partially implemented. In 2018 board reporting included sick leave hours and costs, workplace injuries, the number of employees with excessive sick leave use and the phase those employees are in within the attendance support program, as well as the number of return-to-work and accommodations. A director of accommodations and attendance management was hired in October 2018 and is currently reviewing current-state attendance processes in former regions.

As the Saskatchewan Health Authority works towards standardizing approaches to managing absenteeism and establishing standardized reporting, the board will be provided with updates. This recommendation is expected to be fully implemented by October 2019. That concludes my remarks.

The Chair: — Thank you for the presentation and for all the work on this front. I'll open it up to the committee for questions. Ms. Mowat.

Ms. Mowat: — Thank you. On page 178, figure 1, I think we can see that Heartland Health Region is right around the average of the different regional health authorities in terms of the average sick time that has been taken. So I just want to highlight the fact that, even though we are focused specifically on Heartland today, I think there's a broader provincial perspective that we can take on this as well.

I'm wondering first of all if we've seen these figures improve since this was the 2016-2017 average sick time, and both within Heartland and I guess what the average, the Saskatchewan average looks like.

Mr. Wyatt: — It would appear that we don't have that information with us here today.

Ms. Mowat: — Okay. Is that something that can be provided to the committee?

Mr. Wyatt: — I believe it's probably data that we do have, and we can commit to follow up and return it to the committee.

Ms. Mowat: — Is there any anecdotal knowledge about how this is going?

Mr. Wyatt: — Our conclusion is we don't have anecdotal knowledge that would be helpful, and probably best to return with the data.

Ms. Mowat: — Okay, thank you. The measures that have been identified in the status update — that's the word I'm looking for — I'm wondering, have these measures exclusively been taken within the former Heartland Regional Health Authority, or have these practices been spread throughout the Health Authority as well?

Mr. Matthies: — Good afternoon. I'm Kyle Matthies. Organizational development and employee wellness is my portfolio. What we know is that this is another area where coming together as one provincial Health Authority is going to be advantageous for us, that there's certain areas of the province that were doing better than others. And the work that we're undertaking right now is to understand how this work is happening across the province and where there are best practices, such as those outlined here, that can be uniformly applied across the province.

Ms. Mowat: — So that's something that's being looked at right now, basically.

Mr. Matthies: — That's a current-quarter target for us. Yes.

Ms. Mowat: — Okay. There was some mention from the Provincial Auditor that there hasn't been much use of the employee and family assistance program. Has there been any additional uptake on the program?

Mr. Matthies: — Yes, in the last couple of years our percentage of employees that are using that program has gone increasingly up, such that we're probably going to have to renegotiate that contract actually because we're exceeding the targets that were identified in the first place with that program.

Ms. Mowat: — On page 186 there's discussion about a pilot that

the authority started in April 2017, piloting a slightly different attendance support program with managers at two facilities with the highest amount of sick time per FTE. They were Rosetown and Biggar. How successful was this pilot, and do we know if we saw any improvement in sick time hours as a result of that?

Mr. Matthies: — I don't have that data directly about those two sites in particular now that we're part of one health authority. But what I can speak to is that the model that was used here is similar to what we're moving towards as a province in trying to bring increased supports at the front-line manager level. And this would be one of the areas that we would see HR [human resources] supporting more strongly.

Ms. Mowat: — Okay. That's all my questions, Mr. Chair.

The Chair: — Ms. Chartier.

Ms. Chartier: — Just a follow-up question. You had mentioned increased utilization of EFAP [employee family assistance program]. Is that throughout the Health Authority?

Mr. Matthies: — Yes. I couldn't speak to it in Heartland, but that would be across the Health Authority.

Ms. Chartier: — And in what time period have you seen it increase?

Mr. Matthies: — I know that over the last two years, let's say.

Ms. Chartier: — Is there any analysis done as to why that might be happening?

Mr. Matthies: — I don't have analysis on that. But anecdotally, as familiarity with that program has grown, more people are using it.

Ms. Chartier: — And you say as that program has grown . . .

Mr. Matthies: — I'm sorry. The program hasn't grown. As familiarity with the program has grown, more people are taking advantage of it.

Ms. Chartier: — How long has the program been in place? Like just in terms of familiarity. I mean, EFAP has been around for . . .

Mr. Matthies: — A number of years.

Ms. Chartier: — Yes.

Mr. Matthies: — Our most current EFAP contract has only been in place for a few years with a different provider.

Ms. Chartier: — Is it possible to get stats for the EFAP use?

Mr. Matthies: — That's for that, yes.

Ms. Chartier: — Do you have the last five years perhaps? Or how do you break it down?

Mr. Matthies: — I don't know if we have five but we could get what we have.

Ms. Chartier: — That would be great. And would we be able to table it with the committee?

Mr. Matthies: — Yes.

The Chair: — So I guess just to be consistent, there's been a couple undertakings of late, one to Ms. Mowat and then this one to Ms. Chartier. We'll have instructions on tabling those documents, and would it be . . . Is that an easy document to provide within a couple week period?

Mr. Wyatt: — I think the challenge that Kyle's identifying is, you know, under the Saskatchewan Health Authority time frame and then what would be available when you move back to the individual health authorities. So to the extent that we can provide Saskatchewan Health Authority information, that may be an easier task than going back across all of the authorities. We'll, you know, though, undertake best efforts. But in terms of the timeline, if there's information that's readily available, that may be what's provided on a shorter time frame.

Ms. Chartier: — I'd be interested not just in what's readily available. If it takes a little bit longer, I'd just like to get a little bit of a picture of what's been going on for a few years if possible.

[14:15]

Mr. Wyatt: — We can undertake, we'll ask the authority to undertake that review to see what can be brought back in terms of longer term utilization.

The Chair: — Thank you. Any other questions from committee members at this time? We have all new recommendations so we'll need motions with respect to them. I believe it's been noted and detailed that the first three have been implemented, so I'd certainly entertain a motion with respect to recommendations 1, 2, and 3, along those lines. Mr. Goudy? Mr. Goudy moves that we concur and note compliance with 1, 2, and 3. Agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. 4 and 5, Mr. McMorris moves that we concur and note progress. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — All right, that's carried as well. We will conclude considerations of that chapter and move along to the 2015 report volume 2, chapter 46. And I'll turn it over to the Provincial Auditor's office.

Ms. Clemett: — Chapter 46 of our 2015 report volume 2, on pages 325 to 326, reports the results of our second follow-up of the recommendations we originally made in our 2009 audit on Heartland Regional Health Authority's processes to secure electronic information during the disposal of information technology and communication equipment.

By July 31, 2015 Heartland had implemented the remaining two recommendations. It established procedures for removing confidential information from its ready-for-disposal equipment and regularly tests such equipment to verify that procedures to remove the sensitive information are effective. That concludes

my presentation.

The Chair: — Thanks for the presentation. Thanks as well for the report which details implementation. But I'll turn it briefly to ADM Wyatt and officials if they care to respond, and then open it up.

Mr. Wyatt: — Briefly, both have been implemented. I have nothing further to add.

The Chair: — Ms. Chartier.

Ms. Chartier: — Yay for implementation. Very good. I do have a question though about province-wide . . . So this is for Heartland. Is there a province-wide Saskatchewan Health Authority policy around disposal of equipment?

Mr. Wyatt: — This is an area, and we've heard a few of them today, where the individual former regional health authorities would have their own policies with respect to the disposal of equipment. At this time they haven't been consolidated into a standardized policy.

Ms. Chartier: — So every former region would have had a policy?

Mr. Wyatt: — That's my understanding, yes.

Ms. Chartier: — Okay. Do organizations like eHealth have a policy as well?

Mr. Wyatt: — Yes, that is the case.

Ms. Chartier: — That is the case. And in terms of moving towards a province-wide policy, is that in the works?

Mr. Wyatt: — Yes, and it's under development.

Ms. Chartier: — Under development. Do we have a sense of when that might be complete?

Mr. Wyatt: — I'm advised in the next three months is the time frame that they're working on.

Ms. Chartier: — Okay. Thank you very much.

The Chair: — No other questions at this point with respect to chapter 30 to 46. We'll conclude consideration and move along to the 2017 report volume 2, chapter 37. And I'll turn it over to the auditor's office.

Ms. Clemett: — Chapter 37 of our 2017 report volume 2, on pages 261 to 268, reports the results of our first follow-up of recommendations originally made in our 2014 audit on Heartland Regional Health Authority's processes to manage medication plans for residents in its long-term care facilities. We made 17 recommendations in our 2014 audit. By August 2017 Heartland had fully addressed 9 of our 17 recommendations and was actively working on the other seven. We concluded one recommendation was no longer relevant.

Heartland established policies for medication management in its long-term care facilities. It communicated the policies to staff and, where required, to residents or their designates. Heartland made training resources accessible to staff. Heartland also consistently obtained medication-related information from previous health care providers when residents transferred into long-term care.

As of August 2017, Heartland still needed to use a multidisciplinary approach, so have physicians, nurses, and pharmacists involved in finalizing medication plans for long-term care residents. Only 50 per cent of the files we examined clearly showed evidence of medication reviews by a multidisciplinary team. Medication administration for the elderly is very complex, and using a multidisciplinary approach ensures residents only get the medication they require.

Follow its established policies and procedures for making medication changes for its long-term care residents. This includes obtaining informed written consent from the residents or their designated decision makers before making changes in high-risk medication or when using medication as a restraint. Fifty-five per cent of the files we examined that required written consent did not have it.

Follow its policy for documenting in the long-term care residents' medical records all medication-related activities. Documenting all medication-related activities in a central location like the resident files helps clients get the right medication at the right time and in the form required.

Establish a process to identify trends, needs, and issues related to medication management in its long-term care facilities. Our review of reported quarterly data found the number of residents on 13 or more medications was increasing. For example, 96 residents were on 13 or more medications at the beginning of 2016-17, compared to 118 residents at the beginning of 2017-18. We found Heartland had not analyzed these trends.

Collect and analyze information to improve medication plans for long-term care residents. The long-term care facilities we visited had started a file review process to assess whether residents' files showed staff complied with established policies, so for example, confirm that they obtained written consents. Heartland could centrally collect and analyze the results of these reviews, once available, to identify where and which facilities require additional training or support.

Medication can have a serious impact on the residents' quality of life. Heartland must ensure each long-term care resident has an established, up-to-date medication plan that is followed. That concludes my presentation.

The Chair: — Thanks for the presentation. These recommendations have come to this table before. Thanks for the work that's been detailed on this front. I'll turn it over to ADM Wyatt for a brief response and open it up for questions.

Mr. Wyatt: — Thank you. I will respond on some and not on others where the auditor has concluded the work. So with respect to recommendation no. 1, that's considered partially implemented. A policy was developed in December 2016 requiring a multidisciplinary approach for medication plans and quarterly medication reviews. The region performed an audit of the quarterly multidisciplinary medication review in November

2017. The audit concluded that 94 per cent of facilities had quarterly medication reviews up to date, although only 43 per cent showed documentation or signatures of all of the required participants. Improvement plans were developed with each facility to address the gaps.

Following this work, another audit was completed in November 2018, which showed 88 per cent of required quarterly medication reviews were completed and 72 per cent had evidence of being multidisciplinary. The next audit is scheduled for the fourth quarter of 2018-19.

