STANDING COMMITTEE ON PUBLIC ACCOUNTS

Hansard Verbatim Report

No. 9 — January 11, 2022

Published under the authority of The Hon. Randy Weekes Speaker

Legislative Assembly of Saskatchewan

Twenty-Ninth Legislature

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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Ms. Aleana Young
Regina University

[The committee met at 13:06.]

The Chair: — Okay, we'll convene the Standing Committee for Public Accounts here today. Thank you to everyone for joining us here today. I'd like to introduce the members that are present: Mr. Marv Friesen; Mr. Delbert Kirsch; Mr. Hugh Nerlien; Mr. Dana Skoropad; Deputy Chair, Ms. Colleen Young; Ms. Aleana Young.

I'll introduce officials from the Provincial Comptroller's office. We have Terry Paton, Provincial Comptroller; Chris Bayda, Assistant Provincial Comptroller. Thank you both for being here. That tie looks sharp, Mr. Bayda. I'd like to welcome and introduce our new Provincial Auditor, Tara Clemett, to actually what's her first hearings as Provincial Auditor, so thank you very much. And she'll introduce officials Kim Lowe and others when she's making her presentations.

We've moved these meetings into the Chamber to ensure distancing and safety amidst COVID. And I will also identify and welcome Mr. Todd Goudy, member of the committee.

I'll table the following documents: PAC 37-27, Ministry of Education: Report of public losses July 1, 2021 to September 30, 2021; PAC 38-29, Ministry of Health: Report of public losses July 1, 2021 to September 30, 2021; PAC 39-29, Ministry of Finance: Report of public losses July 1, 2021 to September 30, 2021; PAC 40-29, Provincial Auditor of Saskatchewan: Second quarter financial forecast for the six months ending September 30, 2021; PAC 41-29, Ministry of Education: Report of public losses September 1, 2021 to November 30, 2021.

I'd like to advise the committee that, pursuant to Rule 142(2), the following documents were committed to the committee: *Public Accounts* volume 2 on October 28th, 2021; Provincial Auditor of Saskatchewan 2021 report volume 2 on December 8th, 2021; and Provincial Auditor of Saskatchewan business and financial plan for the year ended March 31st, 2023 on December 15th, 2021.

We'll be dealing with the Ministry of Health here this afternoon exclusively, various chapters of the Provincial Auditor. At this point, I would welcome Associate Deputy Minister Macza to introduce officials that are here with her today. And we won't speak specifically to the chapters yet. We'll then turn it over to the auditor to make their presentations. And then subsequent to that, we'll have the response from the ministry with respect to each of those chapters. So, Ms. Macza.

Health

Ms. Macza: — Good afternoon. So on behalf of the Ministry of Health, thank you for the opportunity to discuss the 2018, 2019, 2020, and the 2021 Provincial Auditor's reports. Ministry officials with me here today to answer any questions are Mark Wyatt, assistant deputy minister for the Ministry of Health; and Billie-Jo Morrissette, assistant deputy minister for the Ministry of Health.

Mr. Chairperson, the Provincial Auditor of Saskatchewan provides an important oversight role for the ministry. Key recommendations are provided to the ministry through the audit process, and the health care system is committed to strengthening services and improving efficiencies identified by the Provincial Auditor and her team. And the ministry has made good progress on a majority of the chapters, and work is under way to address and implement any outstanding recommendations from you in previous reports.

However we recognize that more work needs to be done to continue delivering improvements on these recommendations. Ongoing work will continue in many of these areas we review and discuss today. Our ministry shares the same objectives with the Provincial Auditor and her team to improve health care services for all of Saskatchewan, and we appreciate the detailed reports provided by the auditor and the benefits these reports provide to Saskatchewan people. So thank you.

The Chair: — Thank you very much, ADM [associate deputy minister] Macza, and to the officials that have joined us here today. Just first off, thank you to all of you and to all of those in the Ministry of Health. We're coming together the first time as we've come through the last two years of a historic pandemic, a historic challenge for our province and for the world. And I just want to say thank you so very much to all of you that are here at this table and all of those across Saskatchewan that have been a part of this incredible stepping up of Saskatchewan people in response. And obviously the Ministry of Health has been out there leading the way and on the front lines throughout this, so we offer our thanks.

I'll turn it over at this point to our Provincial Auditor to focus in on the first chapter here today. And I think that these chapters will look . . . they'll be bundled. Some will be bundled together in the presentation; others will be independent. The auditor will dictate that. And then there'll be the subsequent response from the ministry.

I would also identify and table document PAC 42-29, Ministry of Health: Status update, dated January 11th, 2022. And of course, that's the status update that the Ministry of Health has provided this committee, all members of the committee, to be able to focus our work here today. And I just thank all of those that were involved in putting that status update together, as well as all of those that have been involved in the work that's reflected in that document.

I'll turn it over to our Provincial Auditor, Tara Clemett.

Ms. Clemett: — Thank you, Mr. Chair, Deputy Chair, members, and officials. With me today is Ms. Kim Lowe, who leads the annual integrated audit at the Ministry of Health and also worked on a number of the performance audits that we will present on today.

Kim will present the chapters related to the Ministry of Health in the order according to the agenda. This will result in nine presentations, as there will be certain chapters on the same topic that will get combined together. Kim will pause to allow for the committee's discussion and consideration after each presentation. There is three presentations that include new audit recommendations for the committee's consideration.

And before I turn it over to Kim, I would like to thank, obviously, the ministry officials and their staff for the co-operation that was

extended to us during the course of our audit work and especially during the times that we are in, in terms of this pandemic. So now I'll turn it over to Kim.

Ms. Lowe: — Thank you. Chapter 7 of our 2018 report volume 2, which starts on page 47, includes the results of our annual integrated audits of the Ministry of Health and six of its agencies for the year ended March 31st, 2018 and nine benefit plans for the year ended December 31st, 2017.

[13:15]

The only area for improvement we found was with regards to the ministry following its established procedures for removing unneeded user access to its computer systems and data promptly. For example, for one individual tested, the ministry requested removal 14 business days after the employee left the ministry. During the 2018-19 audit, we found the Ministry of Health had a process to promptly remove unneeded user access to its computer systems and data, and followed it. Therefore this recommendation has been implemented and is no longer outstanding. This concludes my presentation.

The Chair: — Thank you very much for the presentation and for the focus of the work. I'll turn it over to the ADM for response. And I believe that this recommendation has already been implemented, but I'll flip it over to the ADM and then open it up if there's any questions.

Ms. Macza: — Yes, thank you. Yes, as noted by the auditor, this is fully implemented and we will continue to make improvements going forward.

The Chair: — Thank you very much. Of course this has been implemented. Are there any questions on this chapter before we conclude considerations? Ms. Young.

Ms. A. Young: — Thank you, Mr. Chair. Just one question for the officials present. Did the ministry encounter any data breaches prior to its implementation, specifically related to this?

Ms. Macza: — I'm not aware of any data breaches prior to this.

Ms. A. Young: — Thank you. No further questions.

The Chair: — Thank you very much. I would welcome a motion to conclude considerations of chapter 7 from the volume 2, 2018 report. Ms. Deputy Chair Young moves. All agreed? That's carried.

We'll move along to our next set of chapters and I'll turn it over to the auditor's office.

Ms. Lowe: — Chapter 7 in our 2019 report volume 1 reports our audit of the Ministry of Health processes to monitor prescribing and dispensing of opioids. This chapter includes seven new recommendations for the committee's consideration. Chapter 28 of our 2021 report volume 2 reports the results of our first follow-up of the recommendations originally made in the audit.

The Ministry of Health is responsible for monitoring the prescribing and dispensing of opioid medications within the province under *The Prescription Drugs Act*. Canada is the second-largest consumer of prescription opioids in the world and a large percentage of youth report using prescription opioids for non-medical purposes.

Saskatchewan Coroners Service reported 303 apparent opioid toxicity deaths in 2020, which is an increase of 69 per cent from 2019. There was 179 deaths in 2019.

In Saskatchewan the number of people receiving prescribed opioids is slowly declining. However, the Saskatchewan rate of defined daily doses per population is above the national level for the top six prescribed opioids. The most prescribed opioids in 2020-21 were hydromorphone, 47 per cent; codeine, 30 per cent; and morphine, 11 per cent.

In Saskatchewan, physicians and surgeons, dentists, and nurse practitioners can prescribe opioids, and pharmacists are the ones who dispense opioids. Ineffectively monitoring the prescribing and dispensing of opioids may result in increased opioid abuse or diversion, leading to overdoses and death, as well as additional cost to the health care system.

We concluded that for the 12-month period ended February 28, 2019 the Ministry of Health had effective processes except in the reported areas to monitor the prescribing and dispensing of opioids to reduce misuse and addiction. We made seven new recommendations for the committee's consideration which I will focus on in my presentation.

Our first recommendation: on page 102 we recommend the Ministry of Health assess the cost and benefit to patient safety of recording hospital-dispensed opioids in the provincial drug IT [information technology] system.

The ministry tracks, on an ongoing basis, key information about prescribed opioids dispensed in Saskatchewan, other than prescribed opioids dispensed in Saskatchewan hospitals. The ministry does not track or know the amount of drugs, including opioids, dispensed in Saskatchewan hospitals, including emergency rooms. Rather, each hospital in Saskatchewan uses its own IT system to track medication prescribed to a patient.

By August 31st, 2021 we reported in our follow-up that this recommendation has not been implemented. The ministry does not anticipate assessing the cost and benefit of integrating hospital-dispensed opioids into its provincial drug IT system sooner than 2022-23. Without information on opioids prescribed at hospitals, prescribers do not have a complete medication profile for a patient. This increases the risk of opioid medications inappropriately prescribed and dispensed.

In our second recommendation, on page 107 we recommend the Ministry of Health participate in a regular review of the list of opioid drugs associated with misuse and addiction that it wants monitored.

The ministry's main monitoring activity is supporting the prescription review program run by the College of Physicians and Surgeons of Saskatchewan. During the audit we found the scope of the prescription review program did not include monitoring all prescribed opioids. We found the monitoring list did not include some opioids controlled under the federal *Controlled Drugs and Substances Act* and did not include opioids

like tramadol, monitored by certain other provinces.

By August 31st, 2021 we found that this recommendation was implemented and that the Ministry of Health participates in regular reviews and updates the list for monitored opioids associated with misuse and addiction. Regularly reviewing the monitored drug lists ensures that it is current and all opioids that are or can be associated with misuse and addiction are monitored by the prescription review program.

Our third recommendation: on page 108 we recommend the Ministry of Health establish a risk-based approach to identify concerns in opioid dispensing in Saskatchewan pharmacies. The ministry does little to monitor dispensing of opioids by pharmacies. It does not have a risk-based process to check if pharmacists are dispensing opioids in a manner that could lead to misuse or addiction.

As of February 2019, over 385 different pharmacies operated in Saskatchewan. The ministry has an agreement with each pharmacy requiring recording of dispensing information. This agreement also gives the right to the ministry to conduct inspections. We found the ministry does not check whether a pharmacy records all prescribed drugs dispensed in its drug claims system and records details accurately as required under the pharmacist agreements.

Also the ministry does not expect the prescription review program to assess the dispensing practices of pharmacists. Rather, the ministry asks the program to inform the College of Pharmacy Professionals when it finds potential misuse of opioids related to inappropriate dispensing. As of August 31st, 2021 this recommendation has not been implemented.

The ministry planned to rely on an external evaluation of the prescription review program to help it establish a risk-based approach to identify concerns in opioid dispensing which has been delayed due to COVID. Because the ministry does not collect data about dispensing practices in Saskatchewan pharmacies, the ministry does not know if any Saskatchewan pharmacies contribute to Saskatchewan's opioid crisis.

In our fourth recommendation on page 110, we recommend the Ministry of Health work with the College of Physicians and Surgeons of Saskatchewan to consider requiring its members to review patient medication profiles prior to prescribing opioids.

We found the College of Physicians and Surgeons of Saskatchewan did not require physicians to check patients' medication profiles prior to prescribing high-risk medication like opioids, whereas Alberta and BC [British Columbia] do. Such checks may help better identify potential opioid misuse prior to issuing a prescription and encourage the use of other treatment options. As of August 31st, 2021 this recommendation has been implemented.

In September 2020, the college approved and publicly posted on its website a policy requiring all physicians to have an account for either the provincial drug IT system and/or eHR Viewer and highly recommends physicians review patients' medication profiles before prescribing opioids. Recommending physicians check the medication profile of a patient prior to prescribing opioids may help physicians better identify patients at risk of misusing opioids and reduce the risk of patients multi-doctoring, that is, obtaining opioid prescriptions from multiple doctors.

In our fifth recommendation on page 111, we recommend the Ministry of Health determine whether the prescription review program is helping reduce the misuse of prescribed opioids in Saskatchewan. The ministry does not actively monitor the prescription drug review program. The ministry was unable to demonstrate when it last evaluated whether the program was making a difference in helping participating health care professional bodies educate and/or discipline members with inappropriate prescribing practices or those contributing to misuse of prescribed opioids.

We further found that the agreement in place at February 2019 included limited monitoring and reporting provisions. We found that the program did not track the number of assessments of potential inappropriate opioid use it completes, nor did it consistently request practitioners provide explanations of potential inappropriate prescribing practices. For example, between April to December 2018, the program identified 150 cases of potentially inappropriate prescribing practices but as of March 2019 had not sent the explain letters to physicians because program management had not yet reviewed them to decide if the letter was warranted.

The program also did not track the number or specific nature of complaints of potential opioid misuse or inappropriate prescribing practice received from the public or practitioners. The ministry was not aware of any of those issues. Obtaining regular — for example, each quarter — information about key program activities would give the ministry a sense of the number and nature of potential opioid misuse cases that exist in the province. In addition, actively monitoring the program would help the ministry show that program funding is spent for intended purposes.

As of August 31, 2021 this recommendation was not implemented. In October 2020 the ministry drafted a business proposal to engage an external consultant for an independent evaluation of the prescription review program in 2020-21, but because of the ministry's involvement in the COVID-19 pandemic response, the ministry postponed plans for an independent evaluation.

In our sixth recommendation on page 112, we recommend the Ministry of Health give those responsible for monitoring inappropriate opioid prescribing access to necessary patient information. The ministry has not given the prescription review program access to sufficient information to enable efficient identification of potential opioid misuse and inappropriate prescribing practices. The prescription review program has access to information in the drug claims system but does not have access to information on the provincial drug IT system, which includes additional information such as direction of use and urine drug screening results. Direction of use includes information such as how many tablets to take per morning and evening.

The program could use the additional information to more efficiently identify potential inappropriate prescribing practices and opioid misuse. For example, having the information about the direction of use for a prescribed opioid would reduce the need for the program to call the dispensing pharmacy to obtain these

details.

As of August 31st, 2021 this recommendation was partially implemented. In spring 2019 the ministry requested eHealth provide program staff access to urine drug screening results stored in eHR Viewer. Management indicated the data-sharing agreement was being drafted, and eHealth planned to resume the necessary work in fall 2021. Having urine drug screening results helped program staff confirm whether patients properly used prescribed opioids or have other non-prescribed drugs present in their body. Not providing the prescription review program with access to complete patient information related to use of medications increases the risk of not identifying potential opioid misuse and inappropriate prescribing practices.

In our seventh recommendation on page 115, we recommend the Ministry of Health give those responsible for monitoring inappropriate opioid prescribing a functional IT system, useful in identifying potentially inappropriate prescribing practices and opioid misuse. The prescription review program did not use the systematic IT approach to analyze prescription data when trying to identify potential misuse of drugs and inappropriate prescribing practices at the time of our audit.

We found the program initiated assessments of suspect inappropriate opioid prescribing based on complaints made to the College of Physicians and Surgeons of potential opioid misuse or when it identified a potential issue in its own analysis. The program conducted a very manually intensive analysis that looked for higher than recommended doses for different types of opioids and prescribing of opioids in excessive quantities.

[13:30]

At the time of the audit, the program was fully aware of the limitations of the data extraction tool it was using and inefficiencies in its approach. It recognized that its monitoring list of about 20 prescribers was likely incomplete. Our analysis of the top five prescribers in the province for the three most prescribed opioids found 3 of 15 prescribers were not on the program's monitoring list and perhaps should have been.

The program also recognized that it was not likely identifying all instances of double-doctoring, that is, when a patient received opioids from three or more physicians at three different practice-site addresses in a calendar month. To improve its ability to analyze prescription information, the program collaborated with the ministry and eHealth Saskatchewan to develop a new ministry-owned IT system to analyze prescription data. As of April 2019, the system was not yet fully functioning.

As of August 31st, 2021 this recommendation has been implemented. By May 2019 program staff were using the now fully functioning IT system daily. The new IT system provides more analytical functionality and reporting. For example it provides reports identifying patients who receive more opioid prescriptions than others, physicians prescribing more opioids than others, and patients multi-doctoring.

Identification is the first step in addressing inappropriate prescribing practices, either through education or to enable the related self-regulated health care professional body to determine if disciplinary action is warranted.

This concludes my presentation.

The Chair: — Thank you, Ms. Lowe, and to you and the Provincial Auditor and your staff team. Thanks so much for such an important and substantial chapter here. I'm glad we're here to consider it here today. Thank you to the ministry. I'll turn it over to Assistant Deputy Minister Macza for comments and then we'll open up for questions.

Ms. Macza: — Perfect. Thank you. With regard to the first recommendation around assessing the cost and benefit to patient safety of recording hospital-dispensed opioids in the provincial drug IT system, the ministry will work with eHealth Saskatchewan and the Saskatchewan Health Authority to assess integrating hospital-prescribing medical records into the provincial drug IT system, and this analysis is expected to be completed in '23-24.

