STANDING COMMITTEE ON PUBLIC ACCOUNTS

Hansard Verbatim Report

No. 11 — March 1, 2022

Published under the authority of The Hon. Randy Weekes Speaker

Legislative Assembly of Saskatchewan

Twenty-Ninth Legislature

Hansard on the Internet

Hansard and other documents of the
Legislative Assembly are available
within hours after each sitting.
https://www.legassembly.sk.ca/Calendar

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Mr. Trent Wotherspoon, Chair
Regina Rosemont

Ms. Colleen Young, Deputy Chair
Lloydminster

Mr. Marv Friesen
Saskatoon Riversdale

Mr. Todd Goudy
Melfort

Mr. Delbert Kirsch
Batoche

Mr. Hugh Nerlien
Kelvington-Wadena

Mr. Dana Skoropad
Arm River

Ms. Aleana Young
Regina University

[The committee met at 09:00.]

The Chair: — Okay folks, good morning. Welcome to the Standing Committee on Public Accounts. Good to have everyone here. I'll introduce the committee members that are here today: Deputy Chair Colleen Young, Mr. Hugh Nerlien, Mr. Todd Goudy, Mr. Marv Friesen, and Mr. Dana Skoropad. Chitting in for Ms. Aleana Young is Ms. Erika Ritchie.

I'd like to welcome our Provincial Comptroller, Mr. Terry Paton, to the committee here today. I'd like to welcome and introduce our Provincial Auditor, Tara Clemett; Kim Lowe; and officials that will be with us here today from the Provincial Auditor's office.

At this time I'll table the following documents: PAC 45-29, Ministry of Advanced Education: Report of public losses, October 1st to December 31st, 2021; PAC 46-29, Ministry of Health: Report of public losses, October 1st, 2021 to December 31st, 2021; PAC 47-29, Ministry of Finance: Report of public losses, October 1st, 2021 to December 31st, 2021.

I guess we're focusing this morning on the Saskatchewan Health Authority and this afternoon as well. Thank you so much to Deputy Minister Hendricks for being here, officials with the Ministry of Health, and leadership of the Saskatchewan Health Authority for your time here today.

I will ask Mr. Hendricks to just briefly introduce the officials that are here today, and then we'll save any other opening remarks or response until we've had the presentation from the Provincial Auditor. But if you can introduce officials, Deputy Minister Hendricks.

Saskatchewan Health Authority

Mr. Hendricks: — Okay, thank you, Mr. Chair. Seated to my right is Assistant Deputy Minister Mark Wyatt; and to my left is Robbie Peters, vice-president and chief executive officer of the Saskatchewan Health Authority. Also with us is Billie-Jo — I'll have them raise their hand behind me — Billie-Jo Morrissette, assistant deputy minister; Melanie DeMarni, who's the director of operations and internal audit with the ministry. As well we have Andrew Will, interim chief executive officer of the Saskatchewan Health Authority; Corey Miller, vice-president, provincial programs; Beth Vachon, vice-president, quality, safety and strategy; Andrew McLetchie, integrated northern health; Sharon Garratt, vice-president, integrated urban health and chief nursing officer; Karen Earnshaw, vice-president, integrated rural health; and Kyle Matthies, who is the executive director of organizational development and employee wellness.

The Chair: — Thank you. Thank you so much. Thank you to the officials that are here today, and thank you to all the other officials and those in Health that are connected to the work that we're going to be talking about today, and that have been involved in these presentations.

I'm going to table the document PAC 48-29, Saskatchewan Health Authority: Status update dated March 1st, 2021. Thanks to the folks as well that were involved in putting that together. It really helps us focus our work here at this committee, so thank you for that.

At this time I am going to turn it over to our Provincial Auditor's office, to our Provincial Auditor. And I understand we're going to be focusing on a grouping of four chapters that are all related here to start. I'll turn it over to Provincial Auditor Clemett.

Ms. Clemett: — So thank you, Mr. Chair, Deputy Chair, committee members, and other officials. With me today is Ms. Kim Lowe. Kim participates in the annual integrated audit of the Saskatchewan Health Authority and was responsible for leading a number of the performance audits that we are going to go through today.

So this morning Kim's going to present the chapters in the order that they do appear on the agenda before you. This will result in 17 presentations, so there's certain chapters that we have combined together into one presentation. So for example, as indicated, the first four chapters have been combined into one presentation. Kim is going to pause for the committee's consideration after each presentation. There are five presentations that do include a total of 33 new audit recommendations for the committee's consideration.

And before I do turn it over to Kim, I do just want to thank the interim CEO [chief executive officer] of the Saskatchewan Health Authority and all the officials at the Saskatchewan Health Authority that do assist us during the course of our work, and especially during the pandemic. With that I'll turn it over to Kim.

Ms. Lowe: — Thanks. The first four chapters on this morning's agenda include the results of our annual integrated audits of the Saskatchewan Health Authority for the years ended March 31st, 2018 to March 31st, 2021. This includes the results of our first annual audit of the authority following amalgamation of the 12 former regional health authorities, for the year ended March 31st, 2018.

These chapters include four new recommendations for the committee's consideration. One was new in our 2018 report volume 2, and three were new in our 2019 report volume 2. For each of the four fiscal years described in these chapters, we found the authority had reliable financial statements and complied with the authorities governing its activities. In addition, the authority had effective rules and procedures to safeguard public resources except the four areas highlighted in our recommendations.

On page 79 of our 2018 report volume 2, we recommended the Saskatchewan Health Authority sign an adequate service level agreement with eHealth Saskatchewan to enable monitoring of the quality and timeliness of eHealth's provision of IT [information technology] services. This recommendation remained outstanding at March 2021.

The authority moved the majority of its IT systems into eHealth's data centre in 2017-18 and signed an operating agreement with eHealth in 2017. We find the agreement inadequate in allowing for appropriate monitoring of IT services. For example the agreement does not include provisions about IT change processes; service levels, for example, response times, system availability; security requirements; and disaster recovery. We also found eHealth had not completed or tested its disaster

recovery plans for certain critical IT systems and data of the authority; for example, lab system, hospital admission system.

Having an inadequate service level agreement increases the risk of the authority not effectively monitoring whether eHealth meets the authority's IT needs. Furthermore, not having completed or tested disaster recovery plans for critical IT systems increases the risk the authority may be unable to restore, within a reasonable time, its critical IT systems and data in the event of a disaster.

On page 82 of our 2019 report volume 2, we recommended the Saskatchewan Health Authority implement an improved code-of-conduct policy including permitted vendor-sponsored travel. This recommendation is now implemented. By December 2019 we found the authority implemented a conflict-of-interest policy including sufficient details on permitted vendor-sponsored travel. The policy requires managerial and practitioner staff in leadership positions to complete an annual conflict-of-interest disclosure form. In addition, the policy requires the chief executive officer, or respective executive leadership team member, to pre-approve vendor-sponsored travel. For 10 staff we tested who are required to complete the annual form, each had signed forms on file. Also for three instances of approved vendor-sponsored travel we tested, the chief executive officer or executive team member approved travel consistent with the policy.