With respect to auditor recommendations 2, 3, 4, and 5, those are reported as implemented by the SHA. I guess I'll go back with brief explanations. So with no. 2, in October 2015 a policy requiring informed written consent from long-term care residents or their designated decision makers for changes in the high-risk medication was created and implemented.

Recommendation 3, clinical nurse educators provide education to all care staff on the use of medications as a restraint through the regional clinical education program. This includes a review of the least-restraint policy and procedure, specifically highlighting the restraint use process and need for consent.

Recommendation 4, medication management policies have been reviewed and approved in December 2016 to ensure the medication planning document process confirms client family involvement and consent in relation to medication plans or medication changes. Staff have been provided with training by managers.

And recommendation 5, the Saskatchewan Health Authority has worked with and will continue to work with staff to ensure compliance with existing policies and procedures in professional practice standards related to documentation. Charting education is provided as part of clinical orientation for all new care staff. Recommendation no. 6 has been identified by the auditor as no longer relevant.

Recommendation no. 7 is considered partially implemented. The region implemented a process requiring monthly reporting of medication incidents and distribution to facility managers, clinical nurse educators, and to respective directors. Incident reports are reviewed and improvement plans are developed to mitigate issues. A policy relating to medication patches was revised, with subsequent education provided to care staff regarding changes for monitoring medication patches and documentation.

The quarter one 2018-19 audit revealed that all facilities had adequate documentation in the medication administration record and were following the revised process. A new template was developed and is being trialled by both the former Heartland Regional Health Authority and the Ministry of Health. Use of this template will ensure adequate documentation of goals and actions are set to address the inappropriate use of antipsychotics. An evaluation of this template will occur in May 2019. Facility managers, clinical nurse educators, and directors will perform ongoing reviews, monitoring, and creation of mitigation plans for medication incidents.

Moving to recommendation no. 8, this is considered to be implemented. Facility care teams have conducted a detailed medication review using current minimal data set, or MDS data, to identify opportunities for individual client improvement. On a go-forward basis, MDS data will continue to be reviewed quarterly for those clients who trigger the quality indicator of potentially inappropriate medication, as well as those clients who are prescribed 13 or more different medications.

The SHA will continue to track medication errors through a regional incident management process. Facility care managers review incidents monthly and the lead improvement process is to mitigate future errors. As well, the region's quality department monitors all recorded incidents to ensure all code 3 and 4 incidents, more serious incidents, are investigated and that recommendations for improvement strategies are developed and managed.

Moving to recommendation no. 9, that has been implemented, as have recommendations no. 10, 11, 12, and 13 through 17. So the remainder have all been reported as implemented by the Provincial Auditor. Thank you.

The Chair: — Thanks for the presentation, for the report. I'll open it up for questions. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. Thank you for all of that information. I'm just looking at recommendation no. 7. I remember when the original audit took place, and the one thing that jumped out at me was the usage of antipsychotics without a diagnosis of psychosis. So I'm really glad that this template has been developed and is being trialled by the former Heartland region and the Ministry of Health.

[14:30]

The evaluation will take place in May 2019, but I'm just curious where else it is being trialled. So it says in the Heartland Regional Health Authority and the Ministry of Health. So what does that mean, in the Ministry of Health?

Ms. Earnshaw: — Karen Earnshaw. I'm the vice-president of integrated rural health services, so the former Heartland is in my area of responsibility. And your particular question relates to the quality indicators. So just for some context, every single facility that provides long-term care in the province reports on the use of antipsychotics without a diagnosis. That information is housed with the Ministry of Health and quarterly they provide a report to every single facility as to whether their facility reports use above the provincial average, and then corrective actions are required.

But in this case, Heartland chose to create a template that they're using right now, but it actually monitors all use, not just those that trigger above the provincial average. So they really wanted to make sure that not only were they then going to report on those that are triggered, but that they really had a process that would look at the use so that they could prevent triggering in their health region. And that template will be evaluated and considered if there is value to be applied across the province.

Ms. Chartier: — Is the benchmark — am I remembering it correctly — 28 per cent, or what is the benchmark for the use of antipsychotics without a diagnosis of psychosis?

Ms. Kratzig: — Hi. Kimberly Kratzig with the Ministry of Health again. So building a bit on our conversation this morning about the quality indicators, the last target that I have is 27 per cent in '17-18, and just noting that the provincial average in '17-18 was 24 per cent. Yes.

Ms. Chartier: — And had that been a decrease?

Ms. Kratzig: — Yes, the provincial average actually looking at the overall data for the province going back to 2007-08 was 33.5 per cent and we're again now at 24.1 per cent.

Ms. Chartier: — Are there places or hot spots where it's . . . former regions or areas that are higher than others?

Ms. Kratzig: — I'm just looking at the data. Overall the trend line does seem to be down. There's some areas that appear a bit higher at times, but overall it looks like most are declining for sure. It's worth noting that the national average, which we only have dating back to '12-13, has also been declining over time. So again, similar to what we talked about this morning, this is sort of an accepted indicator of quality that many provinces are looking at in terms of measuring what's happening in their homes.

This is a bit different. I should just flag. I think the Provincial Auditor was discussing individuals who had 13 prescriptions or 13 different prescriptions. This indicator is a bit different than that in it's measuring people who are receiving an antipsychotic who don't have a diagnosis of psychosis.

Ms. Chartier: — I think that was mentioned in the original report back in 2014. Was Santa Maria part of . . . Was there a pilot at Santa Maria on usage of antipsychotics without a diagnosis of psychosis? Am I recalling that?

Ms. Earnshaw: — Yes, there was a pilot at Santa Maria probably at one time. I would say three years ago.

Ms. Chartier: — And what were the results of that?

Ms. Kratzig: — I can share Regina's data overall. I don't think we have individual home data with us but I would just flag that Regina overall, according to the data that I have, has had quite a decrease. They are currently sitting . . . The former Regina-Qu'Appelle is currently sitting at 19.1 per cent, so quite below the provincial average. And they were at 33 per cent in '07-08. So I think that region as a whole has made some large strides. We could probably find you home-specific data.

Ms. Chartier: — Would you mind? Would it be possible to just have that snapshot of how everybody's been doing over the years? Whatever documents . . .

Ms. Kratzig: — We can table it at some point. And again much of this is online on the CIHI website as well where you can, you know, do comparisons, and it's at the home level, not only at the former RHA level.

Ms. Chartier: — And that's annual though, that CIHI usually gets the details.

Ms. Kratzig: — Yes, that I'm looking at as well.

Ms. Chartier: — And just in terms of . . . We've heard from folks today about the benefits from having one health authority. So we were talking about Heartland here and processes here for Heartland, but how are we going to see this across the province to make sure that all seniors or all those in long-term care are benefiting from good policy around medication management?

Ms. Earnshaw: — So I think it's a little bit of my own personal thing, but I believe that the quality indicators that we track in long-term care are some of the best indicators that we use in the health system, truly because they are a good reflection of the quality that we're providing. So I think the idea that we now will be looking across the province at our rates versus . . . Prior to this, we would look at what we're doing in our own health region and only if you happen to have colleague connections across the province would you be able to capture any of their best practice. But now we will be able to . . . We do; we look at everybody's data.

We can implement across the piece the best practices, such as if this template that Heartland, the former Heartland, is auditing that actually helps us to reduce antipsychotic use before it triggers, then we can actually implement that across all of our facilities. So that's just one example of how a single health authority, we've taken down those fences. We can all see what each other's doing. And we can pick the best from that.

Ms. Chartier: — I guess what I'm asking is if there is a provincial policy yet, and when we can expect to see one.

Ms. Kratzig: — We need you to clarify. A provincial policy on . . .

Ms. Chartier: — We're looking at these recommendations here that were very specific around reducing medication issues. So wondering how that flows upwards to the Health Authority.

Ms. Earnshaw: — So I think that question around what provincial policies have moved from the 12 regions is really . . . I'm going to surmise this morning that we're picking the most urgent and going through them. The fact that the province has the special-care home guidelines which require every facility to actually monitor, I don't see a provincial policy related to monitoring medication administration coming in the most urgent because every single former health region had one, and it's already monitored provincially. So we will get to it, but I don't see it as being the most urgent to say it's in the next three months, like the last question.

Ms. Kratzig: — And I think just building on the conversation that's been had, sort of theme I think throughout today, when you do have, as this audit, you know, many recommendations that have been implemented with improvements, I think that having one Saskatchewan Health Authority, they will be able to look at it and pull the best of the best from each area and end up with a provincial approach that will, you know, hopefully continue to see these quality indicators improve and care improve as well.

Ms. Chartier: — Thank you. I'm good.

The Chair: — No further questions, Ms. Chartier? Anyone else have questions with respect to chapter 37? Not seeing any, we'll conclude consideration of chapter 37. We'll move along to

chapter 32 within the same volume, and I'll turn it over to the Provincial Auditor's office.

Ms. Clemett: — Chapter 32 of our 2017 report volume 2, on pages 235 to 237, reports the results of our second follow-up of recommendations we originally made in our 2012 audit at Five Hills Regional Health Authority with regards to its processes to provide nourishing and safe food services in its owned and affiliated long-term care facilities. By June 2017 Five Hills had implemented all four outstanding recommendations from the original audit.

Five Hills reviewed and updated its nutrition and food services policy and procedures manual. It had a registered dietitian weekly review modified menus to confirm that the meals served at long-term care facilities met nutritional standards. Five Hills followed its policies and procedures to serve food at the appropriate temperature and texture. It required staff at each of its facilities to submit weekly temperature logs to management for monitoring. And finally it conducted audits of its food services as required by its manual. That concludes my presentation.

The Chair: — Thank you for your presentation and for the work. I'll turn it over to ADM Wyatt and officials.

Mr. Wyatt: — We note that the four recommendations that are identified have all been implemented, identified as so by the Provincial Auditor, and nothing further to add. Thank you.

The Chair: — Thank you. And thank you for the work on this front as well. I'll open it up to committee members for questions. Ms. Chartier.

Ms. Chartier: — Just a comment. It's always good to see recommendations fully implemented. So it's great to see.

The Chair: — Not seeing any other questions with respect to this chapter, we'll conclude consideration of chapter 32. We're going to consider two chapters together in the next consideration. Those would be chapter 34 from the 2016 report volume 1 and chapter 39 from the 2018 report volume 2. And I'll turn it over to the auditor's office.

Ms. Clemett: — Chapter 34 of our 2016 report volume 1, on pages 305 to 310, and chapter 39 of our 2018 report volume 2 reports the results of our first and second follow-up audits on the processes of Sunrise Regional Health Authority related to the prevention and control of infections.

By March 2016 Sunrise Regional Health Authority had implemented six of the ten recommendations we first made in our 2014 report related to the prevention and control of infections. Sunrise developed a more robust infection prevention and control plan, developed and implemented new infection prevention and control guidance. It developed and actively trained its staff on expected practices.

We are pleased to report by June 2018 the former Sunrise Health Region had implemented the four remaining recommendations. It communicated its prevention and control practices to the public; supervisors reviewed the adequacy of resident room cleaning done by staff, and management analyzed its infection rates and trends. That concludes my overview of this chapter.

The Chair: — Thank you for the overview and the presentation. I'll turn it over to officials for their response.

Mr. Wyatt: — As noted by the auditor, 10 recommendations all implemented, and we have nothing further to add. Thank you.

The Chair: — I'll open it up for questions. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. Just a quick question. On page 308 of chapter 34 it mentions, "While all facilities documented the level of cleaning carried out, we found all supervisors did not review the cleaning worksheets in all facilities."