With respect to the recommendation to work with the College of Physicians and Surgeons to consider requiring its members to review patient medication profiles prior to prescribing opioids, the Provincial Auditor has noted that this is implemented.

With regard to the recommendation to participate in a regular review of the list of opioid drugs associated with misuse and addiction that it wants monitored, the Provincial Auditor notes that this recommendation has been implemented.

With regard to the recommendation to determine whether the prescription review program is helping reduce the misuse of prescribed opioids in Saskatchewan, the ministry is planning to engage external consultants to independently evaluate the prescription review program and its impact on opioid misuse. This work is expected to be completed in the summer of 2023.

With regard to the recommendation to establish a risk-based approach to identify concerns in dispensing in Saskatchewan pharmacies, the ministry is planning to engage external consultants to establish a risk-based approach to identify concerns related to opioid dispensing in pharmacies, and this work is expected to be completed in summer 2023.

With regard to the recommendation to give those responsible for monitoring inappropriate prescribing a functional IT system useful in identifying potentially inappropriate prescribing practices and misuse, the Provincial Auditor has noted that this recommendation has been implemented.

With regard to the recommendation to give those responsible for monitoring inappropriate prescribing access to necessary patient information, the ministry continues to work with stakeholders, eHealth, and the prescription review program to provide access to the electronic health record viewer for the purpose of reviewing urine drug screens to evaluate appropriate drug use. A data-sharing agreement is under development, and this is expected to be completed in June of 2023. That concludes my remarks.

The Chair: — Thank you for the presentation. Thank you again for those that have been involved in organizing the status update and providing it to us. Just as one note, everything contained in here is all really helpful. Just into the future, if the recommendations by way of number can correspond to the

numbered recommendations within the report, it just allows us to consider them in a way that's organized and makes it simple to know which one we're referring to, for example if we're talking about recommendation no. 1.

And for committee members, what we'll do is when we're passing motions with respect to these recommendations today, we'll refer to them based on the auditor's report from the 2019 report. So we'll refer to her report. Recommendation no. 1 will be recommendation 1 from her report. Thank you very much.

I'll open it up for questions. Ms. Young.

Ms. A. Young: — Thank you, Mr. Chair, and again my thanks to the officials for being here. I believe this is the first time I've been up with the officials from Health in Public Accounts, so you'll forgive me as I'm sure you've detailed some of this information in previous appearances before this committee. And I have done my best to review past committee notes prior to this, but inevitably I will have missed something, so I'll thank you for your indulgence in ensuring accountability and transparency for the Public Accounts Committee of the legislature.

In terms of process I try my best to keep this fairly dialectical, and I do have a few chapters today that I will have some more questions on, whereas there are a number in which my questions will be brief. This is one that I will have some . . . My questions will be lengthier on this one, I think, due to the scope and the importance of the impact of this currently on the province and certainly on the health care system.

So I guess to begin, a couple introductory questions just for clarification for the record and for the committee members, and I have done my best to ensure that I'm speaking to both chapter 7 and chapter 28 and have done my darnedest to ensure that I'm up to date. But in regards to the general statistics as they relate to opioid use in the province, I note that on page 96 in chapter 7 it's listed, I believe, 441,000 prescriptions for opioids for pain management in 2018-19 and 359,000 prescriptions for opioids for addiction treatment in that same year, which is significant when you think about the small population that we do have here in Saskatchewan. And I note in 2020 and 2021 respectively, it was 429,000 prescriptions for pain management and 372,000 for addiction treatment. So while we do see that drop in prescriptions for pain management, there is an almost offsetting increase in the number of prescriptions for addiction management.

And now initially reading through these chapters, I was struck by the volume of prescriptions. Certainly in a province with just over a million people, 400,000 prescriptions for opioids for pain management is significant. So my initial question would be, are those numbers distinct or could an individual feasibly be captured by both measures — prescribed opioids for pain and addiction management?

Mr. Wyatt: — I'm Mark Wyatt, assistant deputy minister. I just want to understand your question better. So is the question whether an individual could receive prescriptions for both pain management and opioid management, or is the question around the total number of prescriptions and whether that includes both?

Ms. A. Young: — The former.

Mr. Wyatt: — Okay. I would expect that it is possible that you may have individuals who could be captured in both categories. If somebody was undergoing opioid agonist therapy treatment, there may be reasons during the course of an individual's treatment that they may well require a prescription opioid for pain management related to either an accident or it could be . . . I would want to defer to a clinician as to whether it would be appropriate, you know, to be prescribing both an opioid addiction treatment at the same time as an opioid for pain management. I guess I wouldn't rule out that possibility. It's probably a question that would be best put to a physician.

Ms. A. Young: — I do have a few more questions specific to some of these numbers. And if there ever is information that you don't have at hand, I am happy to receive it at a later date, as I can imagine preparing for these meetings is challenging, not knowing necessarily the direction of the questioning.

So thank you for that answer. In regards to the total number of individuals who would be receiving prescriptions for opioids, whether for pain management or for addiction, I did try and tease that out, out of some of the figures contained within the auditor's report, but I did notice some of the language changed in terms of how those tables were discussed. So do you have the numbers available of the actual individuals, even for the past calendar year, who would have received prescriptions for opioids for both pain management and for addiction?

Mr. Wyatt: — I'm looking here at a table that spells out the number of individuals who have received an opioid prescription, and I can give you the last three years if that's a reasonable time span.

Ms. A. Young: — Sure. That would be the table on page 97 of chapter 7? I suppose what I'm looking for is the comparable number for those who received opioids for addiction. I did not see that contained within the report.

Mr. Wyatt: — I expect I have it here. I might just need to do a little bit of searching for it specifically. Perhaps if we can just move on to another question, I can see if I find it over the course of this section or report back after.

Ms. A. Young: — Absolutely. I'm also happy to summarize any outstanding questions and forward them along in writing afterwards.

The Chair: — Can I just, as Chair, quickly . . . Thank you very much for the questions and thank you for the undertaking to do your best to find the answers here at the table. Sometimes that's not possible in the time period that we have. So just as far as that undertaking to get information back to the committee for some of these questions, if you're committing to get the answer to the question, if you're able to supply that answer to the Clerk, who will then provide it to all members of the committee and it'll be posted properly. Thank you.

Ms. A. Young: — Thank you. One clarification question as it relates to the drug-related IT systems. I believe on page 102 of chapter 7, it speaks to the gap identified as it relates to hospitals between, I believe it's PIP [pharmaceutical information program] and the drug claims system. This gap identified, I believe, speaks to not being able to capture where it is that the drugs are

dispensed. Is that correct?

[13:45]

Mr. Wyatt: — So with respect to the recommendation dealing with the issue around incorporating hospital prescriptions into the record that's shared with prescribers and pharmacists, if a patient is in hospital and receives an opioid prescription and is dispensed opioids in the hospital, those are captured within the BDM system. And if a patient is then discharged from hospital with a continuation of that prescription, it would then be filled in community and become part of the community database that is available through the pharmacy information program and is shared with physicians on the electronic health record viewer.

And so the concern here is not so much that there's a potential for double-doctoring with patients who are leaving, because all of the prescriptions they receive, both in hospital and anything that they might have been prescribed before they entered hospital, would be reconciled in the hospital itself. And once they have been discharged from hospital, their prescriptions would then be entered into the pharmacy system in the community pharmacies.

I think the issue here is the extent to which for a prescriber, understanding what a patient has received in hospital has value, understanding the dosage levels, understanding the particular type of painkiller that they might have been prescribed. So I think from our perspective we recognize the benefit of having that information made available. Again, not to I guess completely rule out the potential for abuse, but I don't think the issue here is so much a concern around inappropriate use as it is helping to inform prescribers and the pharmacists who are both prescribing and filling prescriptions for someone who has had that hospital history.

And so maybe if I can just add the one comment, it's something we're looking at. There is some complexity to being able to link those databases in a way that's useful. Right now it's not something that is done widely. I think we have one existing example related to the TB [tuberculosis] program where in-hospital prescriptions are captured in the community, linked to the community database. So we have a very narrow example of that in existence, and so looking at how we can move to implementing that on what would be a much more significant basis capturing opioids.

Ms. A. Young: — Thank you. As per that first recommendation, the outstanding recommendation which I believe is recommendation 1 from chapter 7 to use the auditor's system, I do know it's a recommendation from over two, three years ago, and the timeline given is 2023-2024. Can you speak to that?

Mr. Wyatt: — I guess I would say that it's, you know, as we move through a report from the auditor, there's initially some scoping of how we will handle the response. And so, you know, when the auditor's report was initially released, we would have identified some recommendations that could be done more immediately and sort of in that first year, and then look at, you know, over what might be in year two, what might be more complex and move into a third year. In this case because we're dealing with an IT system, as I said, it does involve other partners that need to be involved.

And not to make excuses, but our reality is that a number of recommendations that have involved significant work over the past two years really have not progressed in the way that we would like just because many of the same people — in this example, in our drug plan — who are working on this area are also responsible for things like working with the pharmacy community around vaccine delivery, working on drug shortages issues. And so we really have not been able to, you know, sort of lead some of the policy and in this case, an IT program response just with people being redirected to other priorities.

Ms. A. Young: — Thank you. So as per the update, the status update that you've provided in terms of the planned actions, I believe the ministry will consult with eHealth and the Saskatchewan Health Authority to analyze the potential integration of hospital medication management system on and on and on. Is that then an anticipation of the implementation of this or a commitment to begin that initial consultation by 2023-2024?

Mr. Wyatt: — I think we would be looking at beginning the engagement with . . . Again I'll preface it by saying, you know, subject to the pandemic releasing some of our people to undertake some of this work, I think we would definitely be looking at engaging in some of the consultation part of it in the coming year, in '22-23.

And then, you know, subject to being able to get the resourcing required and the participation of eHealth's resources and the budget to support it, I think we're looking at, I guess on the assumption that this would progress, that we would be looking at implementing over the next couple of years.

Ms. A. Young: — Thank you. Related to that, how many staff related to IT management would have been redeployed due to . . . I apologize, I'm not sure if "IT management" would be the correct term, but those staff that you've spoken of. What would be the number of bodies that's been redeployed due to COVID-19?

Mr. Wyatt: — If the question is related to the people working within the drug plan, it's a fairly small unit. You would have one director and, I'm going to guess, probably four staff who would be involved in working with the College of Physicians and Surgeons around the operations of the prescription review program. And so they would be the staff who would be, I guess, leading that process involving the other partners.

In terms of others who might be involved in this from eHealth, from the SHA [Saskatchewan Health Authority], from, you know, working with private physicians and community pharmacy, there would probably be a much larger group. And I couldn't really speak to, in the example of eHealth, you know, what implications there might be for them.

But I mean, I think in general we know that both the ministry and many of our partners are quite consumed with, you know, managing the pandemic situation. So for something that is not considered mission-critical or related to the pandemic itself, we have stepped back on some of these projects.

Ms. A. Young: — And so perhaps an obvious question then, by way of follow-up as it relates to this recommendation: are there currently adequate resources and authority to address this?

Mr. Wyatt: — I would put this in the category of, you know, if there is an expansion of a program or resources required to support the implementation — both from the eHealth perspective, but also we need to think about the ongoing sort of implementation and operationalization of the system and the, I guess, the extent to which the College of Physicians and Surgeons, through the PRP [prescription review program], would potentially be accessing this and then how prescribers would access it.

Like anything, it really comes down to developing a business case if there is a financial requirement either for the ministry, for eHealth, for the SHA. And so it's not that we have unspent dollars available for this. Like anything, we would develop the proposal, identify what the resourcing costs are, and then seek the funding or other resources that may be required for implementation.

Ms. A. Young: — Moving on to just a handful of perhaps more high-level questions in regards to the "Broad Reduction Strategies for Reducing Prescribed Opioids" section 4.3, chapter 7, page 103. Is it accurate to say that the broad reduction strategies for reducing prescribed opioids are primarily education- and identification-focused?

Mr. Wyatt: — I would agree education is, you know, a very significant part of it. And I think that, you know, the role of the prescription review program is both to support the education of prescribers and as well as the role that they play in monitoring and tracking and, in some cases, bringing it, you know, an enforcement perspective.

Ms. A. Young: — Sorry, can you expand on that last comment?

Mr. Wyatt: — So part of what the PRP was established to do . . . And so I think you're asking about the, you know, the monitoring and enforcing dimension of it — and I don't want to, you know, step past the education role because that is absolutely significant — but I think your question is around the monitoring and enforcement area.

And so part of what . . . You know, going back many years to the time when there was the triplicate prescription program where copies of physician prescriptions went to, you know, to different organizations including to monitor. And so we've evolved from that now to where we have the PRP, the prescription review program, which is undertaking analysis.

And you know, one of the other recommendations speaks to the introduction of not just having the prescribing and dispensing data, but also having this analytical tool that's now available. It gives you the ability to undertake some data analytics around, you know, exceptional patterns of either patient or prescriber or dispenser involvement.

And so that becomes part of the role; that is part of the PRP is to identify where there are atypical patterns of opioid prescribing taking place, or use taking place. And in some cases there may well be a valid reason for a particular prescribing pattern. And that's where the PRP program will make its inquiries with the prescriber, do the follow-up, and understand what the situation is, whether it requires some additional education or whether there is some other issue that needs to be addressed.

Ms. A. Young: — One additional question here in regards to the Saskatchewan drug task force. The auditor notes that the focus of this task force does not include reducing misuse and addiction to prescribed opioids. Can you share for the committee what the work of the task force is and has been, and why that isn't a part of it? I assume it has perhaps a scope or terms of reference that I obviously don't have at my fingertips.

Ms. Morrissette: — Assistant Deputy Minister Billie-Jo Morrissette. So thank you for the question around the drug task force. And I would say the drug task force in the auditor's report, it talks about the drug task force being created in 2016. And the drug task force for a number of years came together and talked about broad issues related to harm or overdoses related to, you know, drug-related harms which, in many cases of course, involves opioids. And so at that time a number of officials would have discussed items like this, but the unique part about the drug task force really is the intersectoral collaboration.

And so just before the pandemic, the deputy minister, Max Hendricks, who couldn't be here with us today, noted . . . You know, this was at a time when we were seeing across Canada opioid-related harms and deaths really starting to rise, and it was becoming, you know, a real national issue. And so he escalated the drug task force to deputy minister-level oversight and has been co-chairing that for a number of the past years.

[14:00]

It's been actively meeting during the course of the pandemic. You know, the pandemic has, as Mark has noted, put some pressure on us in terms of the things that we can advance, but certainly this has been something that has continued to be a priority.

So you know, just stepping back, I would say when we think about overdoses and drug-related harms as a result of opioids, it really is . . . You know, what you see here on page 103 is with respect to some of the prescription programs, but it's a really complex issue.

And so the drug task force was really, you know . . . I'm just looking at its mandate now. It really is focused around monitoring the government's response to substance-related harms along six kinds of areas. And I can talk a little bit about those pillars, but there's been significant activity under way with the drug task force. And its mandate is to broadly monitor what's happening, but I would say moving toward engaging in finding some shared priorities that are intersectoral in nature.

So the membership that we have at that table — I should know them by heart, but I'm just going to look off my list so I don't miss anyone — does include members from a number of different ministries. So the deputy minister of Health chairs the committee, and then we do also have the deputy minister of Corrections and Policing. The deputy minister of Social Services has been a newer member, just acknowledging, you know, that they're an important partner. We have the chief medical health officer, the chief of police of both Saskatoon and Regina, the CEO [chief executive officer] of the Saskatchewan Health Authority, and then we do have the commanding officer of the RCMP [Royal Canadian Mounted Police].

And the most recent activities of that group have been focused on some consultations to try and really get at some of the complexities of the issues and really to try and lend some focus. And the mandate of the group was to come up with priorities and action plans to really address much of what we're seeing from an intersectoral view.

Having said that, you know, I would say if we're thinking about, you know, drug-related harms more broadly, certainly in addition to the work that the auditor has highlighted in this chapter, there's a lot of other initiatives under way that you'd be maybe familiar with. Some of them including things like expansion of harm reduction, you know, the expansion of our take-home naloxone program, continued work as mentioned already in this chapter, and a number of other initiatives.

So that's, you know, at a high level I think certainly the work of the drug task force continues to be really important in achieving intersectoral opportunities. Having said that, you know, each of the agencies at that table really have priority work that is ongoing on a regular basis to try and address some of these issues.

Ms. A. Young: — Thank you very much for that answer. So obviously recognizing there would be a number of strategies outside of the scope of this report that would be working to reduce, I believe that the proper term you used was "drug-related harm" in our community, in regards to strategies for reducing prescribed opioids specifically, I am essentially just trying to get a grasp of, is it the Saskatchewan drug task force that would be primarily tasked with that? Which specific body, if you could just clarify that, and the governance.

Mr. Wyatt: — So the primary lead in terms of addressing issues around opioid prescribing would be through the ministry and its relationship and the partnership with the College of Physicians' prescription review program in terms of addressing that specific area. I mean, it would be part of an element of a broader strategy related to opioid management in the province, but the issues related to prescription management would be more so through the PRP program and the interaction the ministry has with its partners there.

Ms. A. Young: — Okay, thank you. So for prescriptions through the PRP, and then for prescriptions and dispensing, what I'm hearing is, more broadly, it's just through the ministry itself in general.

Mr. Wyatt: — With respect to dispensing — and we have another recommendation that deals with dispensing — I would say the same thing. I mean, right now it is through the ministry working with pharmacies and also through the PRP, but also there's work that, you know, there's a relationship with the College of Pharmacy Professionals that is critical to the extent that pertains to pharmacists and pharmacies.

Ms. A. Young: — One question before I move on in regards to RxFiles. Just, was that contract renewed in March 2020?

Mr. Wyatt: — I will have to get back to you on that question.