On page 84 of our 2019 report volume 2, we recommended the Saskatchewan Health Authority document its due diligence procedures used to validate suppliers before adding them into its financial system. This recommendation is now implemented. The authority implemented a new process in September 2019 to validate suppliers before adding them into its financial system. It requires staff to research and document the validity of a new vendor or change supplier information before making a purchase. For four new or changed suppliers we tested, documentation showed staff completed due diligence procedures as expected.

On page 86 of our 2019 report volume 2, we recommended the Saskatchewan Health Authority separate incompatible duties. This recommendation remained outstanding at March 2021. While the authority made some improvements during 2020-21 in relation to the segregation of incompatible duties, our testing continued to identify incompatible duties. The authority inadequately segregates incompatible duties related to paying suppliers, paying staff, and using journal entries to record financial transactions.

Examples of specific situations we found include not restricting certain staff from entering new suppliers in the financial system and approving invoices for payment, and not restricting certain staff from being able to approve their own pay increments in the payroll system. Inadequately separating incompatible duties increases the risk of not catching errors or identifying situations where staff did not follow expected processes. Not involving more than one individual in making purchases, paying employees, and processing journal entries increases risk of undetected fraud.

Finally on pages 80 and 81 of our 2018 report volume 2, along with pages 86 and 87 of our 2019 report volume 2, we summarize the status of 11 recommendations previously agreed to by this committee in relation to integrated audits of 12 former regional health authorities. Overall by March 2019 we found the authority implemented six of these recommendations, and the five remaining were replaced by the new recommendation around the authority's need to sign an adequate service level agreement with eHealth Saskatchewan for the provision of IT services.

I will now pause for the committee's consideration.

The Chair: — Thank you very much for the presentation and for the focus of the work. I'll turn it over to Deputy Minister Hendricks and officials to respond, then we'll open it up for questions.

Mr. Hendricks: — Okay, thank you very much. So first off with the auditor's recommendation on page 80: "We recommend that the Saskatchewan Health Authority sign an adequate service-level agreement with eHealth Saskatchewan to enable monitoring of the quality and timeliness of eHealth's provision of IT services." As the auditor noted, we view that this is partially implemented. The SHA [Saskatchewan Health Authority] is collaborating with eHealth Saskatchewan on the development of an information technology services agreement. The agreement will be drafted, reviewed, and approved in a staged approach as corresponding supporting schedules are completed.

With respect to the second recommendation, on page 82: "We recommend that the Saskatchewan Health Authority implement an approved code of conduct . . . including permitted vendor-sponsored travel." As the auditor noted, this is implemented now. It was implemented in 2022. The Provincial Auditor has noted this, and so the SHA has approved and implemented a conflict-of-interest policy in December 2019 as well which includes sufficient details on permitted vendor-sponsored travel.

The third recommendation, on page 84: "We recommend that the Saskatchewan Health Authority document its due diligence procedures used to validate the suppliers before adding them into its financial system." Again this is implemented. In September 2019 the SHA implemented a new process for setting up and changing supplier information in its financial system. Staff were required to research and document the validity of a new vendor or change supplier information before making a purchase.

On the fourth recommendation, on page 86: "We recommend that the Saskatchewan Health Authority separate incompatible duties." This recommendation is partially implemented as the auditor noted. Our view is that this recommendation will be fully addressed with the implementation of the new administrative information management system, or AIMS, in 2022.

The Chair: — Thank you very much for the presentation and for all the work on these fronts. I'll open it up to committee members at this point for questions. I see Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. Thank you both to the auditor and her staff for their presentation and to the deputy minister of Health, Mr. Hendricks, and staff for your presentation here this morning and being available to take our questions here this morning.

[09:15]

I do want to just ask your patience and your indulgence with these questions. I am filling in for a sick colleague on the fly. But we are prepared with some questions, and I do want to get into those. But, Mr. Chair, if there's any procedural irregularities I just ask for, you know, your patience.

The Chair: — Watching like a hawk.

Ms. Ritchie: — Thank you. Thank you for that; appreciate that. So with that, maybe we'll begin. So this will maybe go a little bit slow. But anyways, I want to focus on some questions related to some of the items here that are in that sort of partial implementation phase as you've outlined. I understand that the service level agreement has been in development for quite some time. You've indicated a staged approach and a timeline for completion. And I would maybe first of all, if I'm able to, ask the auditor a question first in terms of I think you've highlighted some of the risks associated with that agreement not being in place, and I'm wondering if we could go over that a little bit in terms of the risk that this places Sask Health in.

Ms. Clemett: — Sure. So with any sort of IT service provider arrangement, you always want very much it clear in terms of roles and responsibilities in terms of what is each party responsible for. Obviously from that IT security perspective, it needs to be very clear who's responsible for securing the various systems and data, who's paying for those costs. So from an IT perspective, often things become out of date, I guess, and if not properly maintained or not secured, are then I guess really at risk to vulnerabilities. So it is a matter of making sure you're clear in terms of who's going to be securing those systems, how are you aware that that is taking place.

And then another area we articulate is obviously from that disaster recovery side in terms of the health sector is very much supported by the use of a number of IT systems in the delivery of operations. So it is a matter of who's going to be responsible for recovering those systems in the event of a disaster. How quickly are they going to come back up as such? Again, who's paying for that? Who's testing that? And is it confirmed it is going to work as I guess agreed to?

Ms. Ritchie: — Thank you for that response. So in terms of the outstanding steps that your ministry is undertaking to complete the work, I'd like to get some more detail in terms of how you plan to go about that staged approach. What are those various elements as you're doing that? And you've indicated a '22-23 timeline and how you intend to meet that target.

Mr. Hendricks: — Thank you. So first of all, and I don't want to use this excuse a lot today but it's true in some cases, the work on this obviously was impacted by the pandemic and people kind of having to shift their work to other places. Nevertheless, we do agree with the auditor that a service level agreement is very important for the reasons that you've outlined as well.

There is an IT services consolidation steering committee that resumed meetings at the end of June 2021. And they've established a new project plan in collaboration with the newly engaged project management team. The project plan, they've broken it down into eight work streams that they feel will be critical components to the information technology service agreement, including project governance and management; current state validation; staff transfer; contracts, assets and expenditures; a service catalogue; partnership governance and management — different; future state business and financial model; and the information technology and service agreement. Each work stream has key activities and responsibilities that it is responsible for achieving. And as we noted, the SHA and eHealth plan on having that done by '22-23.

All the work groups have been organized and have started meetings to define timelines. Co-leads for each work stream have been established, team members. Detailed work plans are being developed, and participants from eHealth, SHA, and the Ministry of Health have all been identified to support each work stream.