So what are the challenges? What were the challenges here in getting supervisors to participate? Is it competing demands or not seeing it as a priority? Or what would have been the cause of that?

Ms. Vachon: — Hi. Good afternoon. I'm Beth Vachon, VP [vice-president] for quality, safety and strategy with the SHA. And I think as you've heard throughout the afternoon, lots of times our managers, I think, have been inundated with significant amounts of information and trying to manage all of that with these recommendations.

Sunrise Health Region made it a priority, and so since the initial report this one has been completed. The reviews have been implemented and the managers have made it a priority that they're reviewing those results on a regular basis.

Ms. Chartier: — Thank you. I think again, good work on getting the recommendations implemented. I know sometimes it takes a little bit of time to do that, but it's always great to see them fully implemented.

The Chair: — Any other questions with respect to these recommendations on this chapter? We'll conclude considerations then with respect to chapters 34 and 39 from the 2016 and 2018 reports respectively. We'll move along now to focus on chapter 42 from the 2016 report volume 2.

[14:45]

Ms. Clemett: — Chapter 42 of our 2016 report volume 2, on pages 279 to 286, reports the results of our first follow-up on the processes of Prince Albert Parkland Regional Health Authority, its process to deliver home care services. By September 2016, P.A. [Prince Albert] Parkland had implemented 9 of the 12 recommendations we first made in our 2014 report related to the provision of timely and appropriate home care services. Three recommendations remained. P.A. Parkland still needed to follow its established policies and procedures and complete the needs assessments as required for home care services. For example, 43 per cent of the client files we sampled did not have a falls risk assessment completed. Not completing the required needs assessment may result in a client not receiving all the required services.

Require the review and approval by a supervisor of home care plans. Prepare and approve work schedules consistent with home

care plans. Home care plans outline expected tasks and the appropriate length of time each task should take. Home care plans are supposed to align with work schedules. Lack of review and approval of home care plans increases the risk of errors in home care plans and schedules. That concludes my overview of this chapter.

The Chair: — Thank you for the presentation. I'll turn it over to ADM Wyatt or officials for a brief response and then open it up for questions.

Mr. Wyatt: — Thank you. We note that the first three recommendations have been implemented. With respect to recommendation no. 4, we also consider this one to be implemented. Policies and procedures have been updated and meet the recommendation to complete the needs assessments as required for home care services. These policies have been communicated to all staff, and employees have been trained on them.

Recommendation no. 5, also considered implemented. A daily process has been created to include approval of service requests, care plans, and prioritizing clients for service implementation. This process was implemented in March 2018. Daily approval decisions are documented for audit review and these processes have been established in new work standards.

With respect to recommendation no. 6, we also consider this to be implemented. Provincial and local work is currently under way for home care utilization, and home care plans are an area of continuing improvement. Home care plans should now match work schedules, especially in the last six months, as a full plan-of-care documentation is required for approval by a committee made up of clinical team leads from home care as well as front-line care staff, including assessment department, nursing department, and scheduling department.

And with respect to recommendations 7, 8 and 9, 10 and 11, 12 — those have all been identified as implemented by the auditor.

The Chair: — Thank you for the presentation. Again thanks for all the work and the status update that details all of the actions taken towards implementation I think on all of the fronts here with respect to these recommendations. I will open it up to committee members for questions. Ms. Mowat.

Ms. Mowat: — Thank you. On page 281 of chapter 42, the auditor talks about in-home safety assessments:

> This assesses the safety of the home for home-care staff delivering the service. A safe-visit plan is completed when a risk is identified during the in-home safety assessment.

I'm wondering what types of risks are identified that trigger safe-visit plans.

Mr. Wyatt: — In response to the question around what would trigger an in-home safety assessment and concerns that would arise from that, it would be an assessment of the home environment and if there are specific observations around something that might present a safety risk. I'm not sure that we have a lot of, that we have sort of specific protocols with us here, but that would be the general response.

Ms. Ferguson: — I can provide a bit of insight from what we learned during the audit process. One of the examples that we saw, like over and over again, was actually aggressive dogs in the home, right? And so, you know, so that like a person that would be visiting the home would have to know that there would be a dog in the house that may not necessarily be a friendly dog, and so they'd have to make arrangements so that they could handle that type of situations.

The Chair: — Ms. Chartier.

Ms. Chartier: — On that same topic, is there ever an occasion like obviously if someone is in a home who needs home care . . . I've heard anecdotally both in P.A. and in Saskatoon, and I represent an area where sometimes home care services aren't delivered. I'm wondering what that safe-visit plan might look like. Or if someone is in a home environment that might be in a neighbourhood that some people don't feel quite as comfortable in, how do we make sure people get home care and that workers are safe? Like what kinds of measures get put in place?

Mr. Miller: — Corey Miller with the Saskatchewan Health Authority. I think there's a number of examples of, depending on that assessment so . . . And it isn't just in home care; it's in all home visits. So I just want to point that out. Our mental health workers do lots of home visits as well as home care and often, in that initial assessment, they'll make decisions to do double-up visits. So they'll book appointments that actually send two people to do the visit together.

But you're right. There are circumstances where homes are flagged and often in the communities that you spoke of, you know, there are neighbourhoods and streets that are red-flagged from our police that they're not safe to attend. And we continue to look for opportunities to serve those people in new and better ways.

On occasions today we've spoken about community paramedicine and our partners in EMS to deliver care in some of these high-risk communities. Also we have agreements with our fire and police. In some of our high-risk areas, they can attend with us for those visits to ensure that people get the care that they require.

Ms. Chartier: — So fire and police services in Saskatoon will attend a home care visit in Saskatoon?

Mr. Miller: — So I'm not saying those processes are in place, but we do have agreements with Saskatoon Fire and that is something we have had dialogue and discussion with. There isn't that process in place, but we know certainly our community paramedicine have access and do go into those homes on a regular occasion when they're wearing their other stripes, when they're wearing their regular EMS. We don't have a red-flag zone for those areas to say ambulances won't attend, so our community paramedics, we do have them attending some of those. But it isn't a fully implemented process aligned with home care yet.

Ms. Chartier: — Okay. So just in terms of the . . . I know that paramedics attend calls throughout the city as they should, but I'm just wondering, so often the issue . . . My question is twofold, making sure that people get the home care or community visits,

whatever it is that they need, but also making sure people are safe. So I'm just curious how we differentiate . . . the difference between a paramedic and a home care worker, and how paramedics go in without a problem, but home care is sometimes reluctant.

Mr. Miller: — I'm not sure I . . . Can you repeat what the question is?

Ms. Chartier: — So you said that paramedics will attend these homes without issue and that there's the possibility for community paramedicine to attend to some of these homes, but home care workers won't. But I mean you could have paramedics who are 5 foot 4. I'm just wondering the difference, how we differentiate between home care workers and paramedics in terms of going into some places.

Mr. Miller: — In the EMS world, they're often attending with two paramedics. And they also have, I would say, better tools, as in protection. If they need support and assistance, they have their radios right on them. We have utilized in home care, in a previous time, we have used different tools for team alert. It's almost like a panic button. But certainly, you know, we're not there as a system yet.

But certainly our worker safety is paramount, right. And so that's, I would say, with the new SHA, that is something that we're going to have to work on to ensure that we have safe working environments for our staff and we still have access to providing the right care to the right individuals at the right place, which is often their home.

Ms. Chartier: — Are there occasions where people are denied home care services or community visits, whatever it might be? But home care is the content of this chapter.

Mr. McLetchie: — It's Andrew McLetchie again. I apologize for not being here when the session started. The basic answer about safety and that is that clients are assessed to determine what level of care they need and what the right environment is for that care. And based on that care plan and the needs that they have, a determination is made as to, are they able to be safely cared for at home and what's the level of service they need. If they're not able to be cared for safely at home, we'd look for an alternate place for them to receive care. They wouldn't simply be refused services based on us not being able to meet their needs at home.

Ms. Chartier: — Would they be supported to . . . I'm just thinking it's really expensive to send . . . We've talked about ED visits, and it's really expensive and a ridiculous waste of resources to send someone to hospital, like St. Paul's in Saskatoon for example, to have a dressing change. And I know that that happens. So I'm just wondering how we accommodate, like you've said, if the services can't come to them. Are they supported to get to the necessary services?

Mr. McLetchie: — There are examples of us getting people to places. I think it's on such an individual basis, it becomes part of their care plan. But there are situations where we're in a sense travelling hundreds of — or not hundreds — 100 kilometres to deliver home care to some clients in our province.

And I think probably more in an urban setting, there may be ways to use, whether it's public transport or volunteer services, to get them to care that they might need. But I think our teams do look and say, how do they work with the family, how do they work with the resident or the patient, in order to get them the care they need in the best possible way.

Ms. Chartier: — Thank you.

The Chair: — Is there any other questions from anyone? We will conclude consideration with respect to chapter 42, and we'll focus our attention on a chapter that I think has new recommendations within it, chapter . . . 2018 report volume 1, chapter 8. And I'll turn it over to the auditor's office.

Ms. Clemett: — The former P.A. Parkland Regional Health Authority provides three types of mental health and addiction services — in-patient, services provided in a hospital; outpatients, so services provided outside the hospital; and community rehabilitation and residential — with most services offered in the city of Prince Albert.

At the time of our audit, the Saskatchewan Health Authority planned to establish six integrated service areas within Saskatchewan for the delivery and management of health services as permitted under *The Provincial Health Authority Act*. The former P.A. Parkland Health Region was to be part of the northeast integrated service area.

Chapter 8 of our 2018 report volume 1, on pages 103 to 125, reports the results of our audit on the Saskatchewan Health Authority's processes for providing timely access to mental health and addiction services, formerly the responsibility of the P.A. Parkland Regional Health Authority. This chapter contains 10 new recommendations for the committee's consideration. We concluded that for the period from February 1st, 2017 to January 31st, 2018, the Saskatchewan Health Authority had, other than reflected in our 10 recommendations, effective processes to provide timely access to mental health and addiction services in the former P.A. Parkland Health Region.

[15:00]

I'll now focus my attention on the 10 recommendations. In our first recommendation, on page 113, we recommend the Saskatchewan Health Authority formally assess whether mental health and addiction services are meeting client demand and make adjustments where necessary in its northeast integrated service area.

The last time P.A. Parkland had evaluated its mental health and addictions program was 2007. At the time of the audit, the demand for mental health and addiction services offered by the P.A. Parkland Health Region was outpacing its ability to meet demand. For example, its 39 mental health in-patient beds located in Prince Albert hospital are frequently full, so 83.5 per cent occupancy rate in 2015-16 for 29 adult beds and 94.7 per cent occupancy rate for 10 child and youth beds. Its detox services, a 14-bed facility, regularly and increasingly turned away both brief and social detox clients due to capacity. In 2017, 44 per cent of its clients were refused. Visits to P.A. Parkland mental health outpatient services in 2016-17 increased over 20 per cent from the prior year. While demand for services was increasing, we found that the spending remained fairly constant

and there was minimal increases in staffing.

P.A. Parkland only offers in-patient services in Prince Albert, and it offers outpatient services in limited locations outside of the city. P.A. Parkland was unable to show us how the current locations of its outpatient services aligned with the demand for mental health and addiction services.