Ms. A. Young: — Thank you. One question from section 4.5 in chapter 7, which of course the auditor has noted that the ministry does routinely review the drugs, including opioids, on the Saskatchewan formulary.

It notes that the Ministry of Health paid, I believe, $385.4 million in drug plan and extended benefits in 2017 and 2018. Would you have handy the dollar value paid for prescribed opioids?

Mr. Wyatt: — I will not have it handy. I can provide volumes. And as I was looking in response to your earlier question trying to find the information related to discrete patients, I do have, you know, the number of prescriptions for opioids available, but I don't have that translated into a dollar value.

Ms. A. Young: — Yeah. If that is available, I would be very interested in that — even specifically the distinction which seems to be made throughout these two reports between prescribed opioids for pain and then for addiction as well — to understand the cost of those two areas of prescription as it relates to opioids.

The Chair: — Just to clarify and make sure that we have a good, clear understanding of what information the ministry is undertaking to getting back to us with respect to the various questions. Those questions there, is that information that will be able to be provided in due course to the committee?

Mr. Wyatt: — Sorry. Can you repeat the question for me?

The Chair: — Just as far as the question, I know some of the information isn't readily accessible at this table around like the dollar value or some of these pieces. Just making sure that we're clear that when there's a question asked, if the information isn't here right now, if we can just have a good record of whether or not as a ministry you're committed to undertaking the work to get that information back to the committee or not. In the case of that last question, is that information that you're able to supply back to the committee in due time?

Mr. Wyatt: — Yes, I believe we should be able to provide that information. So we'll take that away and bring it back through the Clerk's office as you've requested.

Ms. A. Young: — I need a bigger desk here. I'm struggling to keep my papers straight. In regards to moving on to some of the outstanding recommendations, I'll move on to the outstanding recommendation: that we recommend the Ministry of Health determine whether the prescription review program is helping reduce the misuse of prescribed opioids in Saskatchewan.

I guess a couple initial questions about the prescription review program as it currently stands. I note that the ministry funds 90 per cent of the costs of this program. Can you clarify for the committee: that remaining 10 per cent, where does that come from? Is that from the college?

Mr. Wyatt: — I believe it will be through the university. I think I would want to confirm that, but that would be my understanding.

Ms. A. Young: — And the auditor's report also speaks to the nature of the agreements for the prescription review panel, and I believe it's noted that they're relatively short in term. And I'm just curious about the reason for the short-term nature of those agreements.

Mr. Wyatt: — Sorry. Can you just . . . I missed the front end of your question. My apologies.

Ms. A. Young: — Sure. So my understanding is that the prescription review panel has been in existence since 1988. And the auditor's report notes on page 110 that, you know, the purpose of the program and its activities generally haven't changed significantly since '88, and that from time to time the ministry extends the agreement for the prescription review panel in one-year intervals before renewing or evaluating it. So I'm just curious as to, given the long-standing nature of the prescription review panel, why . . . I'm curious if you could offer some comments as to the short-term nature of those agreements.

Mr. Wyatt: — I don't know if there's any real, significant reason why they're being rolled over on a one-year basis. Part of it may well be identifying the funding, you know, that's being requested from the program and identifying any additional positions or change in the role that may be accompanied with the subsequent year's agreement. I would expect that's likely the conversation that's happening on a year-to-year basis. It's certainly not the case that we are, you know, revisiting whether we want to continue with this program and with the partnership with the college on an annual basis.

I'm not personally involved in those discussions year to year. My expectation, it would likely be sort of looking at the details of the work plan for the year ahead and any resource requirements that go along with it.

Ms. A. Young: — And forgive me if I'm misunderstanding. My read of this was that it's fairly stable, but does the budget and the scope of the prescription review panel then change significantly year over year?

Mr. Wyatt: — I mean I would say that, you know, there has been a significant change with the introduction of this new IT program, and so that has expanded the type of analytics and the tools available to the college, to the staff involved with the program. And so you know, it would likely involve some discussions around the ability not just to have the program available but also to be able to maximize the value that it brings. So that would probably be the significant change over the last few years.

Ms. A. Young: — And how many FTEs [full-time equivalent] currently support the prescription review program? I noted at some place in the report I believe it says three FTEs and a contractor. Is that the totality of the staffing?

Mr. Wyatt: — Yes, my understanding is just . . . I do have a copy of the report from the PRP, and I believe that was the staff complement it identifies.

Ms. A. Young: — And is the PRP, is it housed within the college or the ministry, or is it arm's-length or independent? Can you help the committee understand the governance structure?

Mr. Wyatt: — It's housed within the college and it is a contractual relationship, a funded program between the ministry and the college.

Ms. A. Young: — So then, you know, we're going to get in a subsequent chapter, chapter 28, on to some of the gaps identified in that program. But is . . . I guess what I'm looking for, as the funder, is it the ministry who is ultimately responsible or would it be the college?

[14:15]

Mr. Wyatt: — The ministry is ultimately responsible. I guess, as with any relationship where you have a program that the ministry is interested in offering but wants to do it through a third party, you enter into that contract with the party. The ultimate responsibility is with the ministry and you are engaging, you know, in this case the college to deliver that program based on some of the expertise that they would have on behalf of the government.

Ms. A. Young: — Thank you. And in regards to the recommendation itself, it was noted that the:

> Ministry is planning to engage external consultants . . . [for] an independent evaluation of the prescription review program [and that] the proposal is currently under review. Once approved, the Ministry will begin the process of engaging an external consultant.

Again with a target date of '23-24. In regards to the language used there, by whom is the proposal currently under review? The ministry?

Mr. Wyatt: — That's correct. It's the ministry that is developing and will be, I guess, determining how we proceed in terms of engaging with that consultant. We've looked at, as you will see in the responses to the recommendations, two areas. One related to undertaking a review of the program, probably as part of that looking at how this program is delivered in other Canadian jurisdictions or at least select jurisdictions, understanding what some of the opportunities are to learn from other parts of the country.

The other part would be related to the dispensing recommendation and again, you know, our intent would be to ask an external consultant to provide some research and some analysis around the benefits and what some of the implications would be around offering that program as well. And as mentioned I think in the information that was shared, this is one that again we would like to have moved ahead on certainly in the past year if not the past couple of years. But it's just been parked as we continue to redeploy our internal staff to other — primarily pandemic-related — priorities.

Ms. A. Young: — Thank you. So is there an estimated timeline for when, I assume, that would be tendered, that contract?

Mr. Wyatt: — I mean, depending on the size of the contract, you know, if it meets a certain value, then it would be tendered. If it's a smaller contract, we may look at either inviting, you know, a small group of consultants to potentially bring proposals forward. So depending on the value of it, it would be procured through . . . You know, we are looking at an external consultant to undertake the review.

Ms. A. Young: — So there isn't a clear anticipated budget then either at this stage?

Mr. Wyatt: — No, we haven't really scoped the work sufficiently to be able to identify, you know, what the work plan and the number of hours it would be associated and to really determine what the total cost for the review will be.

Ms. A. Young: — Thank you. Moving on fully to chapter 28 and the outstanding recommendations, I do have one question as it relates to recommendation 4 from the 2019 report. It notes a policy of the college for all physicians to have an account for the provincial IT drug system or the eHR Viewer. How many physicians do not?

Mr. Wyatt: — At this time I believe the number would be zero.

Ms. A. Young: — Zero. Okay, excellent. Thank you. So these are requirements, not recommendations, then.

Mr. Wyatt: — That's correct. That's something that the college has introduced.

Ms. A. Young: — Circling back to the prescription review program assessment which has been recommended and not yet implemented, and understanding the challenges that of course the ministry has been under in the past nearly three years, I would note that there were a number of instances reported that I think would be of some concern to anyone in regards to some of the failings noted in the previous chapter as it relates to the delivery of the prescription review program.

And you know, I note that these are obviously gaps that will potentially have human consequences when we're talking about the misuse, potential misuse, of opioids. You know, notices around failing to notify practitioners with potential concerns about prescribing opioids; some patients who essentially fell through the gaps and continued opioid misuse due to some of the gaps in the program's activities.

So recognizing the challenges of the past couple years, it's also . . . There are a number of staffing changes that were noted and alluded to as cause for some of the gaps in the service delivery, and I'm just wondering if any of the officials present could perhaps offer some comment as to those and the future review of the prescription review program.

Mr. Wyatt: — I would answer that by saying, I mean I think with respect to the PRP, I think we recognize that there is, you know, tremendous benefit that is derived from the operation of the program, whether you look at some of the education that occurs with prescribers around specific . . . either, you know, general areas related to prescribing opioids, or specific incidents when we look at some of the data related to some of the concerns that come forward around prescribing practices that are identified for concern and followed up. I think we absolutely see benefit in this type of a program and want to improve it in any way we can.

I can't speak to issues around, you know, any personnel changes or kind of the day-to-day operations of the program, but from a ministry perspective, I think we see a strong program that has improved over the past few years. I think some of the work that's been done with the introduction of the IT program is a signal around, you know, making that program more effective. It was in the works before the auditor's report came along, but I will also say that with the benefit of some of the auditor's recommendations, I think we've also seen some enhancements.

And so the goal of any program review or evaluation is to obviously look at some of the strengths and what we want to retain but also identify where there are existing gaps that we can identify within the province. As I mentioned before, look abroad and see if there are other ways of strengthening the program. And from my perspective, I think from the ministry's perspective, this is, like many programs, one that has tremendous benefit to the clinicians who are involved but also to the broader public and patients. And, you know, the goal of any review would be to see how we can strengthen it and build on those existing strengths in the program.

Ms. A. Young: — You noted some changes that have taken place in terms of ameliorating some of the outcomes since that report. Could you expand on those just a little bit further?

Mr. Wyatt: — I'm sorry, could you repeat the front end of your question or repeat the question for me? I just . . . [inaudible].

Ms. A. Young: — Yes, sorry. In your comments you noted some positive changes that have happened since the report, and I'm wondering if you could speak a little bit more specifically to some of those.

Mr. Wyatt: — I mean I would just use some of the examples we've talked about, you know, the requirement that all . . . You know, one example would be the requirement that all prescribers have access to the PIP or the viewer if, you know, if there were physicians out there who didn't have access to it and who were not using that.

And this is where the education comes in. It's one thing to have access to the tool. It's another thing to know in what circumstances one might want to look at, you know, and refer to the PIP when you're prescribing. And I'd be able to identify where there may be a concern around, you know, either a situation where a patient might be receiving duplicate prescriptions or the type and strength and product that you're prescribing.

I mean, you know, I think anything that we can do to improve just the vigilance of prescribers to me is an enhancement of the program. And I think it's an example where using that example is one where I would say, you know, with the benefit of the recommendation, it has led us to that change occurring and the recommendation being implemented.

Ms. A. Young: — And in regards to the auditor's recommendation vis-à-vis establishing a risk-based approach to identifying concerns in opioid dispensing, could you offer some comment as to what the ministry's plan is to really kick-start that process?

Mr. Wyatt: — That's one that we're also, as I mentioned before, we're looking at building into the contract with an external group to look at how again as part of . . . You know, where I think we would start is to look at where there are dispensing review programs elsewhere in the country. My understanding is most provinces do not have dispensing review programs. They have prescription review programs, but not programs specifically on the dispensing side. I think, and again I haven't checked this

recently, but I mean if there was maybe one or two across the country, from my recollection, that would be about all. So this is a fairly rare type of program in Canada is my understanding.

[14:30]

So you know, part of what I think we would want to do is understand where they exist, either in Canada or potentially elsewhere, understand what the nature of those programs are, how we would appropriately implement a dispensing review program. I mean for the most part the expectation is pharmacies are dispensing what the prescriber has prescribed. And now there's a role for pharmacy to be reviewing those prescriptions and making sure that they're appropriate and, you know, potentially following up with a prescriber if not.

Having said that, we do have, and the auditor report notes that there are situations where concerns have been relayed related to dispensing by pharmacies, and there are a number of concerns raised with the College of Pharmacy Professionals each year. Knowing that we were taking this approach of, you know, seeking some assistance in reviewing and looking at that recommendation, the opportunity for developing that program, and how we might develop it, there was an audit process that was undertaken around dispensing practices.

And the note I have on that is that, you know, that audit that occurred from April to June of 2020, there was monthly audits that were undertaken to determine whether there was any inappropriate pharmacist prescribing or dispensing that occurred, and the audit did not identify any significant concerns.

So I mean, you know, as I said, I think this is something that we would consider to be, you know, low risk but not a no-risk situation. We're aware of concerns that are brought forward around dispensing practices, and pharmacists do have some prescribing ability. And in particular, during the pandemic with some greater authority that has been conveyed on pharmacies in relation to opioid prescribing during the sort of an exceptional permission that was granted during, or authority that was granted during, the pandemic period. We also know that pharmacists do have some prescribing role as well.

And so I think that's something that, you know, as I said before, we want to approach through this contract process and look at how we would respond with the potential involvement of a dispensing review program or some other way of ensuring that we are overseeing and ensuring appropriate dispensing by pharmacies.

Ms. A. Young: — Thank you. And you're speaking there in regards to the authority received from Health Canada for that exemption for pharmacies. And to understand there, it's primarily aimed at harm reduction.

Mr. Wyatt: — That's correct, yes. The ability to extend, transfer prescriptions for opioid agonist therapy.

Ms. A. Young: — Perfect. It's probably another question that you don't have handy, but the number of prescriptions within Saskatchewan for — pardon my pronunciation; oh gosh — buprenorphine and naloxone. Do you have those numbers available?

Mr. Wyatt: — Yes I do. I came across them as I was looking in relation to your earlier question, so just one moment. I'll find that.

Ms. A. Young: — I was also going to ask about methadone if you have that as well.

Mr. Wyatt: — I'll see about that one too.

And this may also help to answer part of your earlier question around the number of patients because we do have the number of patients receiving Suboxone, which is buprenorphine and naloxone. So in 2020-2021 the number of prescriptions was 113,597 and the number of clients or patients who received prescriptions was 2,315. And I can give you . . . do you want a couple years' worth?

Ms. A. Young: — Sure.

Mr. Wyatt: — Okay. So moving backwards, in the previous fiscal of '19-20, the number of again buprenorphine, naloxone prescriptions was 92,675 and the number of individual patients was 1,723. And I'll go back one further year to 2018-19: the number of prescriptions was 44,344 and the number of clients was 1,010.

Ms. A. Young: — Thank you. Mr. Chair, no further questions.

The Chair: — Thank you for the questions. Thanks for all the responses as well. I'll turn it over to Deputy Chair Young for some questions.

Ms. C. Young: — I just have one question. A lot of this — as been noted in these chapters, and going back to the member from Regina's question, from 2018-19 with regards to the numbers that were in those charts — is primarily based on the prescribers. And as we know the College of Physicians and Surgeons as well as the College of Pharmacy are independent bodies. And you have done a lot of work with the College of Pharmacy in order to be able to track numbers and do things with them.

Just wondering with regards to your relationship and work that's being done with the College of Physicians and Surgeons, even going back to 2018-19, and what's been done in these chapters as to how much work has been able to . . . how much you're being able to work with them in not just educating their physicians but also accessing data that is necessary to be able to provide these reports.

As you know, the College of Physicians and Surgeons, their basic role is to license physicians not to necessarily collect data, but being as how important this data is, it's a relationship that is necessary in order for us to be able to do this work.

Mr. Wyatt: — And I guess I would answer that by saying, you know, the college's role is to license and, you know, at times discipline, but I think the college would also absolutely say that an important part of their role is to support and to educate and to . . . And you know, this is one way by which, through the relationship that the ministry has with the college, we've been able to work with them, engage them.

You know, to your question around the nature of that

relationship, I would say it's been a very positive involvement that the college has had, you know, in offering this program through their organization. You know, it speaks to the importance of the college in being able to, you know, certainly monitor, and at times it may translate into some type of disciplinary action.

But I think just as importantly is the ability for the college to be a partner with the ministry and partner with their own members in terms of, you know, on the prevention side and the education side in being able to avoid situations where there's inappropriate prescribing taking place.

I mean a lot of what happens, a lot of what may occur is not by virtue of nefarious activity. It may well be prescribers who may not be either aware of or closely monitoring, you know, some of the activities, some of the nature of their patients' prescribing needs. And so that's where being able to work with the college and have them take an education approach as frequently as possible is really important in terms of their relationship with both the ministry but also their own members.

Ms. C. Young: — So is the ministry able to request specific data from the college around the physicians they license, in particular for the addiction management part of things, so that those numbers are segregated out? As was noted, they aren't in previous years.

Mr. Wyatt: — Yeah, we receive data for sure. And you know, in terms of the activities of the program, we receive that through reporting that the PRP, prescription review program, provides to the ministry. In terms of the activities of individual physicians, that's probably not something that we would be routinely seeking. I'm not sure if there had been examples where we would ask the program for information related to, you know, a particular situation.

Ms. C. Young: — But based on the fact that the college has requested — and has been implemented — that all physicians are on the IT program that they have, that's data that should be readily available to the college that, if the ministry was able to acquire, would be helpful. So I don't know where that request would come from, if the ministry is able to request that from the college.

Mr. Wyatt: — Yeah, I mean there's certain information we will have access to, you know, through the PIP, but some of the information related to what they are generating — for example in terms of looking at trends or potentially concerning behaviours — if we're looking for information from the PRP in relation to that, I think that would be something that would be made available to us.

Ms. C. Young: — Thank you.

The Chair: — Any further questions from committee members? Thanks for the engagement of all members in this and for the questions and the work of the auditor. This is a substantial chapter. And of course thank you to the ministry for all their work. And I'll just pass it back over to the ADM.

Mr. Wyatt: — Sorry, I just wanted to follow up on one specific question that was asked, and it was around the RxFiles agreement. I just got information that that was renewed in April 2020 for a three-year period until March 31st of 2023.