The information technology service agreement will be drafted, reviewed, and approved in a staged approach, as I noted, as corresponding work streams and schedules are completed. And so we do plan; the work is in process. We've established the process by which we will complete that work, and we're confident it will be complete in this fiscal year or the next fiscal year.

Ms. Ritchie: — Okay. I'm wondering if that also includes a contingency plan, what sort of barriers maybe have been anticipated that could take that off track.

Mr. Hendricks: — I'll start, and then maybe if Robbie can add . . . Like one of the objectives that I mentioned was staff transfer. So we're transferring staff from the SHA to eHealth. Obviously this requires discussions and negotiations with unions. That again has been stalled, but we're going to be picking up that work. You know, while you may have plans, timelines, that sort of thing to actually achieve those agreements, they don't always happen according to plan. So there are certain elements of this that, you know, are potential I guess, or potentially have the opportunity to disrupt the flow of the progress. But you know, I think that would be one of the chief ones.

Mr. Peters: — I think maybe as Max already alluded to, depending on how COVID continues, if there's another wave or a surge that could obviously impact us, I think the big thing for us is capacity of our staff on both the eHealth side and the SHA side.

We've got a lot of different initiatives. You know, we're transferring Extendicare long-term care homes into the SHA, so we've got a lot of the same people and leaders that are working on these types of initiatives. So there's a bit of a capacity challenge on some of these, so I can see that being a potential barrier too. But I think we are in a good spot in terms of the service agreement and we do have a good draft in place. And we actually have some workshops happening today and tomorrow to continue that. So I think we're in a good spot and able to proceed with that, and I think we've got the right people and commitment on that part of it.

But as Max said, it will be in stages. There's about 27 different schedules attached to that main agreement, and we've identified the core key ones that need to be in place when the main agreement goes in place. But after that there'll be a staged approach in terms of the rest of those schedules.

Ms. Ritchie: — And so given those factors that you've just

identified, obviously COVID has been a disruption to many ministries and obviously not least of which would be Health. So I appreciate that. However, obviously the work needs to continue on and I'm just wondering if there's a contingency plan or a risk assessment. With those risks that we've just talked about, are those part of the plan? And do you have mitigation measures identified? Just wondering about sort of the level of contingency planning that's happening in case those kind of things get in the way of meeting the timeline that you've set for yourselves.

The Chair: — Just before Mr. Will takes the seat here . . . Any other officials that are coming forward, just if you could say your name first and then proceed with your comments.

Mr. Will: — Okay. Andrew Will. Thanks for that question.

A couple things, I think, that are giving us confidence that this will move along is eHealth and the Saskatchewan Health Authority have jointly engaged MLT Aikins to help provide support to preparing those agreements. We've also engaged with some project management support from a company called Gevity. And I think they're now Accenture; they've been acquired by Accenture. That's provided quite a bit of support in ensuring that we have momentum going forward.

And as Robbie explained, part of the approach will be this phased development of the agreement. We believe we're on track to have the initial base agreement in place by the end of this month, so that will be a good step forward. And I think the heavy lifting will be in areas like the financial model and some of the service levels that will be defined in the agreement. eHealth has done about 70 per cent of the work on the service levels, so we've made good progress, even through COVID, in advancing this work. So I'm feeling it's in a good place to be completed within this next fiscal year for sure.

Ms. Ritchie: — But to the question of risk management, can you speak to how that has been worked into the plan?

Mr. Will: — Yeah, thank you. So the other piece of work that we've done, together with eHealth and other partners, is put in place a governance structure that provides oversight to the work that's happening with eHealth and the services that they provide. So it includes, you know, both some committees that look specifically at technology but also at our programmatic needs. And we have, you know, sort of experts from both organizations on those committees.

And then we have an IAC [integrated advisory committee] committee overseeing that from a partnership perspective. And then ultimately that flows up to the DM [deputy minister]-CEO table as well if decisions are required. We're still developing our maturity of being able to do that, but it has started, and we have continued to meet as a committee through COVID.

Ms. Ritchie: — And I think maybe this might be a question to sort of fill in my own knowledge gaps, but I'm wondering if you could just provide me with a little bit of a timeline since project initiation up to this point. Because from what little I know, I understand that this was initiated quite some time ago. But from your response it sounds like you're really . . . sounds like project initiation. I could be mistaken, but I'm just wondering what's been kind of happening between the start and now and how you got to this point.

Mr. Hendricks: — Yeah, so maybe I can start. And so really this was initiated when the Health Authority was created, and so when . . . Best practice is that . . . Well first let me step back and say when the Health Authority was created, eHealth was given responsibility for all provincial IT services. And so with that, best practice would sort of dictate that when you have a relationship of this nature between organizations like the Saskatchewan Health Authority and eHealth, that you have a service level agreement, as the auditor outlined, that defines expectations, deliverable services that are going to be provided, you know, who's responsible for what, governance, all of these things.

And with that and with the creation of the SHA, it was also determined that there would be staff transferred. Information technology, they were part of the former health regions that kind of folded into the SHA and would go to eHealth, and eHealth would be responsible for those employees and overall management of IT.

Now as a service delivery agent, eHealth has a critical function in supporting SHA services, its clinical flows, its administrative flows, that sort of thing. So you know, this type of agreement is really important.

[09:30]

So work began shortly after the creation of the SHA in 2017, and you know, I think it's fair to say we did encounter some, you know, challenges on a few things including the transfer of staff. And then, you know, very shortly after that, as work was starting to pick up and progress, we kind of hit the pandemic. And then, you know, the other element of this — and you'll hear about this on the fourth recommendation — is we concurrently have this AIMS project going on which is drawing on many of the senior leaders and staff that would be required for this project.

And so I think just given this culmination of events, we've seen a delay in this project. But you know, I think there's a strong recognition by Andrew, myself, and eHealth that this is a critical agreement, and we are committed to getting it done as soon as possible.

Ms. Ritchie: — Thank you for that response. And yeah, I appreciate that this is a Herculean task with many considerations. You know, you mentioned the staff transfers, etc., and the AIMS project. So I mean where was . . . I don't want to have to necessarily go over the past but just to really sort of understand what's going on here, maybe I will ask, you know, in terms of like . . . Obviously you had many priorities or undertakings. I'll just call them that.

In terms of that amalgamation, there's many things that you have to undertake when you're making a merger of this sort and a transition. And just wondering sort of how this particular component of the merger — I don't know if that's the right word to call it, but pardon me — you know, how this was seen and the importance or priority that it had as you were doing these other things. Like, maybe you could help me understand the bigger picture when you talk about the AIMS project and all the various moving parts as this agreement was being put into place.

Mr. Hendricks: — So obviously when the Health Authority was created, there were a number of pretty significant, I would guess, work streams that, you know, were under way at that time. And I think when we . . . You know, with these sort of things which kind of fall out of that amalgamation process, you know, they do have attached a high level of importance to them.