Our testing found P.A. Parkland did not always provide in-patient mental health and addiction services in a timely manner; for example, two of eight files of clients accessing care through ER waited a long time before being admitted into a mental health unit. With respect to outpatient services, we noted for the 2017 calendar year P.A. Parkland struggled to meet the wait time for adults and children wanting to see a psychiatrist, in part because three of its psychiatrist positions were vacant. In 2017 P.A. Parkland did not provide timely initial appointments to psychiatrists for youth clients with mild and moderate mental health illness severity levels. For youth clients with moderate-rated mental illness, 20 per cent had appointments within 20 days. So 20 days is the service response target. Eighty per cent did not. In addition, 14 per cent of the 28 mental health client files of clients accessing outpatient services waited longer than the triage rating would suggest.

A periodic comprehensive assessment for determining whether resources meet program objectives is good practice. Not doing a comprehensive reassessment of client demand, relative to mental health and addiction services available, increases the risk of not providing those with mental health illnesses and addictions with timely access to service. Not providing timely access can result in significant human and economic costs.

Our second recommendation, on page 113, we recommend that the Saskatchewan Health Authority implement a provincial integrated mental health record system to record services provided to mental health and addiction clients. P.A. Parkland manually records services it provides to mental health and addiction clients. Its clients can have multiple manual files located at different service areas: detox, mental health in-patient, mental health outpatient, addiction outpatient services.

P.A. Parkland manually tracks assessments and care provided to its mental health and addiction clients in the files, but it does not share the content of the manual files between its service areas. Having separate manual client files does not allow staff in the various service areas to access complete client information for consideration. Establishing one client file in an electronic format would ensure relevant and timely information is readily available for client care.

During our audit in January 2018, P.A. Parkland was participating in phase 1 of implementing a new IT system, the mental health and addiction information system developed by the Ministry of Health. Certain service areas, mental health outpatient services, was using the new IT system to document some client information. At January 2018 the ministry had not yet determined when the system would be in use province wide.

In our third recommendation, on page 114, we recommend the Saskatchewan Health Authority develop a strategy to collect key mental health and addictions client information from health care professionals for the provincially integrated mental health record system.

P.A. Parkland does not have access to information about the provision of all mental health and addiction services to its clients, those provided by fee-for-service general practitioners and psychiatrists, even though these services are publicly funded.

In 2016-17 fee-for-service psychiatrists provided services to over 1,900 clients in P.A. Parkland, and almost 12,000 clients saw general practitioners for mental health concerns. Effectively sharing information is integral for the coordination of mental health and addiction services. The completeness of the provincial record is contingent upon the willingness of those with client information — so general practitioners and psychiatrists — to share and use it.

In our fourth recommendation, on page 115, we recommend the Saskatchewan Health Authority identify and analyze clients who frequently use mental health and addiction services to determine how they might be better served in the northeast integrated service area. P.A. Parkland does not analyze how to reduce the number of readmissions or assess how best it can address needs of clients who frequently use its mental health and addictions services.

Our review of P.A. Parkland's stats found that it had a number of clients who frequently use its mental health and addiction services; for example, it had 48 brief detox clients who were admitted more than 10 times in 2017. In 2016-17, 169 mental health clients were readmitted to the hospital within 13 days of discharge. Nearly 1 in 10 mental health patients returned to the hospital within a month. Better addressing the needs of users with high overall usage of mental health and addiction services may reduce their usage and improve their health outcomes.

In our fifth recommendation, on page 120, we recommend that the Saskatchewan Health Authority collaborate with the Ministry of Social Services to enhance access to housing options for mental health and addiction clients. Between April 2016 and March 2017 the mental health in-patient unit had 14 clients that each stayed in a hospital for longer than 60 days, often because of difficulty in finding alternate places for these mental health clients to live. We noted 3 of the 14 clients who were waiting in hospital longer than 60 days would qualify for supported housing through the Ministry of Social Services, and 6 of the 14 clients were waiting for long-term care beds.

In addition, P.A. Parkland is aware that some of its detox clients with addiction issues have nowhere to go to sleep. For 2016-17 it had 802 detox stays where clients identified as homeless. Providing stable housing could lead to better outcomes for people living with complex mental health and addictions issues.

In our sixth recommendation, on page 121, we recommend the Saskatchewan Health Authority use a model to assist staff in better matching appropriate services to mental health and addiction clients' needs in the northeast integrated service area. As of January 2018, P.A. Parkland was in the early stages of using a new stepped care model available through the new IT system. A stepped care model seeks to treat clients at the lowest appropriate service tier in the first instance, only stepping up to intensive specialist services as clinically required. Use of such a system, as opposed to one-on-one treatment sessions, could

provide appropriate care while also better managing resources.

In our seventh recommendation, on page 122, we recommend the Saskatchewan Health Authority require staff to document post-detox support arranged for detox clients in the northeast integrated service area. While the P.A. Parkland detox centre admits clients and detoxes them, P.A. Parkland does not always guide clients to further treatment support after completion of the detox treatment program as its guidelines expected.

P.A. Parkland did not identify alternative services for social detox clients. Previously it would have referred them to a provincially contracted service for stabilization programming, but this program did not run in 2017. For all 13 client files we assessed that went through the detox program, we did not see evidence that P.A. Parkland connected the clients with further addiction services.

Successful addictions treatment has several steps besides just detoxification, including behavioural counselling and long-term follow-up to prevent relapse. Lack of planned post-detox support can increase the number of client readmissions and substance abuse relapses.

In our eighth recommendation, on page 123, we recommend the Saskatchewan Health Authority assess alternatives to decrease the number of mental health and addiction clients that don't show up for scheduled appointments or treatment in the northeast integrated service area. Our analysis found between 12 per cent and 39 per cent of clients didn't show up for scheduled appointments or treatments in 2016-17. P.A. Parkland does not take into account no-shows when scheduling their appointments. Missed appointments disrupt schedules, potentially leaving staff with gaps during the workday and wasting capacity. Alternatives to decrease the number of client no-shows could include contacting clients to remind them of their scheduled appointments by using text messages, phone calls, and automated phone calls.

In our ninth recommendation we recommend the Saskatchewan Health Authority document evidence of follow-up when clients do not maintain their scheduled mental health and addictions treatment in its northeast integrated service area. P.A. Parkland regularly deals with clients who do not interact with the region until months after their outpatient scheduled appointments. In certain instances the client is readmitted to the hospital for care.

Our testing of 60 files found some clients did not show up for their second appointment. We did not consistently see staff documenting evidence of follow-up with clients who missed their outpatient scheduled appointment. Timely follow-up to assess client health status can help to avoid future hospital visits and reduce overall cost to the client and health care system.

In our 10th recommendation, on page 124, we recommended the Saskatchewan Health Authority accurately track and report wait times to access outpatient mental health and addiction services in its northeast integrated service area. P.A. Parkland reports that it meets outpatient triage benchmarks 100 per cent of the time because it does provide same-day counselling appointments through its outpatient walk-in addictions and mental health clinics. While this is consistent with how other former health regions reported on mental health and addiction outpatient service wait times, it doesn't give an accurate picture. It does not consider the time outpatients wait for second and subsequent appointments.

Because P.A. Parkland does not track the time between the first and second appointments of outpatients seeking mental health and addiction services, we could not determine whether P.A. Parkland provided timely outpatient services beyond first appointment. For 4 of the 28 files we tested, the first appointment was not booked for the client within the time required by the triage rating, and each file did not indicate why. The lateness in booking the first appointment for these four clients ranged from 17 to 79 days late. These clients called to book an appointment instead of visiting a walk-in clinic, whereas if you walk in, clients will basically see a counsellor right away if they want.

Not accurately determining the length of time outpatients wait for a treatment increases the risks of patients not being treated in a timely manner and using incorrect information to make decisions about outpatient services. That concludes my overview of this chapter.

The Chair: — Thank you so much for the presentation on certainly an area that requires, you know, such important focus and shedding some light on some real challenges that exist. I'll open it up to folks for committee . . . or turn it over to officials, assistant deputy minister Wyatt and officials to respond and then open it up for questions.

Mr. Wyatt: — Thank you. This chapter is fairly recent, and so you'll find all of the recommendations are either at a stage of being partially implemented or not implemented, as work is getting under way.

So beginning with recommendation no. 1, we identify that as partially implemented. The SHA is continuing to take actions including reviewing caseloads and clinician appointment availability. Mental health and addiction outpatient services are being reviewed to better understand demand on services.

[15:15]

As well, the Saskatchewan Health Authority is continuing the implementation of the use of the LOCUS [Level of Care Utilization System] which is a level of care utilization scale tool in outpatient services. This work is expected to be complete by March 31st, 2019. The SHA is further implementing the stepped care model and using this framework to look for opportunities to further reduce wait times and provide the most appropriate service.

Recommendation no. 2, also partially implemented. The mental health and addiction information system has been implemented in outpatient mental health and addiction services. Both departments are using the LOCUS tool, which is embedded in the mental health and addiction information system at intake to determine services offered to clients.

The rollout of the MHAIS [mental health and addictions information system] has continued throughout 2018-19. In addition to continuing the roll-out of MHAIS, the provincial MHAIS clinical working group has prioritized the implementation of the provincial suicide protocol within the

electronic health record, which will further the use of the alerts section for risk of harm to self.

On recommendation no. 3, we report that as not implemented. The SHA is currently engaging with key stakeholders to determine how they are going to work with private physician offices and emergency departments to collect client information. This work is expected to be complete by March 31st of 2019.

On recommendation no. 4, we report that as partially implemented. Several key initiatives in the Prince Albert area will help the SHA better meet the needs of individuals with complex needs. As part of the new mental health investments in 2018-19, the SHA Prince Albert has implemented the police and crisis team in October 2018, the transition team as of December 2018, and the community recovery team in February of 2019 to serve clients with complex needs. As these teams have been newly implemented, their progress will be monitored into 2019-20.

On recommendation no. 5, this is not implemented. The SHA is currently working with the Ministry of Social Services to find placement for common clients on mental health in-patient units who are ready for discharge. This work continues on an individual basis. In addition to working with Social Services, the SHA continues to work collaboratively with Prince Albert and area community on research initiatives aimed at housing and homelessness.

Regarding recommendation no. 6, we report that as partially implemented. The SHA has implemented the LOCUS assessment tool as part of the MHAIS. This will ensure that clients are matched with the most appropriate service within the continuum of care. Based on assessment, further development and implementation of the stepped care model of services will occur.

Moving to recommendation no. 7, partially implemented. The SHA has implemented a client action plan process that provides documentation for post-detox support that has been arranged for detox clients. The SHA will develop standard processes to include documentation in client charts when clients refuse further services post-discharge. This work is expected to be complete by March 2019.

Recommendation no. 8 is not implemented. The SHA is investigating technology to support reminder texts and phone calls. The SHA plans to stage PDSAs, which are plan-do-study-act cycles, to determine if text or phone call reminder processes improve appointment attendance rates or if alternative methods would be more appropriate for clients. This work is expected to be complete by June 30th of 2019.

Recommendation 9 is not implemented. The SHA will develop a work standard that outlines processes and content of follow-up documentation for clients who do not attend service. This work is expected to be complete by June 30th of 2019.

In recommendation no. 10, we are reporting that as partially implemented. The SHA mental health outpatient services has changed how they are tracking outpatient statistics to more accurately reflect current state. The SHA is planning on expanding enhanced data tracking processes to include addiction services. Further work on corrective action planning will occur based on this enhanced information. Work-to-date metrics and standard processes for gathering and reporting wait times will also be influenced by the CIHI wait time indicator development. This work is expected to be completed by March 31st of 2019. And those conclude my remarks.