The Chair: — Thanks for that answer, and thanks as well for the undertaking to get the other bits of information back to this committee through the Clerk. And of course, there's still outstanding actions to be taken to implement some of these recommendations so we just, you know, thank all those that will be involved in that work and all the partners and all the stakeholders to ensure implementation in due time. It's certainly an important chapter.

With respect to the recommendations, we'll revert back to . . . just to make sure that we're referring to them with the numbers that they were identified in chapter 7 of the 2019 volume 1 report. And I would welcome a motion that we concur with recommendations 1, 3, and 5.

Ms. C. Young: — So noted.

The Chair: — Moved by Deputy Chair Young. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. I'd welcome a motion that we concur and note progress with respect to recommendation 6. Mr. Nerlien. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — That is carried. With respect to recommendations 2, 4, and 7, I'd welcome a motion that we concur and note compliance. Mr. Skoropad. Moved by Mr. Skoropad. All agreed?

Some Hon. Members: — Agreed.

The Chair: — All right. That's carried as well. With respect to the follow-up chapter, chapter 28 of the 2021 report volume 2, I would welcome a motion that we conclude consideration.

Ms. C. Young: — I'll so move that we conclude consideration.

The Chair: — Deputy Chair Young moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. All right, we'll move along now to, I believe, chapters 26 and 27. But I'll leave that to the auditor to direct, and I'll turn it back over to the auditor's office.

Ms. Lowe: — Chapter 26 of our 2019 report volume 1 on pages 273 to 276 and chapter 27 of our 2021 report volume 2 on pages 207 to 210 report the results of our follow-up audits of the two outstanding recommendations originally made in our 2014 audit related to processes to coordinate the use of lean as a continuous improvement methodology across the health sector.

The two outstanding recommendations have been addressed. We found that the ministry had established and participating health sector agencies were using a risk management model to manage and address issues that affect the use of lean. We also found that the final recommendation is no longer relevant to assess, as the ministry does not have sufficient verifiable data on the outcomes

achieved using lean to report publicly.

[14:45]

The initial focus of the lean initiative was on training, and therefore baseline data was not collected. Evaluating outcomes achieved since 2009, when lean was first used, remains difficult for the ministry because of both the absence of baseline data and the challenges in separating the impact of improvement efforts through lean principles from other contributing factors such as shifting demographics and health sector investments made. Without sufficient verifiable data, the ministry does not intend to report publicly on the benefits realized from the use of lean, and we agreed was no longer feasible.

This concludes my presentation.

The Chair: — Thank you for the presentation. I'll turn it over to Associate Deputy Minister Macza.

Ms. Macza: — Given the auditor's current recommendation on this, we have no further comments.

The Chair: — I'll open it up to committee members for questions. Ms. Young, University.

Ms. A. Young: — Thank you, Mr. Chair. In regards to lean, I'm curious if the officials could offer comment . . . what role, if any, lean has had in the ministry's pandemic response.

Ms. Morrissette: — So you know, I think it's fair to say, and if you talk to many of the leaders in the health system, you know, the foundations of lean, and really what we call continuous improvement these days, continue to be really how we approach our work.

And throughout the course of the pandemic, you know, the response required us to respond quickly to come up with programmatic solutions very quickly, to continuously pivot with changing information and changing knowledge, to build out service lines that we'd never delivered before. And I think it's safe to say that really the foundations of some of what we learned through our lean days, but also through our ongoing commitment to continuous improvement in our health care management system, really were foundational to our COVID response. And I think, you know, there's probably lots of examples.

But some of the things that, you know . . . I'll maybe touch on a few. You know, when we think about the service delivery response required — even just designing assessment centres, setting up drive-through clinics — there are many of those foundational principles that we learned around patient flow, around being efficient.

When you have a demand — and testing is a really good example of this where we have a really high demand for testing — every minute counts. And so the approaches that we were able to glean through this, you know, base of knowledge that we have in the system really help us build those programs and helped us adapt really quickly and get better and better at that as we started to implement some of those programs.

So you know, to answer the question at a really high level, I think it is really fair to say that there are probably hundreds of examples of where the foundational knowledge that we've gained really did position us well for the pandemic experience.

Ms. A. Young: — Thank you. You talk about every minute counting. I got my booster at Core Ritchie on one of those, like, minus 45 days, and I was waiting in line outside with a number of other people. And so yeah, every minute really did count in that weather. And I appreciate hearing those positive examples. I really do.

We did hear, I think, earlier in the pandemic from some sector stakeholders that the — I'm trying to remember the name of the inventory management — the just-in-time inventory management system had led to challenges with supplies of PPE [personal protective equipment] and other essential supplies early on that were being competitively sought in other jurisdictions. Could the committee get an update on any challenges there or whether processes around inventory management have changed since then?

Ms. Morrissette: — I would say with respect to some of the examples that you used around some of the PPE and other issues early on in the days of the pandemic, I would characterize that . . . Maybe there's a couple of things there. One is that really was, you know, global supply chain issues at the heart of much of what we were experiencing at that time.

But what I would say is, through the course of the pandemic and using some of the knowledge that we have around our health care management system and continuous improvement, we were able to make some improvements to the way that we manage those supplies. And so you know, I think there has been lots of good work in the system to really expedite some of the things that we knew we had wanted to do by way of improving some of the supply management.

I would say just with respect to your question around, you know, how are we sitting these days with respect to the supply of some of those critical items needed to manage the pandemic in a safe way, we do have a high level of oversight on all of those supplies. We do have continuous refreshment of those supplies so that we're using them in the best way. You know, we don't have wastage and other things happening. And so we are confident in our supply of many of those things.

We are seeing though in the fifth wave some early signs of that market, you know, tightening a little bit. And we are monitoring that really very closely and making sure that we have enough, and that the distribution systems in place really are well-suited to meet the needs and get them where they need to get so that we don't have this situation of competition or supply chain logistic issues.

Ms. A. Young: — Okay. Pardon me, Trent. We're doing 26 and 27 together, correct?

The Chair: — That's right.

Ms. A. Young: — All right. Thank you, Mr. Chair . . . [inaudible interjection] . . . or Trent. Yeah, let the record show that the Chair is heckling me throughout this and throwing me off my very serious game. Still going.

A couple of questions in relation to obviously chapter 27 and their recommendation no longer being applicable. I guess my understanding is that the office of the auditor had encouraged the ministry to use kind of currently sourced and available data to evaluate the success of lean. And you know, recognizing this is ground that we've gone over a few times, I'm wondering how the ministry plans to measure the success of lean going forward, if that kind of verifiable data on outcomes achieved isn't being tracked.

Ms. Morrissette: — You know, I think we worked really closely with the auditor to try — and we did try several times — to come up with an approach that would get us to where we could achieve this recommendation. And as I think the auditor and our office have, you know, come to the conclusion that we just didn't have the baseline data to monitor kind of at the broadest level of the effectiveness of lean in the system. And you know, it's an issue of baseline, but it's also an issue of there are so many things that contribute to improvement in our system. I mean I don't have to tell the committee this, but it is complex. And so you know, kind of sussing out from an evaluation approach what contributes to what proved to be quite difficult despite us making several attempts to do that.

What I will say going forward, a couple of things maybe. So I think your initial question was a good one and it really does underscore the value. And so you know, the value for us is we have a system now that really has matured its ability and its approach in terms of working toward being a high-performing health system. When we look at high-performing health systems, and we have done this over a number of years — a continuous improvement. And in this case it took the form of lean. But it's a foundational principle of every high-performing health system.

And you know, the answer to the question about how were we served in COVID with those skills I think is, you know, really for us underscores the value that we got out of that. Having said that, we continue to be committed to continuous improvement as one, you know, one prong that underlies a broader health care management system. And so it is important that we are transparent and do have an eye to reporting to our patients and to the public around, you know, what's the value of that approach.

And so it is on our plan to really think a little bit about how we do that moving forward, and how we articulate, ensure the learnings that we are achieving through these kinds of approaches to the broader system to ensure that we're, you know, driving value and really using the resources that we've put towards this really efficiently and effectively. We do have people in our system who are highly skilled in this area. But you know, part of the approach was making sure that everybody in our system has kind of an understanding of the approach.

And so I think through those two things, you know, certainly it is our intent to continue seeing improvements. We haven't sorted out the formal reporting mechanism going forward, but that is a project that we are hoping to press unpause on once we have a bit of capacity coming out of COVID. But I really do want to underscore that, you know, this kind of work is happening every day in our system, but we do need to get to that kind of longer term game plan around exactly what will that reporting look like and how can we tell the public and our patients, you know, what that value is.

Ms. A. Young: — Thank you. A couple more questions here. For the other organizations, and pardon me, I didn't go and do the research to see if they've been subject to an audit, but for example the Saskatchewan Cancer Agency, the former health authorities, who had also undertaken this work — I'm not sure if my question is to the officials or to the auditor here — were those organizations able to evaluate the success of lean or other continuous improvement methodologies? Did they establish baseline data to evaluate that success? Are you aware of that?

Ms. Clemett: — So I'll maybe start by saying they would have been obviously participants and partners as such, and would have been carrying out varying initiatives. And obviously since the work around lean was done too — we used to have always the 12 former regional health authorities — everything has been consolidated into one. And to some degree, lean was about sharing and leveraging some of that knowledge and almost like efficiencies that would have been gained and sort of continuous improvement projects that took place. So some of that would be happening almost like through just the creation of one probably provincial Health Authority now. But no, there isn't.

And back in the original audit, which you won't see because of the previous follow-ups though, there was specific initiatives taken by sometimes the Cancer Agency, sometimes by the regional health authorities. And there was a mechanism in which it was trying to figure out what are we trying to achieve, what are the actions we're going to take, and then did we. What are some of those costs and efficiencies that will be gained? And those projects were analyzed at a more like very individual project level. But nothing holistically is being reported out in terms of efficiencies and benefits realized from lean by these agencies.

Ms. A. Young: — Thank you. And I noted in the report . . . I believe I noted in the report that it was the ministry determined that the available data was insufficient, and that this was communicated to the office of the auditor in I think it was August of 2021. Had this previously been discussed? This was obviously evolving from 2016 to present.

Ms. Clemett: — Yeah. Because if you look, to some degree this has now been almost, you know, 10 years have passed to some degree. So I guess the discussions we had and why we almost originally made the audit again . . . Without the original audit in front of you it's almost like you probably are missing some context that is needed. But as the lean methodology was being rolled out, to some degree again it's just tools that'll be utilized for our continuous improvement, I would argue.

There were intentions to sort of utilize the U of S [University of Saskatchewan] to do a study to sort of figure out, okay, is there certain, I guess, benefits we're trying to achieve, how would we measure those, and then let's report accordingly. A lot of that work sort of never did come to fruition.

And then now so much time has passed, I think as the ministry official has articulated, it's very hard to now figure out if, let's say, we have emergency wait times that have improved since the introduction of lean, is that a result of lean, or is that because we now have larger ERs [emergency room]? Do we have better capacity, and some of that. So it's hard to do that direct correlation. And so we've just decided that it's no longer feasible, and we're fine to sort of no longer have this recommendation on

the plate.

Ms. A. Young: — Thank you. One final question. It notes in chapter 27 that the ministry planned a series of presentations for health sector partners on continuous improvement tools for quality and safety of health care service delivery.

[15:00]

And I was — not in a negative way — I was surprised by that obviously given the pandemic. And it doesn't seem like there are a great many new initiatives coming out just given the kind of all-hands-on-deck mentality that seems to be fairly encompassing. And I'm wondering, did those occur?

Ms. Morrissette: — So we had been talking a little bit about — and it's again related to your earlier question — you know, what could a forum look like where we really were sharing some of those practices and approaches that we used during COVID. Because there are many and we didn't want to miss the opportunity to share. Each successive wave has, you know, harboured our ability to really do that in a way that we wanted to. But certainly we have taken time, as we've gone through the pandemic, to really document best practices, document some of what are happening, which they share those on kind of a more micro scale, or you know, within and between organizations. Just not kind of in that formal way. But certainly that's still on our radar, and something we'll continue.

And again I'd say that we really are committed to continuing on with these approaches and making sure they have this ability and that we are, you know, reporting and sharing. And so that will be considered in . . . You know, it's not just an event, it's kind of an ongoing way of making sure we have this, you know, a plan to kind of continue to do that. And it will certainly include our partners. Much of the work in the system is done by our delivery partners, and where you see the real impacts from a patient perspective are at that level.

And so, to the question around have the other agencies kind of been captured in some of these contemplations: certainly, you know, that's front-of-mind for us in terms of how we can holistically as a system really make sure that we've got a system of sharing and reporting and building and maturing in this space, as many high-performing systems would.

The Chair: — Any further questions from committee members? I'm not seeing any at this time. I think it's fair to say I've been around this Assembly for a bit, and around this lean discussion for a while — over a decade — and I think the member from Batoche is the only other member. That might have been the least animated discussion we've ever had about lean in the Assembly, which is just fine.

I will seek a motion to conclude consideration of chapters 26 and 27 of the 2019 report, volume 1, and 2021 report volume 2, respectively. Mr. Nerlien moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried.

We'll move along now. I believe we're going to be dealing with chapters 27 and 17 together. I'll turn it over to the Provincial Auditor's office.

Ms. Lowe: — Chapter 27 of our 2019 report volume 1 on pages 277 to 283 and chapter 17 of our 2021 report volume 1 on pages 207 to 218 reports the results of our first and second follow-up of the recommendations originally made in our 2016 audit about its processes to provide special needs equipment for persons with disabilities.

By our second follow-up, the ministry, primarily through its service provider Sask Abilities Council, improved some of its key processes to provide special needs equipment. But two recommendations remain outstanding.

The Ministry of Health still needs to work with its service provider to identify special needs equipment on loan that is no longer used and to recover this equipment within a reasonable time frame. By December 2020 the service provider implemented several strategies — such as sent letters, attached stickers to equipment — in an attempt to recover unused equipment but produced little results.

Our review of the ministry's reports found from December 2018 to September 2020 there were 6,248 clients with 13,560 pieces of loaned equipment were either deceased or left the province as of September 2020. We also found that 25 per cent of this equipment would be considered obsolete. Having accurate and up-to-date records will help the ministry and its service provider focus its efforts on recovering equipment that clients have not already returned and on equipment that is not obsolete.

The ministry also needs to assist its service provider in developing a process to complete appropriate preventative maintenance on special needs equipment on loan. In April 2018 the council began reporting to the ministry on a quarterly basis the number of client contacts for preventative maintenance. However clients with special needs equipment on loan do not always respond to the service provider's request to bring equipment for maintenance. Also we found three pieces of equipment the service provider did not perform preventative maintenance on before loaning to new clients.

The ministry still needs to help the service provider to develop a robust process to complete preventative maintenance. Failure to perform proper preventative maintenance on equipment on loan increases the risk of injury to clients.

This concludes my presentation.

The Chair: — Thank you for the presentation. On the focus of the chapters, I'll turn it over to Associate Deputy Minister Macza.

Ms. Macza: — With regard to recommendation 1, implementing further strategies and action plans so that clients receive special needs equipment within an acceptable time frame, we note, the Provincial Auditor has noted this recommendation is implemented.

With regard to recommendation 2, that the ministry work with the service provider to identify special needs equipment on loan that is no longer utilized, and to recover this equipment within a reasonable time frame, the ministry continues to work with

SaskAbilities to identify and pursue opportunities to further improve the return of unused equipment, and an IT system is being explored to assist with this work.

With regard to recommendation 3, that the ministry work with its service provider to track the quality and timeliness of repairs, we note, the Provincial Auditor is noting that this recommendation is implemented.

With regard to recommendation no. 4, that the ministry assist its service provider in developing a process to complete appropriate preventative maintenance on special needs equipment, the ministry is working with SaskAbilities to identify opportunities for improvement here within the existing preventative maintenance processes, and an IT system is being explored to assist.

With regard to the fifth recommendation, that the ministry set out how it plans to measure the success of the special needs equipment program, the Provincial Auditor notes that this is implemented.

With regard to the last recommendation, that the ministry set clear expectations for when its service provider should escalate complaints to the ministry, Provincial Auditor is noting that this recommendation is implemented.

That concludes my comments.

The Chair: — Thanks for the comments. I'll open it up for questions. Ms. Young, Regina University.

Ms. A. Young: — Thank you, Mr. Chair. One initial question just for clarification. The use of the term "service provider," is that a third party or is that referring to Saskatchewan Aids to Independent Living?

Ms. Clemett: — So that is a third party provider; that's the Sask Abilities Council.

Ms. A. Young: — Okay. Perfect. Recognizing the recommendation has been implemented, just in regards to 3.1, just wondering if someone could help me understand. I see that the demand for wheelchairs in particular is increasing. Is this due to an increase in the size of the disability community, increase in aging population? Just looking for some insight.

Mr. Wyatt: — I expect you would probably see a number of factors, and I think you've touched on some of them. Certainly increasing numbers of seniors is going to be a big driver for a program. When you look at the type of equipment that's offered through the special needs equipment program, I would say demographics will be a big driver of the demand for that program for sure.

Ms. A. Young: — And in regards to the grants program that was implemented, are the grants sufficient to purchase the equipment? Or does the grant only fund part of that purchase?

Mr. Wyatt: — In the past we had . . . the ministry did have some involvement in equipment purchases, but we have shifted some of that grant to SaskAbilities so that they are now handling that as well. And so the grant does include acquisition now in addition to the operation of the program.

Ms. A. Young: — Sorry, perhaps I'm not being clear. So if the grant is for me to purchase a motorized wheelchair, would it buy me all of it or just, like, 75 per cent? I guess that's what I'm asking.