You know, similarly though, projects like AIMS — and there was even within the SHA, organizing its organizational structure and how it was managed and its governance — there were several work streams going on concurrently, which I think during a regular time or regular period would have been manageable. But I think, you know, obviously there were some challenges to that, where people that were working on these things have been pulled into other areas.

And so you know, I guess there was an assessment that the combination of all of these tasks was, you know, something that could be managed by the system, but I will acknowledge that it didn't leave a lot of room for an unforeseen event. And so some of these things have been delayed.

At the end of the day, you know, eHealth does provide support for almost 30,000 users within the SHA, 30, 40,000 users within the SHA, thousands of clinical systems, all of our PACS [picture archiving and communications system], you know, our digital imaging, lab systems, all of this. It provides all of that and that's working, and you know, pretty well most of the time.

And so you know, the absence of the agreement hasn't stopped what is existing, but the problem is is that the relationship hasn't been formalized, and some of the accountabilities haven't been formalized. And so that's the challenge. It's kind of like there's a gentleman's agreement right now, and that's maybe not good enough in this situation.

Ms. Ritchie: — Right. Right. Yeah, no, I appreciate what you're saying, and you know, I acknowledge and recognize that the audit is identifying risks and things that, you know, formally need to be established in order to ensure that, you know, the system is robust and protected from any kinds of errors, and heaven forbid, fraud and those sorts of things. And I appreciate that's what you're endeavouring to do here.

I would say though that . . . I would only make the observation and it might be just because I'm just seeing this for the first time, but it does appear to me that there was a fair amount of time before the pandemic occurred in which to put in place the work plan and the governance structure. And so a bit concerned there, you know, appreciating the challenges but just only making that point.

And maybe I'll move along. Thank you also very much for the responses to that question on that new recommendation.

And I will move on to the new recommendation no. 4 where . . . Oh yes, okay, well this is good because I had a question about AIMS. I didn't really know what that was. So the new recommendation is for Health Authority to separate out incompatible duties, and I guess I would start by . . . If you could provide me with a bit of a general overview of what AIMS is and then kind of go from there.

Mr. Peters: — So AIMS is a project that is to replace all of our back office or administrative systems. So it's our finance systems, which includes our payment systems, our collections, billings, our general ledger reporting. It's also our payroll systems, our scheduling systems, HR [human resources] systems, supply chain, purchasing, inventory — so all those different systems.

We continue to operate the former 12 region systems. So right now, you know, in finance I run 12 separate finance systems, and to produce a SHA report, we have to consolidate all that information. So obviously it's not efficient and you don't get the best information from that. So it is a project to replace all those systems with one single solution.

And the solution that we're implementing will also integrate those various systems. So finance will integrate with payroll, supply chain, and so on. So that's basically what the project is.

Ms. Ritchie: — Okay, and so in this case here, I guess what I'm wondering is, in the current situation, what sort of challenges are you facing right now with some of those incompatible functions?

Mr. Peters: — In terms of the segregation of duties, I think some of the challenges are some of the old systems won't allow us to automate some of our controls, or separate, you know, using a roles-based security approach within the system. So I think that's one of our challenges. Obviously having 12 different systems, we have 12 different processes. We have, you know, former regional staff's leadership that we're still relying on to run those systems.

We've had a lot of turnover over the last four years. We've lost a lot of leadership. So I think those are some of our concerns and risks as well in terms of keeping those legacy systems operating effectively and doing what we need to do from them. I think those are some of the bigger things.

And then I think just, you know, as we move from regional-based, kind of, processes to provincial — whether it's policies, work standard, or whatever — it's not as easy to implement those province-wide when you have, you know, those disparate systems or processes. So one of things we try to do is if we are implementing provincial policies, we have a compliance checklist now where our accounting or our finance team does a biweekly check in to make sure that leaders in the former regions are following those new policies or the provincial-based and there's no issues with them. Even though we don't have the single system in place, we are trying to mitigate some of those challenges or gaps as we go.

Ms. Ritchie: — So you mentioned some turnover and loss of leadership. Can you tell me a little bit more about that? How many or what positions? How that's been addressed?

Mr. Peters: — I don't have numbers in terms of how many, but I can say it's fairly significant. When we amalgamated we still, you know, we put in the provincial-based, obviously, leadership structure at the VP [vice-president] and executive director level fairly quickly, and then started moving down to director. And we just implemented managers within the last year.

So it's been a bit of time taken to implement our full org structure which is still not complete in terms of all of our out-of-scope

positions, meaning our non-unionized positions, so specialists and those that report to managers. So we're still working through that.

But what we did initially is we recognized that because we need to still operate all of these different systems, we still need that former leadership in those areas. So we came up with attrition plans in terms of, you know, if someone didn't fit into one of those layers of management that were being rolled out, we would look to still keep them in terms of being able to help operationalize the systems that we had. So that was one thing we did in terms of trying to make sure we still had that experience and knowledge there.

But as those people left, we've struggled in terms of, you know, filling that knowledge gap. We've had to put in temporary positions in a number of different places, which presents its own challenges in terms of retaining people when they don't see their full-time opportunities coming very quickly.

But it's been a very challenging environment, but I think we've managed it quite well. We've got strong leadership in our accounting-finance area and they've been able to manage so far.

Ms. Ritchie: — Yeah. Well I can see how this kind of a structural change could be made more challenging by loss of employees and depending on the systems in place, and as you're making that transition that would be more or less a smooth, or a not-so-smooth transition.

And so I'm just wondering, you know, you mentioned some of that loss of maybe some institutional knowledge, I suppose, with the loss of those individuals. So I'd like to kind of explore that a little bit in terms of the current systems or, you know, how you've been able to sort of transition from whatever the prior state was into your new state with that loss of maybe some people who were retaining some of that knowledge. Like just how have you been able to manage through that from a systems perspective to both identify where there are gaps, and then sort of work to fill them in your processes?

Mr. Peters: — Well I think, like any time you're losing people, you're trying to manage those risks and what the succession plan is going to be. So we have had opportunities where we've been able to move other people up into those positions from those former areas who would also have that kind of skill set or knowledge.

[09:45]

We've brought a number of external people in and have had to obviously train them and get them ready to take on those roles. It doesn't happen overnight, obviously. I don't know. It's been extremely challenging. It seems like almost every week we're having some turnover of some kind. And we've been managing it, but it is a big concern. And the longer the AIMS project draws out and we don't get to that single system and really be able to move to a provincial kind of team, I think that's a bigger challenge for us.

Ms. Ritchie: — And do you have, like . . . Is part of the work development of sort of standard operating procedures? And what is the status of that? Yeah, what is the status of that?