The Chair: — Thanks for the remarks and the work in this important area. I'll open up to questions. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. And thank you . . . There's a lot of recommendations and a lot of information here, so where to start? With recommendation no. 1, with the comment in the status update where it says the SHA is continuing to take action including reviewing caseloads and clinician appointment availability, is the SHA reviewing caseloads in just the northeast integrated service area or across the province?

Mr. McLetchie: — I think there's a particular attention to the northeast service area, particularly the Prince Albert group, but there are groups looking at this across the SHA.

Ms. Chartier: — Okay. Do you have . . . The only number I know is the Saskatoon caseloads. For outpatients to see an addictions counsellor, it's one addictions counsellor for about 250 patients at this point in time. Do we know what it is in the northeast integrated service area right now?

Mr. McLetchie: — We don't have a ratio actually for the northeast that we'd be able to give. I think we have number of patients seen, but we don't actually have it broken out into ratios.

Ms. Chartier: — Okay. So just in terms of I guess finding out what you are reviewing for caseloads, so are you . . . Can you tell me what metrics you're looking for, like what you're reviewing for caseloads? Is it addictions counsellors? Is it addictions physicians? I just am wondering what caseloads you're reviewing.

Mr. McLetchie: — There's a bit of a review of all of those kind of different measures. Right now they're looking at both mental health nursing, kind of general mental health supports that are out there. There's addictions counsellors and they also have a harm reduction clinic in Prince Albert that's being looked at. And I think it's as well an addictions physician group is sort of started and they're at the early stages of trying to figure out how they best utilize that skill set. And I don't know that they're actually looking at the caseload for those individuals, but they are supporting the broader team.

Ms. Chartier: — Okay. So you're reviewing the mental health nursing caseloads, addictions counsellors caseloads, the caseload at the harm reduction clinic, and trying to figure out how best to utilize the addiction physician group. Is there any other measure, anything else being reviewed? Psychiatry?

Mr. McLetchie: — Yes, psychiatry would definitely be another one that's in there.

Ms. Chartier: — Do we have numbers for any of those things? So you said you don't have caseloads at this point in time. You've got numbers of visits?

Mr. McLetchie: — Unfortunately I don't have the stats with me as to where we're at in terms of the program. The work that I'm aware of is focusing on how they're using the LOCUS system and looking at the different levels of care needs that are there, and how the team structure is structured and how it could be better structured in order to ensure people are getting the care they need in the right environment and by the right staff member.

Ms. Chartier: — Okay, I'm just curious. And I understand now, as the auditor has just flagged for me, you have paper records — or they're manual records — so that creates a problem in data. And now I understand why the other recommendations are there. That makes good sense.

But it does say in your actions to implement an overall review of mental health and addictions outpatient services and take actions, including reviewing caseloads. So I understand that this will be done by the end of March, a month from now.

Mr. McLetchie: — I think that that's the hope, is that we'll have a certain amount of this done. I am not sure where we're at in terms of actually achieving that target.

Ms. Chartier: — Will it be a public document, the review?

Mr. McLetchie: — No. The intention was to use it more as a quality improvement document, internal, to improve our flow and to have something that we would gauge our future practice against.

Ms. Chartier: — I'm just trying to get a handle on . . . Like I said I've got some numbers from other places and I'm just trying to get a handle on what it looks like in the northeast service area right now. So in terms of, say, psychiatrists then serving the area, so you had three vacancies and they were filled, or two of them were filled but there was a challenge accessing a youth psychiatrist. Have you resolved that issue or where are you at with psychiatrists and vacancies?

Mr. McLetchie: — Yes. The child and youth position is still vacant and I think there is a challenge across the province with hiring child and youth psychiatrists.

Ms. Chartier: — So what happens if . . . Do children and youth then see the adult psychiatrist or do they get referred out of the area then?

Mr. McLetchie: — It's a bit of a mixed thing. Most of them will see one of the other psychiatrists in Prince Albert, but there's some referrals that are going to the child and youth psychiatrists in Saskatoon primarily.

Ms Chartier: — Saskatoon. And what is the wait time to see a psychiatrist then? So I know in the benchmarks you had 53 . . . So there was a challenge meeting the mild and moderate, but even with the very severe, only 53 per cent of very severe were meeting the benchmark. So I'm just wondering where we're at here in 2019 with kids, particularly children and youth, being able to access psychiatry.

[15:30]

Mr. McLetchie: — Unfortunately I don't think we have the actual time that people are waiting. We do have a stat that's more based on the severity of their assessment. Are they being seen in the timelines set by the province? And so basically if you're very severe, or your mental health condition is deemed very severe, you are seen within the target time. The severe clients are seen . . . Three-quarters of them were seen in the appropriate time. For the mild and moderate, I think this shows where we have a lack of capacity because for the moderate only 17 per cent and the mild only 12 per cent are seen in the appropriate time.

Ms. Chartier: — Thank you. And that's for children and youth?

Mr. McLetchie: — Sure.

Ms. Chartier: — Okay. Before we move on here, I'm not familiar with the LOCUS. Can you just tell me what the LOCUS is?

Mr. McLetchie: — It's a mental health assessment tool that looks at the level of care utilization, so the best way of providing services to clients and what the service level that they would need to meet their needs would be.

Ms. Chartier: — So someone would present and then they would find out if they . . . I need to see a psychiatrist. It might involve meds. Or it's mild and I might be able to just see — or not just — but see a social worker or a community mental health nurse, that kind of triaging. Is that what we . . . Am I understanding that?

Ms. Willerth: — It's Kathy Willerth from the Ministry of Health. So the LOCUS is one of the tools that we've embedded in the mental health and addictions information system. And it is a tool that measures client severity, so client need, and matches it to services available. So it really looks at the point of time that people are either calling intake or coming in asking for service, what are their needs, and it does it in a standardized way. So for the province it's the first time we'll be able to, across the province, be able to assess people's needs in the same way, you know, across the whole Saskatchewan Health Authority. So you're right, it is a tool that measures the severity of the needs, which is really a triage system. So it helps to say, people who are coming in need, you know, this kind of service, and so we don't overserve or underserve but are able to match services to the level of needs.

Ms. Chartier: — Thank you for that. So that is being used province wide then or will be used province wide?

Ms. Willerth: — We're in the implementation phase. So I think the report talks about where P.A. was at at the time, which was pretty early days. They've been working on that throughout '18-19. So it had been introduced in Prince Albert Parkland. It is being embedded throughout the number of programs. It takes a fair bit of time and support to be able to get it embedded both deep and wide.

Ms. Chartier: — I just am going back to the previous question about access to psychiatry. So I'm just . . . Do we have a sense of numbers? You said it was a bit of a mix where children and youth would either see the adult psychiatrist or be sent to Saskatoon. Do we have a number on, like a most recent number on how many kids have had to travel to see a psychiatrist in Saskatoon?

Mr. McLetchie: — [Inaudible] . . . that number myself. I could look it up and get it at another point.

Ms. Chartier: — Okay. I will perhaps maybe sit down and write some written questions for that. That might get at some of that for you. Yes, thank you.

So in terms of the review that's going on right now, what is . . . So a review of mental health and addictions services hadn't happened since about 2007, I think the auditor had said. What are you finding has changed in the landscape of addictions since that time? And when did we start to see the increase, or when did we start to see things perhaps ramp up? So what are we seeing that's different than in that time when the last review took place?

Ms. Willerth: — So since the 2007 review that Prince Albert Parkland did on mental health and addictions, we have, as a province, launched the mental health and addiction action plan. So that plan really talks about an all-of-government approach, you know, that there are many sectors that have a role to play in improving mental health and addictions, and that would be very relevant for the northeast or the former Prince Albert Parkland Regional Health Authority as well.

So those, you know, some of the investments that you are well aware of, that announcements have come out, have been really important for the northeast area. The new treatment centres that predate the action plan have been a really important investment in the northeast area as well, including the Family Treatment Centre, which is commented on in the review; the brief and social detox being a new facility in the treatment centre as well.

So the action plan investments in the North included the earlier reference to the addictions medicine, which is, you know, really improving the physician response to folks who have significant addictions issues. The community recovery teams, the PACT [police and crisis team] teams, and the child and youth investment as well.

So there's been significant improvements, including, I think, that multi-sectoral approach has been important to the former Prince Albert Parkland as well. So they have a number of committees where they've looked at where they could work together to improve a common client's outcomes.

Ms. Chartier: — Thank you for that and that's all very good work. I'm just wondering in terms of the landscape and in terms of addictions and how things have changed. You talk to any police service and they'll tell you — since 2013, crystal meth. Every crime stat that trended down for 15 years started to tick up, all due to crystal meth.

So I'm wondering if in the northeast region, if in your review right now and through experience if you're seeing crystal meth and opioids obviously. I think we're a little further behind other provinces but I'm sure it'll . . . We've had some deaths. But crystal meth, from my understanding, is the real issue, and I'm wondering if that is the case in the northeast region as well.

Mr. McLetchie: — I think definitely there has been a certain amount of drugs and that in the northeast and in the Prince Albert area and I believe — I don't have actually have the figures here with me — but I believe they are seeing an increasing presentation of it. Often that's impacting the ERs rather than kind of the detox facilities. And in many ways alcohol still remains the primary driver of the services. The percentages of people presenting with alcohol-related addictions issues are much greater than those that are currently presenting with drug addictions.

Ms. Chartier: — You're noticing though that those who present it at the hospital or get admitted for mental health issues often are . . . I know in other parts of the province that's gone up, that the number of people who will mention crystal meth use has gone up in other parts of the province. And I'm wondering if that's the same case when people are admitted to your acute psychiatric facility.

Mr. McLetchie: — Yes, there has been an increase in numbers. Again I don't actually have the figures there. I know from conversations I've had with a couple of the psychiatrists that crystal meth has presented a bit of a challenge because it's often . . . It's a time-limited kind of psychosis that kind of comes from it and so the environment of putting them just into the regular mental health ward while they're recovering from it isn't . . . The type of services they require are slightly different. And so there is a bit of work looking and saying, what's the right method to best meet that clientele's needs?

Ms. Chartier: — Thank you for that . . . [inaudible interjection] . . . Sorry, sorry I forgot.

The Chair: — No, it's an important . . . I don't want to break the line of questioning. And I'll bring it over to Mr. Weekes. Just a point though that the auditor does detail on page 111 that one-third of addictions clients also abuse opioids or crystal meth. So I don't know where that trend has gone but certainly that's very substantial. I'll pass it over to Mr. Weekes.

Mr. Weekes: — Sure. Thanks to Ms. Chartier for letting me in. Just one question to the Provincial Auditor. This chapter 8 is about timely access to mental health and addiction services in the P.A. Parkland portion of the new Saskatchewan Health Authority. I was wondering, do you have a plan and a timeline to audit the rest of the province really in this area as well?

Ms. Ferguson: — This is probably one where we'll look to see how the Health Authority and I think the ministry jointly are responding and then go from there in terms of whether or not they're taking a targeted piece for the service area up north or if it's going to be, you know, they're taking on a broader approach.

So I think for us it'll be a little bit of a wait and see. We'll gather the information and then make the assessment at a later point in time, you know. So in saying that, you can see that as an office we do a rolling three-year plan. It's not on the next slate of the rolling three-year plan. We'll use the results of our follow-up here to gain information in that regard.