Mr. Wyatt: — For most of the equipment, it would cover the full cost, and there are some types of equipment where there is some cost to the individual.

Ms. A. Young: — Okay. Which classes of equipment would that be?

Mr. Wyatt: — Probably the best example might be different types of wheelchairs, where it's something that is above sort of the basic level.

Ms. A. Young: — And that would likely be why those seem to be the common threads for the complaints which are escalated to the ministry level. They seem to be specifically around motorized or ultralight wheelchairs, by and large.

Mr. Wyatt: — Yeah. There is a growing interest among clients to look at the ultralight wheelchair. And you know, one of the things that we did was develop a co-pay program where there is funding that's provided to the individual and then they have the ability to also procure the equipment on their own with the availability of some base funding from the SAIL [Saskatchewan Aids to Independent Living] program.

Ms. A. Young: — And is there a set percentage of that base funding that is provided? Is it, like, 50 per cent, or the majority? I'm aware of the increasing cost of these, certainly for the government and also for the individuals.

Mr. Wyatt: — I'm not sure that I would have an answer in terms of the percentage that that would cost. And obviously it would depend somewhat on the cost of the equipment. If you were seeking something that was at a higher cost, it would be a smaller percentage based on the payment through the SAIL program.

Ms. A. Young: — And then one further question about the language used here as it relates to the grants program. Parts of this report discuss equipment as being purchased and other parts obviously discuss it as being on loan. How is ownership considered as it relates to the grants program? Is that equipment then the property of the individual or the ministry?

Mr. Wyatt: — I will have to follow up with you on that question as well. I don't have the detail around that.

Ms. A. Young: — Do you have any numbers available in terms of how many clients purchase equipment through this program or end up just self-funding?

Mr. Wyatt: — Just find some data here. So I think there's some data in the auditor's report around the number of power wheelchairs, other equipment. Hospital beds, manual wheelchairs are provided, and I can sort of provide . . . I guess I can cover some of that basic information around the number of power wheelchairs. For example, in 2021 was 29; and other equipment, two hospital beds, 34 manual wheelchairs, 126 . . .

There's some examples of some of the volumes for specific pieces of equipment.

Ms. A. Young: — And I see in regards to the wait-time periods, just one question. I see that the service provider has indicated that four months is an acceptable period of time to wait for a power wheelchair. Is this an internal target or is this exclusively from this service provider?

Mr. Wyatt: — I mean I think our goal is to provide the equipment in a timely way, and so that's something that, you know, both the ministry and SaskAbilities would see as an important goal.

[15:15]

You know, we have definitely had some challenges in terms of the timelines for providing that equipment. We have seen reductions in the number of patients who are waiting for extended periods of time for different types of equipment, certainly around, you know, the different types of wheelchairs, hospital beds.

We've seen some improvement over the last few years around the numbers waiting over the, you know, the four-month period that's noted by the auditor. And so that's something that we're continuing to work away at and, you know, definitely a priority for that ongoing relationship between the ministry and SaskAbilities.

Ms. A. Young: — Thank you. Yeah, I'm more curious as to, you know, if this is a target — and obviously, like, I appreciate shorter wait times for essential equipment are clearly a goal — but just if this is a target that the ministry is working towards with SaskAbilities, are those targets identified collaboratively or are these set by SaskAbilities or internal to the ministry?

Mr. Wyatt: — They're targets that I know that we are working, you know, working collaboratively with SaskAbilities on. And so I would say it will be a metric and a target that we are both trying to work towards.

And I would note that I did get some information around the grants. And in a situation where a grant is provided to an individual for a wheelchair, for example, that would become the property of the individual, and any maintenance for that equipment would be the responsibility of the individual.

Ms. A. Young: — Excellent segue, thank you so much. In regards to recommendation to the special needs equipment on loan that's no longer utilized and in many cases, obviously, seems to be unrecoverable, does the ministry or the council, or has the ministry or the council undertaken to value or establish the cost of that equipment? Of course noting some of it will be over 20 years old. But I imagine that would show up as a liability somewhere for either the ministry or SaskAbilities.

Mr. Wyatt: — I'm not aware if we have done a valuation of that. I would have to follow up to understand if that's been undertaken.

Ms. A. Young: — So we wouldn't have an estimate available in terms of the . . . even amortized value of all of that equipment.

Mr. Wyatt: — I certainly don't have that with me.

Ms. A. Young: — So appreciating the task before the ministry in regards to recovering I believe it was nearly 40,000 pieces of equipment dating back to 2000, was there confidence that some of this could, a substantial portion of this equipment could be recovered?

Mr. Wyatt: — I mean I think we saw it as a reasonable intervention to make and, you know, with the hopes that that kind of tracking and follow-up with, you know, for example the facilities where some of these wheelchairs and other equipment would be located, would generate some improvement. I don't know that we had a specific goal for that, you know, for that particular initiative.

I would say part of the problem that SaskAbilities has had has been, you know, as the information was shared with the committee indicates, is they're working with fairly rudimentary information. And the ability to track and to be constantly looking at equipment related to the individuals who are, you know, the individuals who are using it, the timelines that they've had it, the maintenance, that is something that is certainly much more effectively managed with a proper database and functionality of a database. And so, you know, that's really where I think we see, you know, probably the greater opportunity now to be able to support SaskAbilities in being able to identify and then follow up where there is outstanding equipment.

Ms. A. Young: — And just two more questions in regards to that equipment. What does reporting look like for that? Is it reported as a loss, you know? Like prior to being here, I came from school division land where, you know, if you had a laptop stolen out of your car, it would show up with the Provincial Auditor as like loss of public money. With 40,000 pieces of equipment, I'm just curious whether this is considered, you know, public assets or is it arm's length through . . .

Ms. Clemett: — Correct. Yeah like the inventory would be recorded really on the council's records as such. And really the ministry's giving them the funding to almost buy that equipment. It's a matter of . . . All that equipment, like you said, is not returned. There is individuals, I think as the ministry official has indicated, that are perhaps waiting for that equipment. They could be using it, so that would be good.

Ms. A. Young: — Yes.

Ms. Clemett: — Or as you indicated, I guess, if that equipment is no longer viable, it's important to just clean up your records. But that would perhaps mean the ministry might need to give more dollars to obviously buy more equipment. But as you can see, there is a fair amount that's fairly old and so probably not worth much anymore anyway, and needs to be, like, really cleaned up. And that would be much easier if they probably had a very effective IT system.

Ms. A. Young: — Yes. And that was going to be my final question in regards to the equipment. You know, with 25 per cent of the equipment being identified as obsolete, but there also being relative wait times for pieces of this equipment for the individuals who require it, whether it was anticipated that this potential IT system would be able to essentially . . . I don't know if the right

term is, like, "triage" the needs for equipment vis-à-vis the age and potential suitability of the outstanding equipment that can still be located.

Mr. Wyatt: — Yeah, and I think the goal would be, you know, with improved monitoring and tracking of equipment that's outstanding and the ability to recover it when it's no longer being used.

And also we're also looking at it from a maintenance perspective, that it would give you the ability to, you know, for SaskAbilities, I should say, to be able to re-use. And you know, I guess, for equipment that is still functional and still considered to meet the current program standard, the ability to re-use that equipment to reduce the number of new pieces of equipment that are required to purchase and reduce the cost, improve the efficiency of the program and the benefit that the program can offer.

Ms. A. Young: — Thank you. In regards to preventative maintenance and the recommendation therein, is there any awareness as to whether any clients or staff have been injured as a result of a failure to perform proper preventative maintenance on that equipment on loan?

Mr. Wyatt: — I'm not aware of any situation as you've described it.

Ms. Clemett: — And the audit didn't find any instances of this.

Ms. A. Young: — The audit didn't. Okay, excellent. Just one, I think, last question. It's noted in the report that the . . . Do you refer to it as the SAIL program? Anyways the program works to establish the affordability of disability supports and helps the government to evaluate those. And I'm curious if there's any comment that can be offered on the interaction of this program with the SAID [Saskatchewan assured income for disability] program and how often the program supports in here are evaluated vis-à-vis the cost of living and kind of meeting basic necessities.

Mr. Wyatt: — I know that there is a close working relationship between the SAIL program and Social Services. I'm not aware, you know, in terms of how they might assess the income assistance provided through social assistance programs and the supports provided by SAIL. I think I would say that the special needs equipment program is a needs-based program more so than an income-based program, and so you know, the requirement for a walker or a wheelchair is identified through individual need.

Ms. A. Young: — Thank you for that clarification. Two last questions. I'm just looking for some comment in regard to the bulk purchasing. I note, I think it was hospital beds that were targeted for bulk purchasing on page 210, and I'm just wondering what the status of that was.

Mr. Wyatt: — I'm sorry, I just want to correct one thing I said. I should note that there is, just on your last question, there is a part of the program that loans low-cost equipment that is restricted to supplementary and family health beneficiaries and those registered with the Saskatchewan income program. And some examples of that equipment would be crutches and bathtub clamps. And so I just want to note that there are some dimensions of the program that would be related to participation in those income support programs.

And I'm sorry, could you repeat — as I was looking that up — could you repeat your last question for me?

Ms. A. Young: — For sure. Just the status of the bulk purchasing that was identified as targeted for, I believe, early 2021. I believe it was bulk purchasing of hospital beds.

Mr. Wyatt: — I will commit to following up with the committee in getting an answer for you.

Ms. A. Young: — Thank you. And my last question on this chapter is, I notice obviously the implementation of the complaints escalation process, and I see as a result of that, complaints, numbers have gone up. And you know, obviously the committee would find it positive that those clear expectations for escalating complaints are there, and I'm just wondering if some general comment could be offered on how that process has unfolded since its implementation and any reflections on that you're able to offer.

Mr. Wyatt: — I guess what I would say there is that there are a number of different types of issues that come forward related to the program and so there are some that are sort of directed towards the receipt of equipment and issues related to the equipment itself. Those are being managed through this process by SaskAbilities. There are kind of more general concerns that come related to the program itself and those would be the types that would be directed to the Ministry of Health as the . . . again coming back to the same sort of concept that we discussed with respect to the prescription review program.

Ultimately the minister is responsible for the program and working with SaskAbilities as the program delivery organization. And so you know, in response to the recommendation, the approach taken was that those concerns that are kind of operational in nature will be managed by SaskAbilities. Those that are more related to the program and its policies go to the ministry. And if there are concerns that are not resolved at SaskAbilities, where there is sort of some opportunity to escalate it to the ministry, the new process incorporates that.

[15:30]

In terms of just how effectively that is working, I haven't heard any further issues with that sort of new standard work in place.

The Chair: — Any other questions from committee members? Not seeing any at this time, I would welcome . . . We've already voted; we've already concurred on these recommendations. There's the two that are outstanding that you detailed the work. Certainly they're important recommendations. But at this point in time, I would welcome a motion that we conclude considerations of the 2019 report volume 1, chapter 27 and the 2021 report volume 1, chapter 17.

Ms. C. Young: — I so move.

The Chair: — Deputy Chair Young, Lloydminster moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll move along now to chapters 22 and 26, and these contain recommendations that we haven't yet dealt with as a committee. I'll turn it over to the Provincial Auditor's office.

Ms. Lowe: — Chapter 22 of our 2019 report volume 2, on pages 155 to 176, reports the results of our audit of the Ministry of Health. We concluded that for the 12-month period ended June 30th, 2019, the Ministry of Health had effective processes, except in the matters of our recommendations, to coordinate the appropriate provision of timely and quality helicopter ambulance services in Saskatchewan. We made eight new recommendations for the committee's consideration. Chapter 26 of our 2021 report volume 2, on pages 197 to 206, follows up on these recommendations.

The Ambulance Act makes the Ministry of Health responsible for providing air ambulance services to any person in Saskatchewan. Saskatchewan provides two types of air ambulance services: via airplane and helicopter. The ministry contracts STARS [Shock Trauma Air Rescue Service], a non-profit organization, to provide 24-hour air medical transportation for critically ill and injured patients by helicopter. The ministry pays STARS $10.5 million each year to deliver helicopter air ambulance service in Saskatchewan, which covers approximately 50 per cent of agreed-upon STARS operating costs.

In 2018-19 the average cost for STARS transport was approximately $14,876 per flight. This includes aircraft maintenance, education of STARS medical staff, STARS dispatch centre, and other expenses. Annually, for nearly 700 patients, STARS transports around 60 to 70 per cent as inter-facility transfers and about 30 to 40 per cent from accident scene calls.

Deciding which type of ambulance service — for example, ground ambulance, helicopter, airplane — to use requires coordination among physicians, facilities, ground ambulance and air ambulance providers. I'm going to focus my presentation around eight of the recommendations.

Our first recommendation: on page 162 we recommend the Ministry of Health formalize the prioritization process for selecting heliports and landing zone locations for helicopter ambulance use.

Under agreement, STARS operated three helicopters in Saskatchewan, one in each base in Regina and Saskatoon and third being a backup. At June 2019 there were six certified heliports in Saskatchewan. The ministry, in collaboration with STARS and the Saskatchewan Health Authority through the heliport landing zone oversight group, decides where to construct heliports.

As of June 2019 the oversight group identified the next priority locations for constructing certified heliports in Prince Albert, North Battleford, and Yorkton. We found that this group used good practice considerations while establishing these priorities, for example, proximity of existing heliports, highest numbers of requests for STARS per year. However we found that the oversight group did not formally document or approve its prioritization process or the factors it must consider. This increases the risk of making inconsistent decisions about priority locations for heliports and landing zones in the future.

As of June 30th, 2021 we found that this recommendation was implemented. The Ministry of Health, through the heliport landing zone oversight group, formalized the criteria used to prioritize decisions about developing new heliports and landing zone locations for helicopter ambulance services. Having a formalized prioritization process helps make consistent decisions and promotes treating communities equitably and providing access to timely helicopter ambulance services.

In our second recommendation on page 165, we recommend the Ministry of Health, working with others involved in the coordination of transporting patients, develop terms of reference for the consultation committee responsible for overseeing patient transports using helicopter ambulance services.

The ministry is also involved in another STARS-chaired committee which in practice oversees patient transports using helicopter services. Representatives from STARS, the Sask Health Authority, and the ministry as part of this committee, annually reviewed the criteria for using particular transport for a patient. The committee also had bimonthly calls to discuss issues encountered during STARS missions. We found the committee did not have a terms of reference. Terms of reference typically sets out in writing a committee's purpose, membership, membership responsibilities, and reporting structure.

As of June 30th, 2021 we found that this recommendation was implemented. The Ministry of Health, working with others, approved a committee terms of reference in May 2021 and helps ensure all members know their roles and responsibilities.

Our third recommendation on page 168, we recommend the Ministry of Health actively oversee air ambulance services, for example, chair committees responsible for helicopter ambulance services oversight. The ministry chairs air medevac advisory committee which purpose is to determine strategic priorities for all air medical services and to collaboratively plan for the provision of critical care air medical services in Saskatchewan.

The ministry-chaired committee includes members from the ministry, the authority, and STARS, as well as others. The committee intended to meet quarterly, yet as of June 2019 there were no meetings since November 2018 because of staff changes at the ministry. We found this committee serves as the only committee or group related to air ambulance service delivery that the ministry chairs. Because the ministry is responsible by law for air ambulance services, it is critical to ensure its committees remain active. As of June 30th, 2021 we found this recommendation was implemented. In October 2019 the advisory committee resumed its quarterly meetings.

Our fourth recommendation on page 169, we recommend the Ministry of Health periodically verify medical staff qualifications and training of those providing helicopter ambulance services. The ministry, in its agreement with STARS, requires all STARS staff to be registered or licensed by a professional regulatory body and for STARS to provide them with ongoing training. The ministry also requires STARS to staff each mission or flight with two pilots and, at minimum, a qualified critical care paramedic and nurse.

We did not find any issues with STARS staffing and training, but yet the ministry does not require STARS to regularly report on staff qualifications or training or actual staffing used on missions. This is contrary to good practice for managing contracts. The ministry is the helicopter ambulance program steward, so it needs to know whether STARS uses appropriately qualified and trained staff on all missions.

As of June 30th, 2021 we found that this recommendation was partially implemented. The Ministry of Health received STARS's report on medical staff qualifications but has not yet received adequate reporting on staff training. A more detailed report on staff training was expected in 2021-22. Without this information, the ministry does not know whether STARS meets the terms of its agreement as well as whether it uses only appropriately trained medical staff to provide air ambulance services to Saskatchewan patients.

In our fifth recommendation on page 171, we recommend the Ministry of Health obtain written reasons where timeliness indicators for helicopter ambulance services are not met. Although not required in its agreement, but consistent with good practice, STARS reports to the ministry each quarter its monthly average dispatch time, so the time between 911 call and STARS helicopter dispatch, and the chute time — the time between dispatch and liftoff — by location and overall.

Even though STARS reports average times, the data does not explain trends or highlight instances where STARS did not achieve the targets or explain why. In terms of dispatch time goals, quarterly STARS report noted that it is not met in 40 per cent of the time, but it did not explain why. Without receiving adequate reporting from STARS about the timeliness of air ambulance services, the ministry cannot understand why there may be delays or take action to better coordinate the provision of helicopter ambulance services.

As of June 30th, 2021 we found that this recommendation was implemented. Each quarter, STARS provides the ministry reports on its timeliness indicators. When STARS has not met the target, the report outlined the reasons why, or the ministry discusses the issues with STARS. Receiving adequate reporting from STARS about the timeliness of air ambulance services allows the ministry to understand the delays and take action if required.

In our sixth recommendation, on page 172, we recommend the Ministry of Health routinely receive and analyze key information about the quality of patient care provided during helicopter ambulance services. The ministry had not determined how best to analyze the overall quality of care provided by helicopter ambulance services. Rather, the ministry relies on critical incidents reports to gain insight about the quality of patient care received through helicopter ambulance services.