Mr. Peters: — When we created the SHA we determined, okay, which policies do we need in place right away on day one — things like signing authorities, procurement policies, things like that. So we had those ready on day one. And then as we've progressed, we've looked at what our other policies and procedures are and which ones we can move to provincial-based. And those ones that don't necessarily align with the systems, we've still been able to move to some provincial-based.

And like I said, we've been working with the teams in terms of, okay, you may not be able to implement it in your system, but there's some manual workarounds that we can do to try to implement those. So there's a lot of education that happens in terms of all of our policies, all of our work standards.

And like I said, just this past fiscal year we developed that kind of compliance checklist that we're using that . . . It lists all of our different provincial policies, work standards, directives, or whatever. And we go through that with our finance teams on a regular basis: are you guys following this? It's not necessarily a full audit obviously. We don't have the capacity to do that, but we're asking the questions, are you following this? Any concerns? Are you aware of any non-compliance with any of these policies? So that's kind of how we've been trying to manage without the AIMS system or the single system at this point.

Ms. Ritchie: — Just going back briefly to sort of the loss of leadership, how many senior-level or executive-level vacancies or resignations have you had to address?

Mr. Peters: — Are you talking just in finance area or overall?

Ms. Ritchie: — Overall.

Mr. Hendricks: — So you know, I think with the creation of the Saskatchewan Health Authority, you know, obviously one of the objectives of that whole undertaking was to reduce administrative services across the health system. And so you know, what we had before was we had 12 health regions that each had separate accounting, financial systems, that sort of thing, as Robbie has outlined. And you know, I would describe it as maybe various levels of sophistication in terms of financial controls, knowledge, expertise, that sort of thing.

You know, at the beginning the auditor went through previous recommendations in the report. You know, we have been cited in the past, going back to 2005, for separation of duties in various health issues and various health regions, and so this isn't something new. And the objective obviously of the authority is establishing a single system where everybody's following a common set of standards, practices. And again with the AIMS system so that they're all integrated through one system combining 12 disparate systems that have to be cobbled together now, and many more systems when you include all the scheduling, you know, HR systems that exist. And so this was the plan to bring this all together.

Now as we move through that, you know, obviously there are certain positions in what would have been the former regional health authorities that, you know, are no longer necessary and/or people perceive that in the future their position might be no longer needed. And so, you know, they make choices, they move

on, that sort of thing. But at the end of the day, we expect it, I think, some of these challenges as we move forward in terms of building the new authority and building this new system.

And so the outcome, hopefully, when AIMS is in place and we to some extent complete, fully complete the reorganization of our health regions into the authority . . . Because that's a pretty complicated undertaking because it's not only administrative. It's clinical. It's everything. At the end of the day, we will have common systems. We will have common standards, that sort of thing.

And you know, I think one of the other overall objectives, as stated at the time that this was created, was to, you know, return some money that we're spending on administrative services to the front lines. And so the objective was to, by not having 12 administrations and having one, to reduce some administrative costs.

Ms. Ritchie: — Yeah. Thank you for that sort of high-level response. I take your point and appreciate that kind of context. And I would also sort of add that I mean clearly I appreciate that this amalgamation would have been an opportunity to draw on best practice and sort of reset in terms of how eHealth performs its work and delivers service.

But maybe I should be just a little more specific in my question as it relates to the loss of leadership and turnover that you mentioned, and ask it specifically within the finance function and just within the last two years. I think maybe that's more pertinent to what we're talking about here today. Could I maybe ask that question?

Mr. Peters: — For what? The question is . . .

Ms. Ritchie: — The question is, in the past two years what has been the rate or level of attrition from the leadership level in the finance function?

Mr. Peters: — I wouldn't be able to answer that offhand. I'd have to find that information and bring it back.

The Chair: — Just on that point, thanks for the question. It seems that it's pertinent, you know, to the chapter. Thank you for the undertaking to get the information on that front back to the committee. That can be supplied to the Clerk, and that'll be shared then with the committee. So thanks for that undertaking. Any other questions at this point, Ms. Ritchie?

Ms. Ritchie: — Yes, thank you. I did have one final question. Given all that you've just provided, you do have a date of June 30th, 2022 for the completion of this recommendation. How confident are . . . that you will be able to achieve that? And what might get in the way of that? And how will you also then cover off for any of those, you know, things that might derail it?

Mr. Peters: — In terms of confidence, I think we're more confident now than we have been throughout the project, or throughout the AIMS project. But with any kind of big IT project like this, I think there's always some risks and concerns still. You know, just this week we had an issue or a bug issue with one of the software pieces. We had a defect. So that slowed down some of our testing abilities. So I think there are some risks there, but we have a steering committee or we have a project management office which they do a daily look at our outstanding issues and our risks.

And you know, we're always looking at mitigation plans. And then those are brought up to our executive steering committee where we talk about the risks in one of our plans. So over the last four or five months, we've put a big push on in terms of identifying those major potential blockers and, you know, how we might mitigate them. So software defects was one of them.

Again going back to people, capacity has been a challenge on this project. One of the issues we have is, you know, we have certain expertise in some areas where they are trying to manage different parts of the project, and they can't do it all at one time and we haven't been able to bring in other expertise. So there are some capacity challenges there.

But again we've taken steps to bring in outside resources, bring in additional SHA resources or other health system partners. Our strategic partner, Deloitte, has brought in more resources throughout the project. So this whole project has been about identifying what those risks are, what could slow us down, and getting on top of them quickly and early before they do become a problem.

Ms. Ritchie: **—** A follow-up question to that, then. You know, as that proceeds, is the budget on track or is there capacity . . . I mean you say you're bringing in other additional resources. I'm wondering about the budget implications.

Mr. Peters: — We have had to come back to government a few different times for some additional funding for this project.

Ms. Ritchie: — Thank you. Thank you, Mr. Chair.

The Chair: — Thanks for the responses and the work. Deputy Chair Young.

Ms. C. Young: — The system is extremely important as to the amount of data and the expanse of the data that it does contain. And though there is still work ongoing on it, how confident are you that the system would be protected if there was a cyberattack? And is there a backup system in place?

Mr. Hendricks: — Actually we would have to have our eHealth colleagues here to answer that because they will manage the data for this system. Their security protocols exist for clinical data. They have similar ones for administrative systems.

So there are always backups. It's a question of whether, you know, you have immediate failover like you have with clinical systems, so that if the system goes down in Saskatoon it's automatically — you know, if Saskatoon got hit by a tornado, God forbid, or something — that it automatically shifts to Regina. And so whether that exists or not, or will exist, I'm not sure. There will be backups for sure. And those are always stored off site, that sort of thing.

After the cyberattack in 2019, even though that was a pretty, you know, it was a significant attack and a novel one because it hadn't been seen across industry before, the one thing that eHealth was able to do was to restore clinical data very quickly from backups.

And so those exist. But again, you know, there's that issue of immediate failover versus going to backup.