Mr. Weekes: — Thank you.

The Chair: — That's it, Mr. Weekes? Back to Ms. Chartier.

Ms. Chartier: — I will go to recommendation 5 here around housing. And we heard just in the auditor's report the challenge with people being readmitted shortly after discharge. We heard

about multiple admissions, those kinds of things; people staying longer than 60 days in the acute psychiatric beds.

I know in, I think it was in 2013 there was a report from both the Health ministry and the then Prairie North Health Region on the need for obviously rebuilding the North Battleford hospital, but developing 120 step-down beds, which would deal with some supported housing to . . . And some of them were to be allotted for Prince Albert or that neck of the woods. So I'm wondering where we're at with . . . That was a key part of the rebuild of the Saskatchewan Hospital. So I'm just wondering where we're at with those 120 step-down beds.

[15:45]

Ms. Kratzig: — Hi, it's Kimberly Kratzig again. Just in response to your question about the Saskatchewan Hospital North Battleford and the 120 beds that had been contemplated at one time, I think that it is recognized that work needs to be done to ensure that there are appropriate step-down options for people to keep the flow moving in and out of our . . . not only SHNB [Saskatchewan Hospital North Battleford] but also our in-patient acute facilities as well. I think that when we had a discussion in Committee on Human Services not that long ago, the minister may have talked about the federal bilateral document that is public that does talk about, you know, the desire to move in that direction. But we have not had any formal announcements about any of those community residential supports.

Ms. Chartier: — And obviously it's not in this budget cycle, like in the 2018-19. That wasn't part, if I recall correctly, it was not part of the 9.2 from the feds.

Ms. Kratzig: — Yes, that's correct.

Ms. Chartier: — Okay. You know what? I think I will pass this off to anybody else. I know that the day is growing short and there's more to do here, but I think I'm going to just sit down and write some written questions so that it might be easier. I know it's always hard when you come and we ask questions that you haven't anticipated and don't have the information. So I'll endeavour to do that when session starts. So thank you for your time.

The Chair: — Ms. Mowat? Anyone else? And thanks again for the attention here. I think . . . Thank you to the auditor's office for placing a light on an area that's so important and so critical, and I think Mr. Weekes's comments were important ones around the focus right across the province. And without a doubt I think that, you know, these are matters that are, you know, sort of close to all of us because we serve many that are in vulnerable circumstances. And certainly in the region we're speaking of, I know I can speak personally that I've had a lot of meetings with folks in through that region who really feel that we have a system that's failing them.

But I don't want to . . . At this table here I know that the debate is a different one than with ministers who are there making choices around resources and the plans on that front. So I just want to say thank you to the officials that are working in this area, as well as all the partners and all those providing service in the area. Because I know as well, it can be incredibly challenging for those that are out there doing all they can, possibly without a system organized with the attention or support that it allows them to be as effective as they can be as well. Ms. Chartier?

Ms. Chartier: — Sorry, my apologies. I do have one more question. This reminded me. Last year some of the money from the fed, you mentioned the bilateral agreement and some of the money was carried forward to this fiscal year and obviously . . . There was $9.2 million from the feds. I'm just wondering if all that's been spent. I know we've seen rollouts just recently of those dollars and I'm wondering what it's looking like. Have those dollars been spent this fiscal year?

Ms. Kratzig: — So just as a bit of a reminder, in the '18-19 budget we announced $11.42 million in federal and provincial investments. All of the initiatives that were announced, I think all of them have now been implemented in terms of funding has been allocated to the Saskatchewan Health Authority for new child and adolescent clinicians and specialist positions. We have launched the . . . Actually there is an announcement coming up to sort of formally announce the mental health capacity building in schools, which is one of the pilots that was announced at the budget time and recommended by the Children's Advocate or the Advocate for Children and Youth.

There has been a targeted physician training program implemented to improve the capacity for general practitioners to work and treat child and youth mental health conditions. We know that most people go to their family physician to begin with, so this has been a successful program. And we've also continued expansion of our suicide prevention demonstration sites with the Mental Health Commission of Canada. So all of that has been implemented.

In terms of the community recovery teams, which I think was what you may have been alluding to, eight communities in Saskatchewan have now . . . They have either launched or are in the process of launching, quite literally, within the next week, their teams. So that's about 40 FTEs. And that's really something that we expect in the Prince Albert area will have a big difference, because this is teams providing wraparound services to those very complex and persistent . . . individuals with complex and persistent mental illness.

We have launched the new PACT teams in North Battleford, Moose Jaw, and Yorkton, so that has happened as well. We've also expanded the addictions medicine service that we talked about earlier in Prince Albert and northern Saskatchewan. So that's in place. And we have increased access to mental health first aid.

So again, all of those dollars have been allocated. We had another pool of money that was looking at expanding the ICBT [internet-based cognitive behavioural therapy], or the internet cognitive-based therapy that the University of Regina is sort of a leader in the country on, and we've seen, you know, good success there as well. So that has happened. And there has been an investment made.

The auditor's report raises lots of observations about the importance of the mental health and addictions information system. So there was funding in the '18-19 budget as well that has been allocated to continue that move out. So again, all of the dollars have been, or all of the initiatives have been implemented.

In terms of all of the dollars, the timing of some of the initiatives starting a bit mid-year or later in the year might mean that we do have some opportunity to provide some additional support, one-time support in areas. So we're just in the process of assessing whether that money sort of continues. It'll be used one way or the other, either towards the initiatives, or a bit of one-time support in different areas where the need is. As we know, there's lots of needs, so we certainly want to ensure that all those dollars are spent.

Ms. Chartier: — Thank you very much. I appreciate that and thank you for your time today.

The Chair: — Not seeing any more questions. Thanks again for all the work that's going to continue in these areas. Looking at the recommendations, I believe recommendations 1, 2, 4, 6, 7, and 10 could be treated with one motion noting concurrence and progress. Ms. Lambert. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay. So that's carried. Looking at recommendations 3, 5, 8, and 9, I think we could simply concur with those recommendations. Moved by Ms. Lambert. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll recess. I guess at this point, just thank you very much to ADM Wyatt and all of the Health officials that are here today. Those that have also departed already, thanks so much for your time here. It's been a long day, I know, in this committee. Thanks for your engagement with the questions that were brought and all of the work that all of you are engaged in . . . [inaudible interjection] . . . And I just, I'm having it noted to me that we maybe didn't deal with recommendation no. 10. I thought I identified that. I maybe didn't read it in on the . . . That would be included with progress, I think. So just to be certain, with respect to recommendation no. 10 and note progress was noted. Would somebody care to move? Mr. Goudy would move that we concur and note progress. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. So just thanks very much again. I suspect there's others that might want to pass a good word. Just thanks for all the time here today. Thanks for all the work and all the partners across the province and for the important work that'll go on in the days to come.

Mr. Wyatt: — Could I also thank the members of the committee, thank the Provincial Auditor's office for their work with the ministry and with the system, and to convey my thanks to all the people who attended today. But also there are others who assist on a daily basis, both with relation to the recommendations that we're discussing but also in helping to prepare those of us who are attending committee. So I just want to convey that to all of our teams, both within the ministry, the Health Authority, Cancer Agency, and eHealth Saskatchewan.

The Chair: — Deputy Chair McMorris.

Mr. McMorris: — I would just also like to echo a thank you, first of all to the auditors for the work that they've done to identify the different issues that need to be addressed. And just as importantly, from the ministry and the Health Authority that have taken those recommendations seriously, implemented most.

Some of them that haven't been implemented is because they're quite new, and it's not that . . . you know, just from the work that has been conveyed over the last however many hours we've been in here, that you don't take any of them lightly, that you work very hard to implement them, and that shows the system is working very well, both from the auditor's perspective but especially from the ministry and the Health Authority's perspective. So thank you very much.

The Chair: — Thank you. With that, we'll recess for a very brief, few minute health break, and we'll line up Finance for some tough questions.

[The committee recessed for a period of time.]

Finance

The Chair: — All right, we'll reconvene the Standing Committee on Public Accounts. And we'll welcome at this point officials of the Ministry of Finance. Thank you so much for taking time with us here today. I know we have Deputy Minister Pandya with us here today as well as many other senior officials. Thanks for joining us. We know it's a busy time in your world right now as well, so thanks for the time before the committee. I'll maybe get Deputy Minister Pandya to briefly introduce the officials that are with him here and then we'll come back to the presentation of the auditor.

Mr. Pandya: — Thank you, Mr. Chair. Good afternoon, members. I'd like to start by introducing my officials. Here with me today is Denise Macza who's the associate deputy minister of the treasury management branch and the treasury board branch. To my left is Karen Lautsch who's the assistant deputy minister of corporate services. Brianna Verhelst is sitting in for Deanna Bergbusch who's the assistant deputy minister of the office of planning, performance, and improvement. Brent Hebert, to my right, is the assistant deputy minister of revenue. Arun Srinivas is the assistant deputy minister of taxation and intergovernmental affairs. Terry Paton is the Provincial Comptroller. Chris Bayda is the assistant provincial comptroller. And Joanne Brockman is the executive director of economic and fiscal policy.

I'd like to just start by thanking the Provincial Auditor and her staff for all of their work and for their constructive approach in addressing all of the questions raised in the context of these audits. Today we'll be covering five chapters, as I understand it: two chapters contained in volume 1 and 2 from 2017 and three chapters from volume 1 and 2 in 2018. I'll note that there are several items that are carried over in 2017 from 2016 recommendations. Those are contained in Finance, 2017, chapter 3 and 2018, chapter 5. Those are very similar chapters and I'll just note that for the information of committee members.

So the summary documentation that we've provided outlines progress made on all of the recommendations. So rather than going over all of that information contained in the summary, I'd be happy to take any questions that you may have.

The Chair: — Thank you. Thank so much. And we'll also be tabling the status update that you provided, so thank you so very much. And at this point we will do that and I'll table PAC 70-28, Ministry of Finance — Status Update, February 26, 2019.

We're going to break the chapters apart for consideration. We're going to first consider chapter 5 of the 2017 volume 1 report. And I'll turn it over to the Provincial Auditor and her office to make presentation and then we'll flip it your way.

Ms. Ferguson: — Thank you, Mr. Chair, Deputy Chair, members, and officials. I just want to introduce Ms. Melanie Heebner that's our principal within our office who works within the Ministry of Finance and is actually responsible for the Ministry of Finance annual audit. So she's well positioned to be here with us today. And Kim has removed her Health hat and she retains her PAC liaison hat behind us here.

I'll take a moment to thank the deputy minister of Finance and the officials for the co-operation extended to our office during the course of this work. The Chair's laid out the manner in which we're going to present. I just want to highlight, just so that the rest of the members know, that we are going to combine the next two chapters, the 2017 volume 1, chapter 3 and 2018 volume 1, chapter 5 together into this single presentation and then the other two will be separate presentations.

So Ms. Heebner is going to make the presentation before us on this first chapter, on RAMP [revenue administration modernization project]. It contains two new recommendations for the committee's consideration.

Ms. Heebner: — Thank you. The Ministry of Finance administers many types of taxation revenue such as provincial sales tax and tobacco tax. Since 2014 the ministry has been updating its taxation revenue administration processes including related IT systems. It refers to this initiative as RAMP, the revenue administration modernization project.