We found ministry management unaware of the quality-of-care indicators STARS tracks. In practice, STARS tracks several quality indicators, for example the percentage of successful advanced airway placements. The lack of a regular, timely tracking of key quality-of-care indicators limits the ministry's ability to analyze performance information for helicopter ambulance services and to take timely action to address issues with quality of care.

As of June 30th, 2021 we found this recommendation was not implemented. STARS tracks six quality-care indicators related to medical procedures completed during a mission. The ministry did not receive this information from STARS during 2020-21, although it expects to receive this information beginning in quarter one of 2021-22.

In our seventh recommendation, on page 174, we recommend the Ministry of Health receive periodic and detailed reporting on the number and reasons for cancelling or declining requests for helicopter ambulance services.

We found the ministry did not ask or obtain adequate information from STARS about reasons for declined helicopter service requests and cancelled missions to determine whether it provides sufficient and appropriate helicopter ambulance services.

For the period from July 2018 to May 2019 we analyzed the reason why service request submissions were cancelled or declined. In particular we found 82 per cent of uncompleted missions resulted from STARS being asked to stand down, and 10 per cent of missions not accepted or declined resulted from STARS being on another mission. Periodically analyzing declined or cancelled service requests and missions would give the ministry a better understanding for the appropriate use of STARS and the barriers affecting STARS' ability to respond. Not doing such analysis increases the risk the ministry may be unaware of potential risks or barriers to provide timely and appropriate air ambulance services in the province.

As of June 30th, 2021 we found that this recommendation was not implemented. Each quarter the ministry receives reports from STARS on its operations and activities. This includes the number of calls received, the number of missions, and the number of patients transported. The reports do not explain why STARS declined service requests or why missions were cancelled. Ministry management indicated they expect to receive this information quarterly from STARS beginning in late summer 2021.

In our final recommendation, on page 175, we recommend the Ministry of Health receive periodic reports on the maintenance of helicopters used to provide air ambulance services. The ministry did not expect STARS to share, nor did it receive summarized results from Transport Canada's inspections of the three helicopters used to provide air ambulance services in Saskatchewan. Our audit found STARS declined 16 requests for potential missions due to unscheduled maintenance on eight different days. While the ministry received information on scheduled maintenance dates, it did not ask for or receive any details about unscheduled maintenance, including the time helicopters were out of service, the reasoning, the number of missions declined as a result, and STARS' strategy to minimize future instances, if needed.

As of June 30th, 2021 we found that this recommendation was implemented. The Ministry of Health receives quarterly reports on STARS's maintenance for the now four helicopters used to provide air ambulance services in the province. It also receives results from Transport Canada's inspections of STARS's operations which includes helicopter maintenance. Having properly maintained helicopters increases availability and keeps staff and patients safe.

This concludes my presentation on this audit.

[15:45]

The Chair: — Thanks so much for the presentation, and for the focus I'll turn it over to Associate Deputy Minister Macza.

Ms. Macza: — Thank you. With regards to these chapters, recommendation no. 1, the Provincial Auditor notes that this recommendation has been implemented.

With regard to recommendation 2, the Provincial Auditor also notes that this recommendation has been implemented.

With regard to recommendation no. 3, the Provincial Auditor also notes that this recommendation has been implemented.

With regard to recommendation 4, the ministry considers this recommendation implemented as it has worked with STARS to provide more detailed reporting to verify that staff are completing all required training. STARS has now begun including the percentage of air medical crew in Regina and Saskatoon who have met the required education requirements in its quarterly reports to the ministry, and this information was first provided in Q1 [first quarter] of '21-22 report, reviewed by the ministry in August 2021.

With regard to recommendation no. 5, the Provincial Auditor notes that this recommendation has been implemented.

With regard to recommendation no. 6, the ministry considers this recommendation implemented as it has worked with STARS to provide six quality-of-care indicators as part of its quarterly reporting to the ministry. This information was first provided in Q1 of '21-22 report, and received by the ministry in August of 2021, and was again provided in the Q2 report in November of 2021. STARS will continue to provide this information on all subsequent quarterly reports.

With regard to recommendation no. 7, the ministry considers this to be partially implemented as it continues to work with STARS to implement a process to share and periodically review with the ministry the number and reasons for cancelling or declining requests for helicopter ambulance services. STARS currently includes the number of cancelled or declined requests in the quarterly reporting to the ministry, and is in the process of including the reasons behind that. The ministry anticipates that this information will be included in quarterly reports to the ministry by March 31st of 2022.

And finally, with regard to recommendation no. 8, the Provincial Auditor notes that this recommendation has been implemented. That concludes my comments.

The Chair: — Thank you for the report, the presentation, and all the work that's gone into addressing these recommendations. I'll open it up for questions. Ms. Young, Regina University.

Ms. A. Young: — Thank you very much, Mr. Chair. A handful of questions just in regards to the general coordination of ambulance services in Saskatchewan. How is it established when air ambulance — like, the planes — are used as opposed to STARS?

Mr. Wyatt: — There is a central dispatch process. When a call comes in, there is a triage process and a determination whether it should be handled by road, air ambulance, or STARS.

Ms. A. Young: — And then I note in the report I believe the agreement with STARS was renewed in 2021. Is that . . . does that sound . . . I think that's accurate. Are you able to detail what the terms of the current agreement are in terms of length and ministry contribution as well as that of the Crowns?

Mr. Wyatt: — I'll just take a moment.

Ms. A. Young: — Somebody very wise once told me that *Hansard* never shows your pauses, and I try to remind myself of that all the time when I ramble.

Mr. Wyatt: — So with the contract renewal, it extended the agreement for another 10 years. And when we look at the funding from the various organizations, the funding from the ministry is increasing from 10.5 million to 11.8, $11.9 million as part of the renewed agreement. It had been fairly consistently in the 10.5, $10 million range throughout the initial agreement, and the new agreement does provide for a commitment for increased funding through the life of the agreement.

Ms. A. Young: — And any clarification in regards to contributions from the Saskatchewan Crown corporations?

Mr. Wyatt: — I don't have information on Crown contributions. I know that there were private partners who supported the acquisition of the new aircraft, as well as the federal government also provided funding for the new aircraft.

Ms. A. Young: — In regards to the average cost per STARS transport and their rates described on page 157 of chapter 22, it struck me that the cost for helicopter ambulance was less than I would have anticipated for a resident in Saskatchewan, which is noted as $465, of course not including the cost of any ground ambulance service. And then, comparatively, it goes on, a Saskatchewan resident pays between 245 and $325 plus the $2.30/kilometre rate for ground ambulance. So I guess is it feasible that a resident could pay more for transportation for a by-ground ambulance than helicopter ambulance?

Mr. Wyatt: — I mean the fees for ground ambulance are a combination of your base rate as well as the mileage charge, or the per-kilometre charge. And so the cost there would be dependent on whether it is sort of a short-haul trip or a longer-haul trip. Certainly a longer-haul trip could involve a significant cost based on the mileage fee.

I think, whether it's road or air, the goal is to try to make it a manageable fee for the individual. And so you know, clearly with respect to the higher cost of a STARS trip, you know, we're not trying to do this on a cost-recovery basis or a, you know, percentage basis, but more from what would be considered affordable for an individual.

Ms. A. Young: — So to make sure I understand, the means of the patient then would be taken into consideration when evaluating whether to use ground transportation or air ambulance. Obviously I wouldn't assume that would be the case in a crisis, but it's noted I believe around 60 or 70 per cent of the

utilization of STARS is for that patient transfer as opposed to crisis response.

Mr. Wyatt: — That decision would primarily be a clinical decision, and you know, what is the most appropriate way to transport the patient either in an emergency response or a transfer situation. Certainly, you know, there may be instances where, you know, patient means could be part of the discussion for a transfer, but I would expect that these are typically decisions that are made based on what is the safest means of transportation for the individual based on their medical condition.

And you know, obviously when you get into remote situations, then it's more just on what's feasible in terms of, you know, the ability to use road ambulance versus air in the far North.

Ms. A. Young: — But that $465, kind of, base fee for helicopter ambulance, that's not a sliding scale? That's the least and the most that an individual in Saskatchewan would pay?

Mr. Wyatt: — Correct.

Ms. A. Young: — And in regards to the cost per STARS transport for the ministry, the report notes in '18-19 it was $14,876 per flight. Do you have the current cost per flight?

Mr. Wyatt: — I don't. I don't appear to have that available with me.

Ms. A. Young: — Is that something we could potentially get at a later time?

Mr. Wyatt: — Yes, we can commit to following up on that for sure.

Ms. A. Young: — Thank you. You know, going through this report. . . . Perhaps I've just been subject to the advertising and the fundraising campaigns for STARS, but my understanding kind of as a, you know, just an average citizen prior to this was that STARS was primarily trauma response or accident response. And it's apparent that a significant amount of the work that they do is the critical work of transporting patients between health care facilities.

And I note in the report some differences highlighted in figure 2 on page 159 of chapter 22, even between Regina and Saskatoon as the two bases. And I'm curious if you have available the percentage of patients transported to Regina. What percentage of that would be trauma or accident care versus just a simple patient transfer? And then again for Saskatoon.

Essentially what I'm interested in is which of the two hospitals would see more patients being transferred in or out versus that kind of initial crisis transport.

Mr. Wyatt: — That's something I can follow up and see if we have available. I certainly don't have that sort of detailed data with me today.

Ms. A. Young: — Thank you. Moving on to the outstanding recommendations, or the partially implemented recommendations I should say, I'm specifically interested in 3.7. I understand it is in process, but I'm wondering if you could offer some further comment on some of the . . . I don't want to use the word "challenges" but some of the challenges in implementing that recommendation to date.

Mr. Wyatt: — My understanding with respect to that recommendation is it's data that STARS has and it's really just looking at how it's presented into their quarterly reports that they provide. And so we don't anticipate any significant issue. I think as outlined, we're expecting that reporting to begin in this coming year. And so I'm not sure that it's going to be problematic for them to be able to provide it but probably just a matter of, sort of, converting a lot of data into something that can be digested as part of a quarterly report.

Ms. A. Young: — So then one question, I guess, perhaps just looking at some of the metrics provided in regards to STARS's reasons for cancelling or declining service requests and missions. I note — and I mean I hesitate to speculate, you know, a trend from a couple years' worth of reporting — but I do note that there's been increases both in use and increases in a few categories for reasons for cancelling or declining services.

Specifically I would note the category of "other" has increased from 24 to 113. "Weather" has gone up from 758 to 1,404, and of particular interest, maintenance delays have gone up from 21 to 89. And I guess I'm just looking for some comment on those. My assumption would be perhaps with the category of "other" . . . Figure 5 on page 205 of chapter 26 notes aircrafts require decontamination, and I'm not sure that would be COVID-related or if that's simply a new measure. But recognizing, you know, the first measure in the first chapter is evaluating, I believe, a period of one year, and this is looking at kind of 18 months, so of course there will be more. But it also seems like the occurrences have increased.

[16:00]

Mr. Wyatt: — Yeah, you know, I'm not in a position to really sort of delve into what some of those other categories would be. You know, as indicated, this is information that has been collected in a raw form. They do share data around, you know, the reasons for cancellation with the ministry. Something like the question around contamination, I would have to follow up to understand.

You know, obviously any time that you have a patient in an emergency vehicle, there's, you know, the potential for . . . An ill individual, you know, occupying an emergency vehicle, clearly those vehicles need to be cleaned after the patient has been transported into care. And so I would expect that that's, you know, a standard expectation.

I can't say that I understand whether that would be a more significant reason for a mission not being completed during COVID than it would be in the past. That's just something that, at an operational level, I would need to get some advice on.

Ms. A. Young: — I shouldn't make assumptions. I think I was . . . That was my baseless speculation, just because that decontamination element hadn't been listed in the previous figure from chapter 22. So perhaps I'm looking for examples of COVID when there are none in reading that in.

Ms. Clemett: — You are correct in assuming, like your assumption is correct. So during the course of the audit, the decontamination was because of COVID, which would obviously take longer. And hence if a call comes in, they might have to decline.

Ms. A. Young: — Thank you. Of the 700 patient flights listed in the 2019 report, are you able to provide how many flights there were in 2020 and 2021?

Mr. Wyatt: — The numbers I have for total numbers of transports either as transfers or provided care: for 2020-21 the number was 702; for 2019-20 the number was 706; for 2018-19 the number was 676.

Ms. A. Young: — Thank you. And apologies, as I believe I may have missed this in your introductory comments, Associate Deputy Minister, but the detailed report on staff training that was noted by the auditor, this report has been received?

Mr. Wyatt: — Yes, it has.

Ms. A. Young: — Okay, excellent. Thank you. My last question is in regards to the transportation between facilities. Have there been a significant number of patient transfers associated with the pandemic?

Mr. Wyatt: — There have definitely been patient transfers through the pandemic period, and we had actually supported STARS to add some additional staffing time and capacity in order to be able to . . . It'll be part of the level-loading process where needed and in situations where you had, you know, hospitalized patients where there was over capacity in one facility.

You know, one of the principles of acute care management through the pandemic has been trying to use all of the resources of the health system. It's one of the benefits of having the Saskatchewan Health Authority is the ability to work across their various facilities in being able to relocate patients where there is an over-capacity situation in one site and bed availability in another. So that's being done through road, air, and both air and rotary.

Ms. A. Young: — Do you have available the number of transfers that would have been specifically related to the pandemic?

Mr. Wyatt: — Again I don't have that here today, but something that we could endeavour to follow up with the committee on.

Ms. A. Young: — Thank you. I have no further questions.

The Chair: — Thanks for the engagement. Good questions. Thanks for the responses. Any other questions from committee members at this point? The member for Batoche is fixing his glasses. I thought his hand was going up, but no question there.

I would welcome a motion to concur and note compliance with respect to recommendations 1, 2, 3, 4, 5, 6, and 8. Mr. Friesen. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. And with respect to recommendation 7, I'd welcome a recommendation to concur and note progress. Mr. Goudy was moving quick there, back there. Moved by Mr. Goudy. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried as well. We'll move along to a real passion of mine, local meat processing. And I'll kick it over to the Provincial Auditor's office.

Ms. Lowe: — Chapter 36 of our 2019 report volume 2, on pages 281-284, reports the results of our third follow-up of the four recommendations originally made in our 2012 audit of the Ministry of Health regarding strengthening their processes that help keep meat safe in Saskatchewan.

By July 31st, 2019 the Ministry of Health had fully implemented the remaining four recommendations. It finalized and approved slaughter plant standards, revised the food safety regulations to include slaughter plants, allowed for the online posting of inspection results, and began running reports of overdue follow-up inspections. That concludes my presentation.

The Chair: — Thank you very much. I'll flip it over to Associate Deputy Minister Macza for her response.

Ms. Macza: — Thank you. With regard to all four recommendations, we would note the Provincial Auditor's position that the recommendations have been implemented and agree. Nothing further.

The Chair: — Thank you very much. And I'll open it up for questions. No questions from Ms. Young, Regina University. No questions over here.

I know that these are of long-standing discussion. I think they're a decade on. And certainly we thank everybody that's involved in this important work. And as I say, local meat production is something I'm a big fan of, so we need to make sure we have the measures in place to support that very good value-add agricultural activity in Saskatchewan.

I'll entertain a motion to conclude consideration of chapter 36. I see that Mr. Nerlien moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. And we will move along, and I'll turn it back over to the auditor's office to focus in on chapter 17 of the 2020 report volume 1.

Ms. Lowe: — Chapter 17 of our 2020 report volume 1, on pages 215 to 219, reports the results of our first follow-up of management's actions on the four recommendations we first made in 2017 regarding the Ministry of Health's processes to detect inappropriate fee-for-service payments to physicians.

At December 31st, 2019 the Ministry of Health had implemented two and partially implemented two of the four recommendations. The Ministry of Health completed a cost-benefit analysis and proposed new IT system alternatives to support identifying inappropriate physician billings for insured services before

making payments. As well the Ministry of Health revised the criteria to determine which potential physician over-billing cases to refer to the joint medical professional review committee. The revised criteria considers the individual physician's pattern of billing that depart from the physician's peer group. However the Ministry of Health still needs to use a comprehensive risk-based strategy to detect inappropriate physician billings for insured services before making payments.

The ministry has identified some general risk areas but has not completed detailed work to develop a risk-based strategy. Use of a new risk-based IT system would allow the ministry to assess significant amounts of data to identify suspicious activity quickly and with less manual intervention before payments are made. This would also reduce the amount of effort needed to assess and collect inappropriate payments back from physicians.

The ministry also needs to still assess options to conduct more investigations into physician billing practices that it suspects of having inappropriately billed the government. The ministry recognizes that a new IT system will be needed to do this work efficiently. Having a better system to identify inappropriate billings would also reinforce with physicians the importance of having appropriate fee-for-service billing practices. This concludes my presentation.

The Chair: — Thank you for that report and that presentation. I'll turn it over to ADM Macza.

Ms. Macza: — Thank you. With regard to recommendation 1, the Provincial Auditor has noted that this is implemented, and we agree.

With regard to recommendation 2 about using a comprehensive risk-based strategy to detect inappropriate billing for insured services before making payment, the ministry has identified some general risk areas but has not completed detailed work to develop such a strategy. We are working with the vendor to have our new IT claims system built and implemented by the end of '22, and at completion of this new IT system, it is expected that the ministry will have the ability and be able to develop a comprehensive risk-based strategy to detect inappropriate billings before payment.

With regard to recommendation 3, I would note the Provincial Auditor notes that this has been implemented, and we agree.