Mr. Peters: — I would just add we are, as part of the project plan and the different work streams — so finance, supply chain, human resources — we are building business continuity plans as well. So if a system does temporarily go down, we'll have some contingency plans in place in terms of how we'll continue to operate.

The Chair: — Would you like eHealth to report out with more specificity?

Ms. C. Young: — [Inaudible] . . . or something at this point in time, yes.

The Chair: — So just, it was referenced that eHealth might be able to provide more specifics on this front. If you can just refer the question to eHealth and if they're able to provide a response to the member's question to the committee in the coming days, that would be appreciated. Mr. Nerlien.

[10:00]

Mr. Nerlien: — Thank you, Mr. Chair. Just a quick question. Ultimately who's responsible, eHealth or SHA or who?

Mr. Hendricks: — For?

Mr. Nerlien: — For a failure in the security risk management system today.

Mr. Hendricks: — Ultimately, you know, eHealth is a treasury board Crown. It's responsible to the Minister of Health. And so you know, obviously eHealth, the management are responsible to the minister to make sure that we have security systems that are adequate to protect against outside vulnerabilities.

There's certain, you know, I think, risks that are very, very hard . . . You can't protect against everything. You know, some of the most sophisticated systems in the world these days are being successfully hacked. And you know, eHealth, I think, even though they did have an issue that led to the cyberattack which was, you know, a person opening an email, you know, that at the end of the day it did a very good job of containing the attack and worked closely with technology partners to suppress it and to actually disseminate information to other industries so they could prevent the same type of attack.

So you know, a lot of security-related issues are issues that users make every day. It's not changing passwords. It's opening and clicking on suspicious emails or other things, right? And that's what caused this. And so really hard for an organization. We can educate on it, but it takes one person to kind of not get the memo and do something.

The Chair: — Not seeing any other questions at this point, and I know we have lots more on our agenda. Good questions. Thanks for the responses. Thanks for undertaking to get some information back to committee members here, as well to the officials. What I would look for . . . We have a few new recommendations here that haven't been considered at this table before. With respect to chapter 14, the first chapter before us here today, I would look for a recommendation that we concur and note progress. Anyone? Moved by Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. Moving along to chapter 12 of the 2019 report volume 2, I would look for a recommendation that we concur and note compliance for recommendations 1 and 2. Moved by Mr. Nerlien. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. And with respect to recommendation 3, I would look for a recommendation that we concur and note progress. Moved by Mr. Goudy. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried as well. With respect to the final two follow-up chapters, chapter 12 and 11 of the 2020, 2021 volume 2 reports respectively, I would simply look for a motion that we conclude considerations. Mr. Nerlien moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. Okay, we'll move along here this morning. I'll turn it back over to the Provincial Auditor, and we'll turn our attention to the 2018 report volume 2, chapter 23.

Ms. Lowe: — Chapter 23 of our 2018 report volume 2, on pages 135 to 149, sets out the results of our audit of the processes that the Saskatchewan Health Authority had to analyze surgical biopsies efficiently at its Regina and Saskatoon labs.

A surgical biopsy is a procedure that involves the surgical removal of tissue, often to determine whether a patient has cancer. This chapter includes seven new recommendations.

In May 2018 the authority reported backlogs in examining biopsies. It noted labs in Regina and Saskatoon had almost 3,000 biopsies awaiting examination. Long waits for health care services can contribute to declines in health and can impact the health care system overall. Increased wait times for the results of biopsies and diagnosis cause patients stress and anxiety. In addition, it delays treatment which can mean the difference between life and death.

We concluded that for the 12-month period ended July 15th, 2018, the Saskatchewan Health Authority had, except for the areas highlighted in our seven recommendations, effective processes to analyze surgical biopsies efficiently in laboratories located in Regina and Saskatoon.

In our first recommendation, on page 140, we recommend that the Saskatchewan Health Authority assess the impact of the surgical biopsy labs receiving accreditation through different bodies.

Each lab uses a different set of industry-recognized accreditation standards to show it has appropriate and suitable standards and processes for analyzing surgical biopsies. At July 2018, the authority had not determined whether the labs should continue to

receive accreditation from different bodies. Each lab operates under a five-year licence, issued by the Ministry of Health, that requires each lab to participate in the Saskatchewan College of Physicians and Surgeons' laboratory quality assurance program. Under this program, labs can choose recognized accreditation bodies to accredit the labs.

The former Regina Qu'Appelle Regional Health Authority selected the College of American Pathologists to accredit the Regina lab. The former Saskatoon Regional Health Authority selected the Western Canada Diagnostic Accreditation Alliance to accredit the Saskatoon lab. While the Saskatchewan College of Physicians and Surgeons recognizes both of these accreditation bodies, having the labs accredited by different bodies may result in unnecessary costs and variations in lab operation practices.

In our second recommendation, on page 141, we recommend the Saskatchewan Health Authority enter into a written agreement with the Office of the Chief Coroner about surgical biopsy lab services it provides for forensic autopsies.

Except for its relationship with the Office of the Chief Coroner, the labs have clearly assigned responsibility to staff for the various analysis stages of biopsies of tissue specimens — pre-analytical, analytical, and post-analytical stages. Each lab provides the Office of the Chief Coroner with support, including technical lab staff and access to equipment, supplies, and space for the forensic pathologist to conduct forensic autopsies. However we found neither lab clearly set out responsibilities of technical staff with respect to handling requests for analysis of forensic autopsies relative to handling other requests for surgical biopsies.

There was no written agreement with the Office of the Chief Coroner about support provided for forensic autopsies or the responsibilities of each party for the handling of these cases and related specimens. Not having a written agreement increases the risk of the authority and the Office of the Chief Coroner not having clear or common expectations and understanding of each party's responsibilities, obligations, and processes to resolve differing views if any. In addition, lack of a written agreement may result in authority staff within labs making decisions about the handling and processing of requests for biopsy analysis inconsistent with the authority's expectations. This could cause scheduling conflicts for technical staff and delays in processing surgical biopsies.

In our third recommendation, on page 144, we recommend the Saskatchewan Health Authority implement a consistent approach for prioritizing and issuing timely diagnosis reports for surgical biopsies. We found the Regina and Saskatoon labs have different target turnaround times for processing requests for analysis of surgical biopsies in issuing diagnosis reports. They also use differing approaches to prioritize those requests. In addition, the target turnaround times do not always align with good practices.

Consistent with good practices, we found both the Saskatchewan lab and the Regina lab to some extent varied target turnaround times for processing and issuing diagnosis reports based on the assessment of both priority and the complexity of the biopsy. Unlike the Saskatoon lab, we found the Regina lab did not have documented prioritization classifications and associated target turnaround times for biopsy specimens. Lack of documented guidelines increases the risk that staff do not prioritize requests consistently.