The ministry planned to implement RAMP in four phases at a cost of $35.5 million. Chapter 5 in our 2017 report volume 1, starting on page 55, reports on the results of our audit of the ministry's processes during the 12-month period ended January 2017 for managing the implementation of RAMP. We found it had effective processes other than two areas reflected in our two new recommendations. I will focus my presentation on each recommendation and explain why we made it.

On page 61 we recommend that the Ministry of Finance establish how and when it will measure and report to stakeholders about the benefits achieved from its revenue administration modernization project.

The ministry had not started reporting on expected benefits to its stakeholders nor established what information on expected benefits it would report, how often, and when. By January 2017 the ministry had identified some but not all information necessary for measuring and reporting on expected benefits. In addition it had determined some but not all baselines and targets for its expected benefits set out in the RAMP business case. Without establishing processes, the risk of the ministry not accurately measuring the benefits of implementing RAMP and demonstrating that RAMP achieved the productivity, revenue, and efficiency gains set out in the business case increases.

On page 63 we recommend that the Ministry of Finance report all costs incurred when reporting on its revenue administration and modernization project. We found that monthly reports included information about costs, but the costs did not reflect all of the costs incurred to the date of the report. They did not include costs incurred but not yet recorded in its financial records.

For example, we found one monthly report did not include point six hundred million of one million in costs. Management told us they gave verbal updates to the steering committee on total costs upon request. Minutes of steering committee meetings did not provide evidence of verbal updates on total costs. Not reporting complete cost information about the project decreases the ministry's ability to properly monitor costs and may result in inappropriate decisions about the financial status of the project. That concludes my overview of this chapter.

The Chair: — Thank you for the presentation. I'll turn it over to Deputy Minister Pandya for a brief response, then open it up for questions.

Mr. Pandya: — Thank you, Mr. Chair. I would note with respect to the second recommendation that with regard to Finance reporting all costs incurred when reporting on revenue on the revenue administration project, that we concur with the recommendation and we've implemented changes effective May 17, 2017. I would note just for the information of committee members that that was an issue of timing with respect to that meeting, and we've now put in place processes to ensure that there is a timely update on project costing that goes into the steering committee.

With respect to the benefit realization plan that was prepared for the project, as part of the project plan, we have always contemplated further refining those project metrics as part of our final release date, and we are happy to speak to those in any detail if there's any questions about that.

The Chair: — Thank you very much. A little bit of ice in my throat there, sorry. I'll open it up for questions. Ms. Mowat.

Ms. Mowat: — Thank you very much. I've just got a couple of quick questions here. In terms of the RAMP project, can you just speak a little bit to progress to date? Did it follow the expected timelines? Did it follow the expected budget?

Mr. Pandya: — Yes, the project is currently on time and on budget, and I have Assistant Deputy Minister Hebert with me if you'd like any other details in terms of the evolution of the project.

Ms. Mowat: — Okay. So figure 2 on page 57 sort of outlines the expected completion date for different components. I'm to understand that those were completed as expected on that table?

Mr. Hebert: — Yes, all of those components have been implemented with exception to the two: the taxpayer services portal and the international fuel tax agreement which was added into the project into this year. Those will be completed by the end of March.

Ms. Mowat: — Okay. And what's the rationale for the delay on those pieces?

Mr. Hebert: — The delay was, partway through the project we were asked to administer education property tax. And so that wasn't contemplated when we began the project. And so we implemented education property tax as part of this project and it delayed the completion of it to the end of this fiscal year to accommodate that request.

Ms. Mowat: — Okay, thank you. And I don't think I have any other questions that haven't been answered already, so that concludes my questions for this chapter, Mr. Chair.

The Chair: — Any other questions from committee members? Not seeing any, I think with respect to recommendation 1, I'd certainly welcome a motion that we concur and note progress. Mr. Weekes.

Mr. Weekes: — So moved.

The Chair: — Places. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. With respect to recommendation no. 2, I would welcome a motion that we concur and note compliance. Mr. McMorris. All agreed?

Some Hon. Members: — Agreed.

The Chair: — And that's carried. And I'm just told . . . I think we had a couple of technical issues, so we just have to take a very brief recess to figure out what's going on.

[The committee recessed for a period of time.]

[16:15]

The Chair: — Okay, it seems that we've worked out the technical glitches here with the camera system there. We'll move along now and, as was mentioned by the auditor, we'll treat the next two chapters together as a package and that would be the 2017 report volume 2, chapter 3, and the 2018 report volume 2, chapter 5. And I'll turn it over to the auditor's office.

Ms. Heebner: — Chapter 3 in our 2017 report volume 2, starting on page 25, and chapter 5 in our 2018 report volume 2, starting on page 31, report the results of our 2017 and 2018 annual integrated audits of the Ministry of Finance and its agencies respectively.

These chapters contain two new recommendations along with an update on the status of previous recommendations. I will focus my presentation on the two new recommendations for the committee's consideration.

On page 31 of chapter 3 in our 2017 report volume 2, we recommend that the Ministry of Finance, through working with others responsible for public reporting of losses, for example the Crown Investments Corporation of Saskatchewan and the ministries of Health and Education, clarify the nature of losses of public money and property to report publicly.

We found that the content of public reporting of incidents of losses was inconsistent across the government. Since 2006 treasury board has required public quarterly reporting of incidents of losses that ministries and treasury board Crown agencies report to the Ministry of Finance.

Provincial Comptroller directives in place in 2017 required the Provincial Comptroller to report to the Standing Committee on Public Accounts losses of money and property over $500 due to fraud or similar illegal acts by employees or fraud by third parties that ministries and treasury board Crowns have reported. Other agencies, including the Ministry of Education, the Ministry of Health, and the Crown Investments Corporation of Saskatchewan, are also responsible for publicly reporting losses.

Like these other agencies, Finance publicly reported losses of public money and property over $500 due to known or suspected theft by employees and contractors. However, unlike these other agencies, we found that Finance did not publicly report losses due to theft by parties external to the government. The public and legislators may assume that the government consistently publicly reports all losses resulting from known or suspected fraud or similar illegal acts.

As reported in our 2018 report volume 2, Finance amended its directive regarding public reporting of losses of public money to clearly not require public reporting of losses due to unknown third parties. It communicated this change to other agencies responsible for public reporting of losses.

On page 37 of chapter 5 in our 2018 report volume 2, we recommend that the Ministry of Finance perform regular reviews of its user accounts for its key tax revenue IT system. Finance started using its new tax revenue system in 2016. During 2017-18 Finance implemented the second of four phases of this new system. However by March 2018, Finance had not yet established a process to regularly review user access for the system to assess that user access was appropriate. This concludes my overview of these two chapters.

The Chair: — Thanks for the focus of your work and for the presentation. I'll turn it over to Deputy Minister Pandya and officials for a brief response and then open it up.

Mr. Pandya: — Thank you, Mr. Chair. I would note with respect to public loss that the ministry agrees with the recommendation, has issued clarification as noted by Provincial Auditor's office. And I would note with respect to the second new recommendation that we've implemented a new policy within the Ministry of Finance to ensure that there is timely removal of user access. I'll be happy to take any questions.

The Chair: — Thank you. Opening it up to committee members for questions. Ms. Mowat.

Ms. Mowat: — Thank you very much for the presentation and response. With regards to the first chapter — I'm looking on page 29 of chapter 3 — there's reporting here in the fourth paragraph: the law requires us to report when a special warrant approved the payment of public money. For the year ended March 31, 2017, cabinet approved, through orders in council or special warrants, spending of 1.1 billion. The Legislative Assembly later approved these amounts through appropriation Acts. I'm wondering what

was the total value of special warrant funding in 2017-2018.

Oh sorry, we found it . . .

A Member: — The 1.1, is that the number you found?

Ms. Mowat: — 0.1

A Member: — Oh, okay.

Ms. Mowat: — So we found the answer in the next chapter, for the folks who are following along diligently at home. I was looking for it earlier, didn't find it, so thank you very much. And thanks to the auditor's office for answering the question.

I'm on page 30 now. There's discussion about, on October 2017 finance was working on changes to the Provincial Comptroller's directives to clarify public loss reporting requirements. Are there policy changes that have resulted from this?

Mr. Paton: — Yes, there were policy. . . actually clarification to policies, the way I would word it, and that clarification was issued last year.

Ms. Mowat: — Can you provide a little bit of detail on that?

Mr. Paton: — Yes I can. This policy goes back a number of years, in fact, back to I think 2005-06 where there were a couple of fairly major frauds that occurred in government, and they were employee related. At that time government approved a policy that would require reporting of losses to this committee on a regular basis. And we've been doing that ever since 2006, I believe.

The policy was developed primarily to report on employee losses where there was fraud by either employees, contractors, or suppliers of government. And we've been reporting on that basis consistently for the last 10, 12 years. Recently the auditor reviewed that chapter and I guess the actual wording of the policy, and in their view the interpretation of the word "fraud" indicated that it would be broader than just what treasury board had kind of anticipated. So the policy that we've clarified now reflects what we believe treasury board intended back in 2005-2006. So the frauds that we have been and will continue to report at this time relate to employee fraud where there's either employees involved, subcontractors, or suppliers of government services.

Ms. Mowat: — Thank you. On page 32 under "Timely Determination of Disaster Recovery Requirements Needed," the auditor notes that as of August 2017, Finance did not know if Central Services could recover certain of its other critical IT systems that Central Services hosts. And it said that this contrasts with the activity related to Finance's other critical IT systems. Are these other critical IT systems hosted internally?

Mr. Pandya: — Yes, they are. So the recommendation specifically refers to disaster recovery plans for the debt and investment systems, and those are hosted internally in the Ministry of Finance. In terms of the summary document that we provided to the Chair at the outset of these discussions, we noted as part of our planned actions going forward that we're planning for replacements of these applications, and that's planned to occur in 2019-20. So the debt system, the money market system, and the sinking fund system.

So the new applications will be required to have disaster recovery capability. Those systems are past useful life and we've deemed through working with the Central Services ITD [information technology division] division that it's not cost-effective to put in place a new disaster recovery for those systems. What we have done is we've mitigated the risk in terms of disaster recovery by ensuring that we'll have access to all of the taped backup data with respect to those in-house systems should there be any sort of a negative event.

Ms. Mowat: — Thank you. I also have a question about the quarterly estimates on resource surcharge revenue. So I understand that the model for potash and uranium provided reliable annual estimates but not quarterly estimates. I'm wondering, is there an appetite to find a model that . . . Like is this a priority or is it sort of seen as something that is going to be liveable for now because the annual estimates seem to be working out? Just wondering what the folks in the ministry's perspective is on these quarterly . . .

Mr. Pandya: — I have ADM Hebert joining me but maybe I can just open by answering the question that, you know, having reliable estimates as part of our budget-making process is important, and that we are certainly focused on annual estimation. And I think as you know, for potash, etc., that we have in place what we believe to be good workable annual estimation models.

The volatility with oil and gas has been something that's been particularly challenging for us in terms of doing quarterly modelling. So we'll focus . . . As a ministry we've agreed that we'll focus on year-end estimation models and that we're not planning on doing any additional work on quarterly estimation models. We've done a significant amount of work on those models.

And you know, you just have to pick up a newspaper, look at what's happened in oil and gas over the last year and just know that every single model we would have told you would have been inaccurate. But year over year those models are, you know, there's a greater level of surety. But maybe I could have . . . If you have any follow-up questions, I'll have Mr. Hebert respond.