With regard to recommendation 4 around assessing options to conduct more investigations into physician billing practices that it suspected of having inappropriately billed, the ministry has identified several options to increase the number of investigations into physician billing practices. Some options have been implemented, while others are being assessed. Routine data on physician payments are performed. Analytics on physician payments are performed to identify required post-payment investigations on certain billings or payments, and these investigations have resulted in recoveries of inappropriate billing payments.

With that, that concludes my comments.

The Chair: — Thank you very much for that. I'll open it up for questions. Ms. Young, Regina University.

Ms. A. Young: — Thank you very much. In regards to recommendation 3.1 in regards to the new IT system, I believe you indicated that it was forthcoming in 2022. I'm curious, who was the successful proponent for that IT contract?

Ms. Macza: — It's a consortium of individuals that were successful in implementing it. The work on that started at the end of last fiscal year. So in the current fiscal year, we're in full-out mode of implementing it, and expectations are that we're on time and on budget and will be finished implementing it by the end of '22.

Ms. A. Young: — Okay. So it's not, like, an IBM [International Business Machines] or someone, or an Aeon. It's a group of . . .

Ms. Macza: — A group vendor.

Ms. A. Young: — Vendors.

[16:15]

Ms. Macza: — We're modelling it against the system that was recently implemented in Manitoba, so learning from what they have implemented and building on that.

Ms. A. Young: — Well then I must ask, has Manitoba been successful in implementing their new IT system?

Ms. Macza: — They have.

Ms. A. Young: — Okay. Wonderful. Good to hear. Just a question in regards to the risk-based strategy still needed, the partially implemented recommendation 3.2. I guess I'm curious if the physician pre-verification process could just be, at a really high level, described.

Ms. Macza: — Sorry?

Ms. A. Young: — The physician pre-verification process.

Ms. Macza: — The physician . . .

Ms. A. Young: — Yeah. It says the ministry has a pre-verification process to check the validity of fee-for-service billings. And I have no idea what that means.

Ms. Macza: — I'm sorry. Where are you reading this from? What page is it?

Ms. A. Young: — Chapter 17, page 217, second paragraph, first sentence.

Ms. Clemett: — I'll maybe just add some context.

Ms. A. Young: — Sure, thank you.

Ms. Clemett: — So basically what happens is though the physicians are billing, and there is a mechanism right now whereby the ministry has an IT system that it almost, like, red flags certain of those billings to sort of say, these perhaps might not sort of meet our needs and be appropriate payments to make. As a result there is a very manual process where we have a number of staff that have to really, like, dive into the details: do

these payments make sense? Do we release or do we stop, type thing.

With the implementation of really the new IT system that they're planning to implement from the ministry perspective, it will do a better job of almost making things go in the correct buckets, where it will kind of be the payments come in; this one really isn't in line with certain requirements, therefore it is being stopped and rejected. There won't be as much, like, we have to check this; we have to look into it further. And in other cases, this makes sense; let's let it through; let's pay.

Ms. A. Young: — Okay. Perfect. Thank you. And I think that actually answers my next question as well. Broadly speaking, in regards to inappropriate physician billings, the numbers noted on page 219 in regards to the recoveries that are ordered by the JMPRC [joint medical professional review committee], are these numbers consistent in regards to the number of payments that are collected back from physicians every year?

Ms. Macza: — These would be recoveries for payments made to physicians inappropriately.

Ms. A. Young: — And so the number of investigations completed during this three-year window, this is pretty par for the course?

Ms. Macza: — Yes. Yeah, for example in '21-22 there was seven investigations completed, and the recovery was about in around $2 million at that time.

Ms. A. Young: — Is there an average cost that could be provided of physician over-billing, or would it just simply be dividing, you know, like, 1,783,000 by the eight recoveries and assume it's that? Okay, perfect.

And I guess my last question here is, you know, taking the $1.7 million, nearly $1.8 million of recovery ordered on the, you know, like, over half a billion dollars paid out annually is a lot of money to an individual, but it has to be considered within the context of what is annually paid out under the fee-for-service agreement. But is there an actuarial estimate of what the actual risk is to the Ministry of Health for physician over-billing? Like, do we assume that 1.7 is an accurate capture of the cost?

Ms. Macza: — Are you asking, do we feel it reflects the average number of over-billing that might be taking place? I guess I would say that with the implementation of a new system, we'll be able to better assess what is actually happening, because the current system in place — I mean, as the auditor knows — was put in place in the '60s, and is held together by, you know, tape and glue. So we are quite excited about the new system and the functionality and the things it'll enable us to do, and the fact that it'll allow us to focus on the areas of risk and put in place appropriate rules to avoid overpayments as opposed to making the payment and discovering the error after it has happened and then go through the whole recovery process, which is not an efficient way to execute this.

Ms. A. Young: — Thank you. That was to be my final question on this, is whether with the implementation of a new system there would be an anticipation of both those payments being . . . whether those payments would be caught beforehand — so they would never occur — or this committee might anticipate seeing an increase in the number of investigations or recoveries pursued. But what I'm hearing is the anticipation is that that work will not have to take place because the payments will never go out in the first place.

Ms. Macza: — That is the goal, yes.

Ms. A. Young: — Okay.

Ms. Clemett: — Or you could also probably make enhancements to the IT system as you identify, like you said, risks that come through. Yes, as this new system . . . and you almost just, you know, make some modifications to coding and scripts and then you do block before it goes out the door. Yes.

Ms. A. Young: — Okay.

Ms. Macza: — Yeah. It will be a process where we'll learn the capabilities of the system as we go along, and we will focus on, you know, where we'll have them, you know, where the most risk is associated and go through it that way.

Ms. A. Young: — Thank you. No further questions.

The Chair: — Thank you for those questions. Any other questions from committee members? Mr. Nerlien.

Mr. Nerlien: — Thank you, Mr. Chair. Just a quick question. How are nurse practitioners' activities billed into the system? Or are they not at all? Are they under the supervising position or are they . . .

Ms. Macza: — They would not be paid through the claims project that we're talking about now. They would be paid as an employee through the SHA.

Mr. Nerlien: — Right. Okay. Thank you.

The Chair: — Not seeing any other questions, I'd welcome a motion to conclude considerations of chapter 17. Deputy Chair Young moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll move along to chapter 32 of the 2020 report volume 2. I'll turn it over to the Provincial Auditor's office.

Ms. Lowe: — Chapter 32 of our 2020 report volume 2, on pages 241 to 247, reports the results of our third follow-up audit on the ministry's effective strategies for preventing diabetes-related health complications.

The Ministry of Health has made some progress on implementing the three outstanding recommendations from our 2012 audit, but more work is required to help prevent diabetes-related health complications in people living with diabetes. The ministry needs to take steps to obtain complete data from physicians about health care services provided to patients with chronic diseases like diabetes. It needs complete data to do meaningful analysis about the effectiveness of those health care services. The ministry primarily collects data about individuals with chronic health

conditions from physicians through an IT system, CDM-QIP [chronic disease management quality improvement program]. CDM-QIP tracks key health care services like whether A1C blood levels were tested twice a year.

The ministry has not been successful in obtaining more information about all individuals living with chronic health conditions because the use of CDM-QIP by physicians has not increased. Without sufficient information on the condition and care received, the ministry is unable to assess the services people with diabetes receive.

The ministry needs to analyze the data on the effectiveness of programs and services delivered by the Saskatchewan Health Authority to people living with diabetes, like the extent of key diabetes-related complications such as amputations. At August 2020 the ministry had not developed key diabetes-related metrics, like the number of amputations, to assess whether services delivered prevented diabetes-related complications. Such metrics would also allow the ministry to assess if the authority is effectively managing its diabetes programs.

This concludes my presentation.

The Chair: — Thank you for the presentation and the important focus again of this work. I'll turn it over to ADM Macza.

Ms. Macza: — Thank you for that. With regard to recommendation 1 in regard to collecting and analyzing the information to assess services delivered, in '21 the ministry worked with eHealth on the ongoing reporting and frequency and quality requirements for the program and examined how the accountability arrangements for the information technology and the information management services needed to support the program can be strengthened.

We've reviewed the governance arrangements around this program with the SMA [Saskatchewan Medical Association] to ensure the program is meeting its original objectives of timely, reliable information for health system to use in improving the care and support of the Saskatchewan citizens with this chronic condition.

With regard to recommendation 2, the Provincial Auditor knows that the ministry agrees that this recommendation is no longer relevant as it's a subset of other recommendations.

With regard to 3, the same applies to number 3.

With regard to recommendation 4, in '21-22 the ministry undertook work to begin augmenting available clinical data from the SHA with physician-clinic billing data to ensure a comprehensive understanding of the current state of deployment of the chronic disease management quality improvement program by the providers across all health networks. The ability to track the variability of diabetes incidence and prevalence across the health . . . [inaudible] . . . and the use of the quality improvement program by providers in each program will support more effective targeting of initiatives and resources and enable the assessment of the effectiveness of the initiatives in preventing and delaying diabetes and related health complications.

With regard to recommendation no. 5, the ministry has advanced work here too to inform the chronic disease management quality improvement program with clinical flow sheets to improve the care management of the citizens with diabetes. And we've begun aligning the management quality improvement program data with other sources of clinical data to assess the impact and the variability care management and services are having on known complications of poorly managed diabetes.

And with that I conclude my comments.

The Chair: — Thank you very much. I'll open it up for questions. Ms. Young, Regina University.

Ms. A. Young: — Sorry, just one quick question on this. The report notes that . . . or I believe the report notes that physician and nurse practitioner use of the CDM-QIP system has declined since 2017, and in reading this report it appears that physician uptake is a bit of a challenge. So I'm curious as to the feedback or any major trends in terms of complaints or reasons for the lack of uptake on that.

Ms. Macza: — Sorry, whether we have updated data on that?

Ms. A. Young: — Yes, even anecdotal. You know, the report notes that the use of this system by physicians and nurse practitioners has declined since 2017, and I guess I'm just looking for some further comment on that in terms of what the reasons for that are or if you could comment on kind of ongoing outreach or education work that's been done.

Ms. Macza: — Yeah, in terms of the outreach and improvements in that, it's something we're concerned about in trying to engage physicians more. We have been engaging with the SMA to determine the root cause and see if there's more that can be done.

I'd have to say that the work associated with and any further engagement we were trying to do with the physicians has been curtailed by the pandemic, but we have engaged with them to restart this as soon as we can and to see what more we can do to enhance engagement here.

[16:30]

Ms. A. Young: — And then just one last question. Is there an anticipation due to the pandemic that there will be an increase in diabetes-related health complications?

Ms. Macza: — Well I don't think we have any solid data on that yet. But I can only imagine the fact that the average citizen is having difficulty accessing hospital services because of the impact of COVID would lead to implications like that, yes.

The Chair: — Any other questions on this chapter? Again thanks for identifying the actions that are still required towards implementation, and certainly that's important work. And certainly we're also mindful of, you know, what the system's been up against these last couple years.

So I would welcome a motion to conclude considerations of chapter 32. Mr. Nerlien. Or sorry, Mr. Friesen. Sharp tie and all and I screw that up. Mr. Friesen moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — All right. That's carried. We'll move along to our last chapter for consideration today. This chapter does have new recommendations — it's a fairly recent chapter — new recommendations that haven't been considered by this committee. And I'll turn it over to the Provincial Auditor's office.

Ms. Lowe: — Since 2004, health care organizations like the SHA must report by law critical incidents to the Ministry of Health. During the 2019-20 fiscal year, health care organizations reported 290 critical incidents to the ministry. In 91 of those 290 reported critical incidents, a patient died. Through effective use of critical incident reporting, the degree of injury and the types of critical incidents that occur in Saskatchewan health care facilities should reduce over time.

Chapter 6 of our 2021 report volume 1 on pages 51 to 75 reports the results of our audit of the Ministry of Health's processes for using critical incident reporting to improve patient safety. It contains 10 new recommendations for the committee's consideration.

We concluded that for the 12-month period ended December 31st, 2020 the Ministry of Health had effective processes except in the areas outlined in our 10 recommendations for using critical incident reporting to improve patient safety. I'm going to focus my presentation on each of the 10 recommendations.

The first recommendation on page 58: we recommend the Ministry of Health reassess the types of adverse health events it requires health care organizations to report as critical incidents. The types of critical incident events outlined in the *Saskatchewan Critical Incident Reporting Guideline, 2004*, do not fully align with good practice as defined by the Canadian Patient Safety Institute and Canadian Institute for Health Information.

We found the guideline does not consider some of the 15 "never ever" events that the Canadian Patient Safety Institute notes as adverse health events to report as critical incidents. The guideline does not include reporting of two types of "never" events, with one being patient death or serious harm due to uncontrolled movement of an object, like a pair of scissors in an MRI [magnetic resonance imaging] area.

In addition, we found the guideline does not consider serious health care-associated infections as critical incidents like the Canadian Patient Safety Institute includes as hospital harm events. Also, Ontario's critical incident reporting guideline includes health care-associated infections as an incident type. Without requiring incident reporting of all "never" events and certain types of infections, the ministry does not know the root causes or contributing factors of these type of critical incidents occurring in the Saskatchewan health care sector.

The second recommendation is on page 59. We recommend the Ministry of Health ask health care organizations to include root causes of the incident when reporting critical incidents. A standardized critical incident reporting form has been developed for reporting incident information to the Ministry of Health. However it does not include sufficient information requirements to enable the ministry to understand the root causes of a reported incident. Not asking health care organizations to report information on root causes limits the ministry's ability to effectively oversee whether the health care sector does enough to prevent the occurrence of similar critical incidents.

Our third recommendation is on page 60. We recommend the Ministry of Health obtain missing critical incident information from reporting health care organizations. The ministry provincial quality-of-care coordinators are to assess critical incident reports as they are sent by health care organizations to ensure they contain the required information. We found the ministry does not always confirm the completeness of the critical incident reports.

For 3 of the 25 critical incident reports tested, the location field was blank. The lack of location information about where the incident occurred reduces the usefulness of data when looking for trends and problems in specific health care locations. For 9 of 30 critical incidents tested, the date the SHA classified the event as critical incident was blank. Without having all dates, the ministry cannot monitor if it is receiving the incident notification from the health care organization within three business days as required by law.

Missing critical incident information impacts the ability of the ministry to do reliable analysis and draw valid conclusions about whether systemic issues exist that may impact patient safety and whether planned actions are sufficient and put in place within a reasonable time to reduce the risk of similar incidents from occurring.

Our fourth recommendation is on page 62. We recommend the Ministry of Health follow up when receipt of critical incident reports are beyond established reporting deadlines. *The Critical Incident Regulations, 2016* set out time frames by which a health care organization is required to notify and report the results of its investigation to the ministry. Health care organizations must give notice to the Ministry of Health within three days of becoming aware of the critical incident and must conduct an investigation on each critical incident and submit a final report on the investigation within 60 days of becoming aware of the critical incident. The ministry may allow extensions for submitting final reports up to 180 days of the health care organization becoming aware of the critical incident.

Our analysis of initial notifications of critical incidents found the ministry often receives around 30 per cent of them later than the three business days required by law. Our analysis of reports of completed investigations found the ministry often receives over 30 per cent of the reports later than the 60 business days required by law. On average the Saskatchewan Health Authority takes over 100 days to provide the ministry with these final investigation reports. The ministry does not follow up with the authority to determine why it takes longer than the required deadline to receive notifications and final reports.

While the ministry grants extensions to the deadlines, we found that it does not record the reasons for the extensions granted even though the law requires reasons for requesting an extension to be provided. Delays in receipt of initial notifications of critical incidents causes delay in the ministry becoming aware of the most serious events of harm to patients in the health sector. Delays in receiving results of investigations means the ministry does not undertake timely assessment of planned actions for improvement.

Our fifth recommendation is on page 64. We recommend the

Ministry of Health analyze the nature and types of incidents reported as compared to other health data sources. The Ministry of Health has no mechanism to determine if it receives reports of all critical incidents expected. Health care organizations, by law and through policies, track and report on a number of different types of adverse events. Since December 2019, federal law requires reporting of medical device events to Health Canada. Both the Canadian Institute for Health Information and Health Canada publish this information. In addition, the Saskatchewan Health Authority tracks various types of incidents occurring in its facilities.

We found the ministry does not use available data about adverse events reported to other agencies to determine if it is receiving the expected reports of critical incidents. Our analysis suggests under-reporting of critical incidents to the ministry. We found significant differences between the number of adverse events tracked and reported and critical incidents reported to the ministry. For example, the authority reported 24 medical device failures to Health Canada, but only reported 17 medical device critical incidents to the ministry during the same time frame. Lack of complete critical incident data compromises the validity of the ministry's analysis of critical incidents and limits its ability to determine patient safety improvements needed.

Our sixth recommendation is on page 67. We recommend the Ministry of Health, or responsible health care organization, apply consistent criteria to assess whether planned corrective actions effectively address causes of critical incidents. The Ministry of Health's assessment of planned corrective actions included in individual critical incident reports adds limited value to improving patient safety.

The ministry has a medical review committee to review planned corrective actions in critical incident reports. We found the committee does not follow good practice in that it does not have written guidance to aid its review of whether corrective actions effectively address the underlying causes of the incident or warrant additional corrective actions. We also found that the committee does not formally document its analysis of critical incident reports. The ministry also does not require the reporting health care organization to change the corrective actions in the final critical incidents report to align with the ministry's suggestions.

Our assessment of planned corrective actions of 21 critical incident reports found the planned corrective actions included in eight reports did not sufficiently address all of the contributing factors noted in the report. In each of these eight reports the ministry did not ask the authority to add any corrective actions. Using formal criteria to assess corrective actions would aid in determining their adequacy. It would also help determine whether planned corrective actions sufficiently address the contributing factors and root causes, and whether there is a need for further actions.