We also found that the target turnaround times for each lab were not always consistent with good practice. For example, the Saskatoon lab allowed more time than good practice for some of its turnaround time targets, for example, priority 3 specimens, and less time for others, for example, breast cancer biopsies. Inconsistent prioritization strategy for processing and analyzing specimens may result in some patients and health care providers having to wait longer for diagnosis results than others, resulting in delayed care for patients. Inconsistent turnaround times for processing and providing diagnosis results leads to providing patient care inconsistently across the province.

In our fourth recommendation, on page 145, we recommend the Saskatchewan Health Authority assess the cost-benefit of electronically tracking the location of surgical biopsy specimens throughout the key stages of the lab analysis process.

We found neither lab maintains information about surgical biopsy specimens in a manner that enables ready tracking of the location of a specimen throughout the entire analysis process. In addition, neither lab maintains information regarding the complexity of a case and the time taken to complete each key point of analysis.

Good practice expects the labs would track information about the biopsy analysis process electronically to easily identify where a specimen is at in the analysis process. Collecting and maintaining information manually results in labs not being able to easily identify who has control of the specimen or determine how long each point of the process takes, for example, how long it takes lab technical staff to prepare the specimen for analysis. This can result in staff wasting time locating a specimen.

Not having an adequate tracking system makes it labour intensive for the labs to determine if their target turnaround times are reasonable and to determine reasons for not achieving them. In addition, it increases the risk of labs losing or misidentifying specimens in the process, which may result in labs providing untimely or inaccurate diagnosis results to health care providers, and in turn their patients.

In our fifth recommendation, on page 147, we recommend the Saskatchewan Health Authority formally assess the surgical biopsy process at its surgical biopsy labs to identify factors inhibiting timely diagnosis.

We found the authority does not know why labs are not achieving turnaround targets, or whether its labs are appropriately staffed. Neither lab tracks the number of surgical biopsy analysis requests by their complexity and priority or the time it takes to complete each tracking point in the biopsy analysis process. In addition, neither lab tracks workload of technical staff to evaluate the productivity of the work units.

Our testing of 34 surgical biopsy requests and assessment of data compiled from each lab's IT system found neither lab is issuing patients' results timely. We found the Regina lab's average for issuing diagnosis reports was 18.7 days in 2017-18, compared to its target turnaround time of five days. We also found one

instance where the Saskatoon lab took 222 days to issue a diagnosis report.

Neither lab had formally determined whether its target turnaround times were realistic, or analyzed reasons for delays. By not meeting their turnaround time targets, the labs are putting patients' health at risk, as timely diagnosis is required to begin any required treatment.

In our sixth recommendation, on page 147, we recommend the Saskatchewan Health Authority educate health care providers on properly completing surgical biopsy requisitions for Regina and Saskatoon labs. We found requisitions that each lab receives from health care providers are not always complete and/or the priority of the request is not always properly classified. Our testing of 34 requests found one instance where a requisition form was missing key information. This error on the requisition resulted in a delay of 44 business days in completing the diagnosis report for the patient.

Incomplete requisition forms from health care providers can result in delays to diagnosing a patient's biopsy. Providing health care providers with training or better guidance on completing requisitions, and when to identify a biopsy as urgent, could help reduce the number of errors on requisitions received.

In our seventh recommendation, on page 149, we recommend the Saskatchewan Health Authority require its labs to keep records of preventative maintenance completed by technical staff on its surgical biopsy equipment.

We found the authority does not require the labs to track the completion of preventative maintenance. For all 10 pieces of equipment we reviewed at the Regina lab, the Regina lab kept adequate records of maintenance completed, including records of who did the maintenance and when. However, for all six pieces of equipment we tested at the Saskatoon lab, the lab did not keep track of when its staff last performed preventative maintenance.

Not documenting when preventative maintenance on surgical biopsy equipment is completed, and by whom, increases the risk of not completing maintenance as expected. Lab equipment must receive appropriate maintenance to ensure analysis is properly completed.

I will now pause for the committee's consideration.

[10:15]

The Chair: — Thanks so much for the presentation and the, you know, really important focus of the work when you think about the impact on people and patients. I want to thank as well all those that work in the labs and all the pathologists that are working so hard and so dedicated to their service, dedicated to patients every day. I'll turn it over to Deputy Minister Hendricks for response, then I'll open it up for questions.

Mr. Hendricks: — Yes, thank you. So with respect to the auditor's recommendation on page 140, that the ". . . Authority assess the impact of the surgical biopsy labs receiving accreditation through different bodies," the SHA considers this implemented. The provincial executive committee for laboratory medicine has assessed the impact and approved the use of both the Western Canadian Diagnostic Accreditation Alliance and the College of American Pathologists to provide accreditation to ensure the SHA surgical biopsy labs meet the highest levels of quality. Basically they consider them equivalent.

The auditor's second recommendation on page 141, that the ". . . Authority enter into a written agreement with the Office of the Chief Coroner about surgical biopsy lab services it provides for forensic autopsies," the SHA considers this implemented. The SHA signed a memorandum of understanding with the Office of the Chief Coroner, and that was completed and signed on December 14th, 2020.

The third recommendation on page 144, that the ". . . Authority implement a consistent approach for prioritizing and issuing timely diagnosis reports for surgical biopsies," the SHA considers this recommendation partially implemented. Provincial performance metrics have been established. Standardized turnaround times for data for Saskatoon and Regina are provided to the executive director of lab medicine, the provincial head of lab medicine, and the VP and executive physician of provincial programs, as well as the Ministry of Health, monthly.

The provincial anatomic pathology discipline-specific working group created a draft standard operating procedure that will be implemented to all five anatomic pathology labs, following review and approval by the anatomic pathology provincial discipline-specific committee. The provincial standard operating procedure is expected to be reviewed by late February 2022 with implementation to follow thereafter.

In terms of the fourth recommendation, on page 145, that the ". . . Authority assess the cost-benefit of electronically tracking the location of surgical biopsy specimens throughout the key stages of the lab analysis process," the SHA considers this recommendation partially implemented. Saskatoon did implement a specimen-tracking system in December 2018. An RFP [request for proposal] for immunochemistry instrumentation was completed in June 2020, which included a specimen-tracking system for Regina as well.

With funding approved for the project, vendor installations were scheduled for the fall of 2021 for both Regina and Saskatoon. However, implementation was delayed due to COVID-19, and we're currently waiting for IT support from both eHealth to complete the server space and interfacing.

For the fifth recommendation, on page 147, that the ". . . Authority formally assess the surgical biopsy process at its surgical biopsy labs to identify factors inhibiting timely diagnosis," the SHA considers this recommendation implemented. After a thorough review, constraints were identified that impact the turnaround time that inhibits timely diagnosis. The review identified the need for additional grossing workstations in Regina to assist with workflow. Renovations were completed and three new grossing stations were installed in February 2021.