Ms. Mowat: — I think that's fine. I was just curious as to what your perspective was on it and that makes sense to me. It's working better than a crystal ball I suppose. And you know, like . . . And I make light of it but I understand that it's quite complex models that are being used here so I appreciate everything there. I think that's all I have for questions on these chapters, Mr. Chair.

The Chair: — Thank you for the questions. Thank you for the response. Does anyone else have questions with respect to the chapters before us? Mr. Michelson.

Mr. Michelson: — Just one thing. And you did make reference to it, I think it's on page 33, following processes to remove unneeded user access. Can you just explain how that was done? Because this has been something that's been dogging us for a number of years, of trying to get people off the user system when they move or leave.

Mr. Pandya: — Thank you for the question. So you're quite right, this has been a perennial issue, I would suggest, probably across every ministry of the government. And we have been working within the Ministry of Finance to comply with central direction from Central Services ITD in terms of deregistration of users. There's a one-day, currently a one-day standard; so one day, you know, after somebody leaves the ministry they are required to be deregistered from all of our IT systems. And although that standard has been in place across the Government of Saskatchewan, you know, ministries will have greater and lesser degrees of success with compliance.

And I would respectfully submit, I think that the fundamental issue is around education and awareness in terms of making sure that, at the front line, supervisors know that they are responsible for ensuring staff that are leaving the ministry that there's a process engaged in advance of those staff leaving, that they are deregistered, an application for deregistration is put through Central Services.

As I said in my opening comments, we've based on this latest work, in terms of Ministry of Finance's success on this initiative, I've implemented ministry wide a new deregistration guidelines that supplement the Central Services ITD guidelines. And what we're doing is we'll make sure that not only are supervisors, you know, made aware of this. I've issued a ministry-wide email on this question. Not only are supervisors made aware of their responsibilities in this regard, but ultimately we'll hold executive leadership team within the Ministry of Finance responsible and accountable for ensuring that supervisors within the various divisions of Finance are compliant with the policy.

Mr. Michelson: — As far as I know, there's been no big issues about it. But it certainly opens a door, so I'm glad to see it's addressed. Thank you.

The Chair: — Any other questions at this point? Not seeing any, we have two recommendations that are new here that we need to vote on, one from each of the respective chapters. The first one, it's been stated, has been fully implemented. So I'd welcome a motion that we concur and note compliance.

Mr. Michelson: — I would so move that we concur and note compliance.

The Chair: — Mr. Michelson moves. All agreed?

Some Hon. Members: — Agreed.

[16:30]

The Chair: — That's carried, and that's with respect to recommendation 1 from the 2017 volume 2 report, chapter 3. With respect to the other new recommendation — that would be the 2018 volume 2 report, chapter 5 — I think we can note progress there. So I'd welcome a motion along those lines. Mr. Goudy. We concur and note progress with respect to recommendation no. 1. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll conclude consideration of chapters 3 and 5, and we'll move along to chapter 19 of the 2018 volume 1 report. And I'll flip it over to the auditor's office.

Ms. Heebner: — Thank you, Mr. Chair. Chapter 19 of our 2018 report volume 1, starting on page 241, reports the results of our second follow-up of Finance's actions on recommendations about internal audit in ministries we initially made in our 2012 report volume 2, chapter 30.

By December 2017 the ministry had implemented five of the remaining six recommendations. It evaluated various organization models for internal audit and collaborated with ministries on methodology and tools to support risk-based internal audit planning. The Ministry of Finance also worked with ministries to implement appropriate internal audit reporting structures to support effective internal audit, ensure that internal auditors have appropriate competencies, and develop risk-based internal audit plans.

However, by December 2017 ministries with an internal audit function had not developed effective quality assurance programs for internal audit as suggested in the Government of Saskatchewan's financial administration manual and by professional standards. Without having a periodic, formal quality assurance program, ministry internal audit functions may not maintain an environment of continuous improvement, risk non-compliance with professional standards, and have inconsistent work methods. This concludes my overview of this chapter.

The Chair: — Thanks for the overview. Of course this has been before this committee before. There's details of the actions taken by the Ministry of Finance, and thanks for those actions. A brief report from the deputy minister of Finance or others, and then I'll open it up to committee.

Mr. Pandya: — Thank you, Mr. Chair. So I would note that, you know, Finance welcomes these recommendations. We've been working to and have marked progress on these recommendations. We'll continue to work to help ministries with respect to the outstanding recommendation vis-à-vis quality assurance programs.

I would note that we formed a working group — the heads of ministries, internal audit areas — to help them address this issue. That working group has met quite recently, and we'll certainly continue to report on progress on that front. And if there's any questions, I'd be happy to take them.

The Chair: — Sure. Thank you very much. And I'll open it up for questions. Ms. Mowat.

Ms. Mowat: — Thank you. I see that Finance decided to continue with the decentralized internal audit model across ministries. I'm just wondering if this is a common practice amongst governments?

Mr. Pandya: — I would note, as part of . . . I should actually have Mr. Paton, Provincial Comptroller, respond to this. I'll just take it very briefly. We did do an assessment of different models as part of our work on the implementation of the first five recommendations that the auditor's office had made on this question and deemed that a decentralized model would be more effective in the Saskatchewan context. If there's a specific

question about the appropriateness of that model, I can turn it over to Mr. Paton to answer.

Ms. Mowat: — No, I think that's fine. You analyzed different models to see what was appropriate and came up with that option. Okay. There's mention of an outside consultant's recommendations in 2007. I'm on page 243, and I'm just wondering if you can speak to the takeaway from this consultant's review?

Mr. Paton: — Maybe I'll just speak to the outstanding issue, if that's fine. And that relates to whether or not we should have a quality assurance program across ministries. As the deputy minister mentioned, we've recently established a working group, and we're working with eight different internal audit organizations within the Government of Saskatchewan. They are looking into how they could work towards accomplishing this last objective.

So I guess the development of internal audit in Saskatchewan in government is growing slowly, and I anticipate that we'll be able to address this last recommendation during the coming year. There's a couple of options available whether or not we look at kind of a peer-to-peer review set-up or do we go and engage one of the other external audit groups such as KPMG or Meyers Norris Penny to help us do this and perhaps provide that assurance across all of our agencies.

Ms. Mowat: — Thank you. And so specifically I was just looking at the use of a consultant's review in 2007 to help make this decision. Was the takeaway from that review that a decentralized model would be appropriate?

Mr. Pandya: — Thank you for the question. Yes, that was exactly the conclusion. So we'd analyze pros and cons versus different models — centralized model, decentralized model, external models. That was the recommended approach, and that's why we chose to go that route.

Ms. Mowat: — Thank you. And you already answered my other question, so I'm done.

The Chair: — Are there questions from folks. Not seeing any, we don't have any new recommendations. Thanks again for the actions that you've taken to implement all those recommendations, and we'll move our attention along to . . . We'll conclude consideration of chapter 19 and move our consideration to chapter 20, 2018 report volume 1.

Ms. Heebner: — Chapter 20 of our 2018 report volume 1, starting on page 247, reports the results of our first follow-up of six recommendations made for coordinating the use of lean across government ministries and certain other agencies in our 2015 report volume 2. While these recommendations were specific to the lean initiative, we made them with recognition that the overall intent of lean was to create a culture of continuous improvement and promote the use of continuous improvement processes.

Since September 2016 Finance is responsible for providing support and guidance to government ministries and those agencies on continuous improvement processes including lean. Continuous improvement is part of a larger government accountability framework, the planning and accountability management system.

By January 2018 the Ministry of Finance had implemented the intent of all of their recommendations. The ministry had set key measures and some targets to enable assessment of its overall success related to the use of continuous improvement processes. It had gathered information to assess the overall success of the use of continuous improvement processes. It used this information to report to ministries and to the public on the use of continuous improvement processes.

Each ministry in their annual report also reports some information to the public on the results of certain continuous improvement projects. In addition, the ministry delivered continuous improvement training to meet needs of ministries. Also the ministries of Education and Advanced Education gave agencies in their sectors timely feedback on their efforts in using and promoting continuous improvement processes. This concludes my overview of this chapter.

The Chair: — Thanks for the overview and the focus. This again has come to this committee before and thanks for the status update with all the actions that have been taken. And I'll flip it over to the deputy minister.

Mr. Pandya: — Thank you, Mr. Chair. I don't have any comments. I think the auditor has noted that we've implemented the intent of all the recommendations related to that chapter.

The Chair: — Thank you very much. I'll open it up to committee member for questions. Ms. Mowat.

Ms. Mowat: — Thank you. So I'm on page 248 of chapter 20. So there's a discussion about the government changing its approach to continuous improvement. I'm wondering, was there a formal mandate for this change or how did this information come about? Cabinet? Treasury?

Mr. Pandya: — Thank you for the question. So what we had conducted was a program review of all of our program review work across government, if you're following. And one of the conclusions of that program review work was that we move away from a mandated approach with respect to the previous continuous improvement model and move to a model that would consider multiple approaches in terms of achieving continuous improvement.

Ms. Mowat: — On page 249 the auditor refers to the office in Finance of planning, performance and improvement. Can you speak to how many FTEs are in this office and . . . Yes, that's a good start.

Mr. Pandya: — Thank you again for the question. There's currently 11 FTEs including the assistant deputy minister within that branch.

Ms. Mowat: — Okay, thank you. And it said that they've set key measures and some related targets. Can you provide some detail on what that looks like?

Mr. Pandya: — I'll have Brianna Verhelst who's the ED [executive director] in that branch just to answer your question.

Ms. Verhelst: — Thank you. So we have set some performance measures to consistently track improvement work across government and those include actual cost savings, cost avoidance in dollars as well as FTE cost savings and cost avoidance, efficiency, customer satisfaction, and safety.

In terms of the three targets on the use of the system, we measure progress every two years with the use of the planning and accountability management system. And so based on some of the opportunity areas that were identified in our last survey in 2017, the targets we have are 100 per cent use of organizations use the system, 100 per cent of organizations use risk results in their strategic and operational planning and continuous improvement work, and lastly that 100 per cent of organizations use customer information in their continuous improvement work strategic and operational planning.

Ms. Mowat: — Thank you. I appreciate you providing the measures and the targets at the same time. It saves follow-up questions. I have no further questions, Mr. Chair.

The Chair: — Thank you for the questions and responses. Any other questions from folks around the table? Not seeing any, we'll conclude considerations with respect to chapter 20. And I think this concludes — unless anyone wants to offer some insight into the budget that's just around the corner — we will conclude consideration with respect to the Ministry of Finance. And thank you to Deputy Minister Pandya and all the officials that are here with us today and all those doing the very important work that you do. Thank you, thank you for that.

Mr. Pandya: — To you, Mr. Chair, and to the committee members, I know you've had a very long day. I'd like to thank the Provincial Auditor's office for their ongoing and constructive engagement, not only with the Ministry of Finance but across the Government of Saskatchewan. And finally I'd just like to thank all of the officials around me who know everything in the Ministry of Finance, and I just want to thank them for their continued good work. So thank you.

The Chair: — Thank you. Thanks to the auditor and the auditor's office for their work around this table. Thanks to committee members. And at this time I'd ask for a motion to adjourn. Moved by Ms. Lambert. All agreed?

Some Hon. Members: — Agreed.

The Chair: — This committee stands adjourned to the call of the Chair. Thank you.

[The committee adjourned at 16:42.]