Our seventh recommendation is on page 68. We recommend the Ministry of Health monitor the status of implementation of corrective actions set out in the critical incident reports. The Ministry of Health does not know whether planned corrective actions that health care organizations, including critical incident reports, are implemented and improve patient safety. The ministry does not record the planned corrective actions and their status in its critical incident IT system. As a result, the ministry does not know the extent of critical incident corrective actions not implemented at any point. Not following up in monitoring the status of implementation of planned corrective actions may lead to the same critical incident occurring again.

Our eighth recommendation is on page 71. We recommend the Ministry of Health and/or responsible healthcare organization utilize criteria to determine when to issue patient safety alerts. The Ministry of Health does limited analysis to identify whether systemic issues are causing reported critical incidents and to support its issuance of patient alerts. Good practice expects a patient safety alert to be an official notice of advice or instructions to health care providers on how to prevent specific incidents known to occur and cause serious harm or death.

Our testing of four patient safety alerts issued between 2017 and 2020 found the alerts did not provide health care providers with specific guidance for reducing the risk to patients. Instead, they required the SHA to develop the guidance to address the risk identified in the alert. Also the ministry does not have written guidance to aid in deciding when incidents of harm to patients warrant the creation of a patient safety alert and the content of the alert. Not using standard criteria to determine when a patient safety alert is warranted increases the risk that an alert is made for a minor or localized issue or that an alert is not made for a systemic issue and incidents continue to occur.

Our ninth recommendation is on page 73. We recommend the Ministry of Health analyze critical incidents for systemic issues. The Ministry of Health does limited analysis of reported critical incidents and therefore has limited ability to identify systemic issues in the health care system.

We looked at the four highest subcategories of reported critical incidents in 2019-20 — stage 3-4 pressure ulcers, falls causing death, suicides while in care, and medication errors — and found that very few patient safety alerts issued by the ministry related to these subcategories over the last three years. In addition, while it does analyze some trends, the ministry does not assess trends by facility location to determine if a localized problem exists that warrants further investigation.

[16:45]

We found the critical incident reporting form does not include where the patient died or was harmed. This information would then allow the ministry to determine if a facility is having a higher number of critical incidents and is facing challenges in providing adequate patient care. Not sufficiently analyzing reported critical incidents and corrective actions limits the ability to identify systemic issues in the health care system.

Our final recommendation is on page 74. We recommend the Ministry of Health work with the Saskatchewan Health Authority to monitor the effectiveness of patient safety alerts. The ministry does not follow up patient safety alerts to determine if they are effective in improving patient safety. For example, the ministry does not complete an assessment several years after the patient safety alert was issued to see whether reported critical incidents in the area improved.

Good practice in Alberta requires a review of patient safety alerts

every three years to confirm recommended practice in the alerts aligns with the best practice. Otherwise patient safety alerts are reissued. The review may also determine if the patient safety alert is no longer applicable, as the issue has been resolved. Without following up on the patient safety alerts, the ministry cannot determine if they are implemented and successful.
That concludes my presentation.

The Chair: — Thank you very much for the presentation. Certainly an incredibly important area of focus here. I'll turn it over to ADM Macza.

Ms. Macza: — Thank you. With regard to recommendation 1, work is under way to review and revise the critical incident subcategories, and the target date for completion is March 31st, 2022. To inform this assessment we are currently conducting a jurisdictional scan, assessing our current categories and subcategories of adverse health events, and reviewing best practices to incorporate those in Saskatchewan.

With regard to recommendation no. 2, work is under way to include root causes in the critical incident reporting template, and our target date for completion is March 31st, 2022. Initial training on root cause analysis for SHA patient safety staff has been completed, and the ministry will provide direction to the SHA and health care organizations to include root cause analysis where appropriate in critical incident reports.

With regard to recommendation no. 3, work is under way to improve the clarity of the reporting template and train SHA staff in using the form. Target completion date is March 31st, 2022. The ministry will develop the processes to follow up with the SHA and health care organizations when information is missing from reports.

With regard to recommendation no. 4, work is under way to improve the timely submission of critical incident reports, and the target completion date is March 31st, 2022. Since March of 2020, when SHA risk management and patient safety staff were redeployed to COVID-related duties, reporting timelines were exceeding due dates. So with the return of the SHA staff to their home positions, the backlog of reports should proceed.

The ministry has resumed the practice of setting a 60-day due date for submission of critical incident reports, and the Ministry of Health provincial quality-care coordinators and data analysts will resume monthly monitoring of reporting timelines and subsequent SHA follow-up in spring of 2022. The ministry will develop processes to follow up with the SHA and health care organizations when reports are late.

With regard to recommendation no. 5, work to address this recommendation is expected to commence in '22-23 with a target completion date of March 31st, 2023.

With regard to recommendation no. 6, work to address this recommendation is expected to commence in '23-24 with a target completion date of March 31st, 2024.

With regard to recommendation no. 7, work is under way to monitor the implementation status of critical incident recommendations. The target completion date is March 31st, 2023. The SHA is resuming work to track status of recommendations that started prior to COVID, including implementing a critical incident registry for the purpose of centralized visibility of critical incident recommendations and progress. They aim to have the registry operational in February with the goal of providing access to all portfolio senior leaders, area chiefs of staff, and provincial heads. The ministry will work with the SHA on developing standardized status reports to the ministry.

With regard to recommendation no. 8, work to address this recommendation is expected to commence in '22-23 with a target completion date of March 31st, 2023.

With regard to recommendation no. 9, work to address this recommendation is expected to commence in '23-24 with a target completion date of March 31st, 2024.

And finally with regard to recommendation no. 10, work to address this recommendation is expected to commence in '22-23 with a target completion date of March 31st, 2023.

And that concludes my comments.

The Chair: — Thank you very much for that report and the important work that's under way on these fronts. I'll open it up to committee members for questions. Ms. Young, Regina University.

Ms. A. Young: — Thank you, Mr. Chair. One question to, I believe, the auditor just prior to my specific questions for the officials. This being both a fully new report and an annual report, can you help me understand this? Like, the recommendations are all new but these will be coming back then annually to this committee?

Ms. Clemett: — No. So this was a performance audit. So when we do our performance audits and make those recommendations, we do follow up on those recommendations we've made, usually in two to three years' time frame. So it'll come back to you with regards to all these recommendations in a follow-up chapter format, probably in two to three years' time. So there is always, as the ministry's indicated, there is some time frames that things do take some time to obviously implement and address. So it does sound like a fair amount of progress will hopefully be made by the time we do come back and look at that.

Ms. A. Young: — Thank you for that. Just an initial question to bring us up to date. Page 53 of course notes that there were 290 critical incidents in 2019-2020, unfortunately with 91 of those resulting in deaths. Do you have the numbers available for 2020 and 2021?

Mr. Wyatt: — Yes, so the total number of critical incidents in 2020-21 would be 196. And for 2021-22 I believe the number is 128 critical incidents had been reported and that was not for the full year. That was for Q1 and Q2.

Ms. A. Young: — And for those past two years would any of the critical incidents be COVID-related?

Mr. Wyatt: — We don't have a category of COVID-related. And so I can't really comment on whether and how many of the incidents might have some relationship to COVID.

Ms. A. Young: — Perfect. I will try and be efficient with my time here. Of the two types of critical incident reports that are not included in the guidelines, as noted by the auditor's report in relation to recommendation no. 1, have either of these types of events occurred and, if yes, when and how many?

Mr. Wyatt: — The information I got on that is that those reports were not identified as a category of critical incident, but if you had a situation where, you know, using the example of scissors in an MRI area, if that had occurred, there's an "other" category. And so there are many, many events that don't have their own category, but if they're in small numbers could well be reported as an "other" event. And so my understanding is, I think there was. When I asked our staff about this, it was identified that there had been, you know, one such event in the past and it had been reported as an "other." So that's something . . . I can't tell you how many might have occurred but we believe that that "other" may have captured previous events of this type. And you know, there are many other types of critical incidents, as I said, that don't have their own category but would still be reportable, just not under a specific subcategory.

Ms. A. Young: — But they would be captured as critical incidents.

Mr. Wyatt: — That's correct. Yes.

Ms. A. Young: — Okay. Moving on to recommendation 2. This may be a question for the officials; this may be a question for the auditor. In regards to the discussion of root causes, I guess I'm looking for some clarification and I'm curious as to whether root causes would include socio-economic or issues of race, gender, or orientation? I'm thinking in particular of the situation of Joyce Echaquan in Quebec or Janette Sanderson here in Saskatchewan.

Ms. Clemett: — Yeah, in terms of the reporting form, I don't believe there was like that much in terms of details around the specifics of the patient. It was rather trying to be fairly, like de-identified to some degree. It's more about, you're right, the situation. So I think from our perspective it's more about looking at the event and why it's occurred and is there more, you know, underlying causes that need to be examined to some degree and thought about. Thinking about that root cause and then making sure the actions obviously address those versus just the event itself.

Ms. A. Young: — But when we consider root causes — and recognizing, you know, the necessity of keeping specific patient information off the form — it wouldn't be the expectation of the auditor or the intention of the ministry to include things like race or gender on that form. Like what I'm hearing is it wouldn't inform an analysis of systemic issues.

Ms. Clemett: — Yeah, and you're thinking then it could be addressed through some type of culture or training or something. I know at this point the form did not capture that type of information, so I don't know if the ministry's leaning towards . . . I mean, there is obviously . . . When the investigation is done, those discussions do hopefully lend itself to bringing through some of that information at that SHA level.

Mr. Wyatt: — I guess what I would say is, you know, I'm not an expert in root cause analysis, but I mean, you could have any number of different, you know, underlying factors that could contribute to an event. And I don't think we are going to exclude any particular factor that, you know, that the review of the event would identify as being a contributing element. And I think that's the, you know, I think the difference between just sort of doing a review and actually moving to root cause is to really identify, are there other systemic issues that are involved here? And you know, if we were to identify something related to race or, you know, gender or socio-economic consideration, you know, I think that's something that would be, you know, factors that the group undertaking the review would need to identify as part of the root cause.

I mean, they've completed — I believe it's through the institute for health improvement — the training, and I believe the elements of root cause analysis are part of that. And so I guess without understanding the modules of that training or the method by which you undertake root cause through that process, you know, hard to specifically identify whether that was part of the training they've undertaken. But you know, I do think that the goal here is to look beyond, you know, why did a particular event happen in the moment to, you know, looking more deeply at whether there are factors related to either the patient themselves or the care environment that go beyond just, kind of, the specific nature of the incident itself.

[17:00]

Ms. A. Young: — Thank you. Yeah. I believe it notes elsewhere in this report that even the geographic location isn't necessarily captured. So I guess in asking these questions, my interest is in whether as the ministry improves the collection of data as it relates to critical incidents and the reporting and the dissemination of that information to hopefully address some of these systemic issues, whether kind of those broad demographic issues — whether it's location-based, whether it's race, gender, age — would be reflected.

Mr. Wyatt: — I guess all I can say is, you know, I think that's the intent of root cause analysis is really to look at the deeper underlying causes. And we're not ruling out anything as part of that analysis.

Ms. A. Young: — Thank you. In regards to recommendation 3, I note that the auditor speaks to the impact that these outstanding issues have on the ministry's ability to analyze or draw conclusions as to systemic issues impacting patient safety. But I'm also curious if there are . . . And forgive me. As I said at the start, this is my first time up with Health I believe, but would there be liability issues outstanding for the SHA or for the ministry due to the lack of information or perhaps the delayed nature of reporting as it relates to these critical incidents?

Mr. Wyatt: — I would first just differentiate critical incident reporting from sort of the risk management process, you know, that the SHA or a health organization might be involved in. And so the whole intent of critical incident reporting is to support learning and prevention of critical incidents. And so the reviews are undertaken in an anonymized fashion — or de-identified fashion I should say — to ensure that you aren't inhibiting reporting. And so the goal of critical incidents is really to identify back to the issue around what are the causes of these incidents and how do we prevent them in the future. And really the

intention is to separate them from, you know, the risk, kind of the litigation or risk management process with families.

I guess the other way I would answer your question is, you know, there are some facts that may not be included that we would consider to be quite relevant to an event, and there may be other times where a blank field is not all that relevant. You know, there are circumstances where . . . The weight of a patient is the example that our team talked about. The weight of a patient being filled in might be quite relevant in the case of a medication error and whether there was, you know, a higher dosage used in a medication event. Alternatively, the weight of a patient who might wander off in a long-term care facility or somebody who might commit suicide in care, probably less critical.

And so from our perspective, I think the purpose for having these fields is to have them completed and especially where there is relevance to them. If it's not relevant to the incident, it's something that we'll need to work through in terms of how we, I guess, you know, how we reflect that in the reports that are coming back if they're not going to be filled in. From my perspective, I think our goal would be to have them filled in, you know, in any situation. And if there's a reason not to have them completed, that's probably something we would want to see documented.

Ms. A. Young: — So just to make sure I'm clear then, what I'm hearing is the incomplete reporting isn't necessarily reflective of an incomplete understanding of a critical incident within the ministry or the health care facility and would not have and has never had any negative implications for the ministry or that facility in regards to any action with a patient's family.

Mr. Wyatt: — I mean I would say the "not necessarily" is an important part of your framing of this. I mean, you know, I would say there are situations where it may not be pertinent to the event, and it's hard to say. There may well be situations where relevant details that were not completed in the critical incident report might well have helped to broaden the understanding of the event, and I just can't really speculate on whether that's the case or not.

As it pertains to, you know, any legal liability issues again, you know, these are really separate processes, and I'm not aware . . . I have no way of being able to respond in terms of whether a vacant field in a critical incident report could somehow translate into a liability issue.

Ms. A. Young: — Thank you. And I'm breezing through these as quickly as I can, so I appreciate the committee . . . In regards to recommendation 6, critical incident training, I believe February 21 was noted for training on page 64, and I'm looking for an update on that patient safety fundamentals training. I did look to the update on recommendation 6, and I'll confess I wasn't fully clear on training on the hierarchy of effectiveness of recommendations, what that meant.

Mr. Wyatt: — So just with respect to training, as per the earlier reference, there has been some additional training provided and completed through the institute for health improvement . That's around root cause analysis and actions. As indicated here, this is a recommendation that we'll continue . . . You know, we've got a '23-24 completion date, and I would just say, you know, there's a commitment to improving the type of reporting that is provided related to the critical incidents.

The training around these is partly a . . . The effectiveness of critical incident reporting is partly around the reports themselves, but also around how the implementation is affected through the organization. And that's where, you know, some of the training is important in terms of how these are disseminated to different service lines within the Health Authority and, you know, what the expectations are related to the implementation of critical incident reviews across the organization.

Ms. A. Young: — For that critical incident training, am I misunderstanding that it has not been provided since 2017?

Mr. Wyatt: — I think that's a question I'll take away and follow up on.

Ms. A. Young: — I guess my two last questions. One, on page 67, there's a comment noted that:

> The Ministry indicated that it does not expect or propose corrective actions with significant cost implications.

And I understand the likelihood severity balance, that that obviously has to be undertaken when calculating risks, and certainly when it would come to critical incidents.

But I guess I perhaps find it a bit concerning. I'm curious, what would constitute "significant" for cost implications? Or I suppose if there's a threshold, like would an incident have to happen a certain number of times before it would be considered? Or is that safe to assume under development?

Mr. Wyatt: — Yeah. I'm just, you know, reviewing that particular section, and I think it references a context around a mental health, you know, design of a mental health unit. And so from my perspective, this probably relates back to issues around root cause.

And are there factors related to facility design that may have a broader impact of the nature of a particular incident? And I think that's where you have to do that risk assessment if it's a singular event with a relatively low risk of repetition and a significantly high cost. That's probably something that we would want to undertake that sort of risk assessment around. There's certainly no direction with respect to critical incidents to say that any remedial action has to fit within a certain budget figure. That's not the case.

Ms. A. Young: — Thank you . . . [inaudible] . . . conversations we can wrap up?

The Chair: — Well and this is a really important area, so my thought would be, you know, we can be mindful of time. I think if there's some additional, you know, an additional question or two today, this is appropriate to deal with it now because we have the officials. If it's more protracted than that — this is an important area — then we could flip that consideration into the agenda tomorrow. We're going to have folks here as well.

But I'd say, like we're down the stream of questioning. My preference would be if we don't have another half an hour of

questions or hour of questions, I'd rather see resolution here. If officials are comfortable with . . . How many more questions?

Ms. A. Young: — [Inaudible] . . . that can be good, yes.

The Chair: — Because it's a super-important area that shouldn't get any, you know, shouldn't be abbreviated for any considerations on this end. Do you have any other questions at this point that you'd like to put?

Ms. A. Young: — I can wrap it up, yes.

The Chair: — Okay. Any other questions from committee members on this chapter? Again this is a new chapter that's been brought by the auditor. It's a really important focus and the questions that were brought here today are really important.

Thanks for the undertaking of the work that's going on on this front. I think for anyone watching at home, they need to know that the . . . We have a really robust follow-up process as a Public Accounts Committee brought to us by the Provincial Auditor's office and how they follow up. So we hear the undertakings of work that are going to occur. The auditor's office then follows back in to ensure that's happening and it's all publicly reported out and back to this table.

So not seeing any other questions at this time, we do have brand new recommendations here. We have the 10 recommendations, 1 through 10. There's been progress that's certainly been identified. I'd welcome a motion with respect to noting progress or concurring and noting progress. Is there someone that would care to move that?

Ms. C. Young: — I'll so move that.

The Chair: — Deputy Chair Young. On all 10, yes. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay, that's carried. Not seeing any other items on our agenda right now, I would welcome a motion of adjournment from a committee member. Mr. Nerlien. All in favour?

Some Hon. Members: — Agreed.

The Chair: — That's carried. This committee stands adjourned until tomorrow at 8:30 a.m. Thanks, everyone.

[The committee adjourned at 17:13.]