The sixth recommendation, on page 147, that the ". . . Authority educate healthcare providers on properly completing surgical biopsy requisitions for Regina and Saskatoon labs," the SHA considers this partially implemented. A provincial general

surgical requisition was developed in consultation with stakeholders. The new form was approved by the clinical standards forms committee and made available for clinicians to use in the fall of 2021. The implementation plan and training package was to be discussed at the September 2021 quarterly meeting, which was postponed until late 2022.

And then lastly, the seventh recommendation, on page 149, that the ". . . Authority requires labs to keep surgical records of preventative maintenance completed by technical staff on its surgical biopsy equipment," the SHA considers this recommendation implemented. Maintenance logs have always been in place but were not consistently completed by staff in Saskatoon. Staff have been reminded to complete the logs. Management reviews the maintenance logs weekly at a minimum to identify non-compliance in a timely manner. Management implemented this recommendation immediately after the audit.

Thank you. That concludes our response.

The Chair: — Thanks for the report, and thanks for all the important work on these recommendations. I'll open it up to committee members for questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. I note that it's listed in the auditor's report that Saskatoon has an average of 12.1 days for biopsy diagnosis, and Regina an average of 18.7. I'm wondering, you know, those are the averages, but sort of what's the shortest or the longest that you've seen in terms of those turnaround times? And then, you know, what leads to these discrepancies between our two urban centres?

Mr. Miller: — So Corey Miller, vice-president of provincial programs for the Saskatchewan Health Authority. To answer your question, in the range there's a wide variance. We have some surgical reports that can get out the same day in a rapid response, and we have some greater than 50 days, and that can be for a number of reasons.

And I would say for the short, it would be because it's a very urgent request and requirement for the surgeon who's requested it for that patient. And the same could be for the long wait. Often those instances would be we'd be waiting for a result to come back from out of country or out of province, where we might send for a secondary review to the Mayo Clinic would be an example. We have contracts with both . . . Mayo Clinic would be probably our main connection, but we send also for a secondary review to Vancouver quite often as well.

Ms. Ritchie: — I'd like to understand that a little bit better in terms of how common a practice that is, the kinds of diagnostics that have to go out of province versus in.

Mr. Miller: — Great question. Pathology is becoming a more and more specialized service, so it's less generalized and more specialized. And that is why we're seeing more and more of our pathology services be centralized into Saskatoon and Regina and away from our rural sites. It's not because we're trying to centralize. It's difficult for us to recruit pathologists into a single practice because you don't have the ability to consult with a dermatology-specialized or oncology-specialized, so it's rare for us to have pathologists who want employment in a single or a double practice. They want to be in a group practice, no different than in a larger institution or a specialized institution like the Mayo Clinic. They may have people who are very specialized in genomics and genetics, hematopathology.

So I would say we're sending less and less out of province, and the area that I would key on specifically is the areas of genomics and our hematopathologists. And we have a really great lab in Saskatchewan that a lot of people don't realize called the Advanced Diagnostic Research Lab which is in the College of Medicine. They do fantastic work. And in the report it also says people refer some of their difficult cases to our teams as well because we have some people in Saskatchewan who specialize in certain pathology services that they don't have any services. And that's not uncommon for Alberta and BC [British Columbia] to send samples to us as well.

Having that genomics lab in Saskatoon, if our colleagues from the Saskatchewan Cancer Agency were here they would say that they are exponentially sending us more and more of that specialized service, because they used to send it out and it would take three to four weeks to get those results that they can get back now in three to five days. So there are some cases where we send out and it's a longer response. There are cases where we are able to now service them locally.

And not all pathology cases are equal, nor is the process and the procedure to prepare the slides to be read by our specialists. So some slides can be prepared in an urgent manner and they'll be a quick read. Then they send it through our processes where it's processed and reread. So it's not uncommon for there to be a preliminary read and then an amendment to the report that is then reissued to the surgeon or to the requesting clinician.

So that does make the range very variable because there are so many different types of procedures as well as different types of pathology that our team is looking at.

Ms. Ritchie: — So the auditor's recommendation in this example is, you know, ensure that, you know, basically that you have a process, a consistent approach for prioritizing and issuing timely diagnostic reports. And I appreciate what you're saying in terms of, well, obviously complexity. And due to the nature and the type of diagnostics, obviously things are going to need to look a little bit different. So in the SOP [standard operating procedure] that's been produced for this process, maybe you could speak to kind of how it's accounting for those factors.

Mr. Miller: — So I think there's a couple of the recommendations from the Provincial Auditor that touch each other.

Ms. Ritchie: — Oh, sorry. Yeah.

Mr. Miller: — So the example that I would use with recommendation no. 6 was around educating health care providers and having a standard requisition. So similar to the previous chapter that we reviewed talking about amalgamating the Health Authority, each health region had its own lab forms and we're amalgamating them into a new common form.

Having and educating our referring clinicians — it's not just physicians, clinicians — is very important because if the pathologist in the back office doesn't see the patient, they don't

meet the surgeon often, and it's important that they prioritize what are we looking for and how urgent is it. And if all we get is a piece of paper saying "breast cancer," and it doesn't give us the specific type of breast cancer that they're suspicious of . . . There are different ways in which we prepare different specimens for different reasons. So I think it's important that we have a standard form.

We agree very much with the Provincial Auditor. We agree that this will be ongoing. It's not specific just to laboratory. Many of our ordering services . . . The more information that our pathologists, radiologists can get from the ordering physician, the easier it is for us to then prioritize how quickly does this need to be seen.

So the example I would give you is a lady with a stage III breast cancer is far more urgent than somebody where they're doing a scrape of some derm off of their skin in a family physician's office. That can wait. This needs to be prioritized and processed ahead of it. So that's where it's important for . . . That requisition is an important piece, as well as our processes.

So when the lab is receiving specimens, it's not just coming from the operating room. It's coming from the emergency room. It's coming from family physicians. It's coming from ambulatory care. So that intake process and that requisition, it's important that we have processes in place that allow our team to prioritize: this needs to go in the urgent today/tomorrow box; this can be in the Friday box — it's not as urgent. And when our pathologists are picking up the work that has been processed and ready to be read, it also needs to be in a prioritization so that they know these cases are more important than the other cases.

Hence why I think there are three or four of these recommendations that touch each other. Having the ability to track and monitor where are these specimens in the process because the process can take days, and in that time frame, the referring clinician may change the urgency or they may be asking, "I expected these results yesterday and I still haven't gotten them."

[10:30]

To find the specimen can take hours without a tracking system, which then takes people off the line and furthers that takt time. And the experience that we've seen in Saskatoon, to Deputy Minister Hendricks's point, with the implementation of the tracking in Saskatoon, has saved many, many hours a week of not just the pathologists, but the entire team that could be processing samples in the meantime. So we do have that system ready to be implemented in Regina. We just need to get it implemented with the IT support from both eHealth and our digital health. I hope that helps.

Ms. Ritchie: — Yeah, certainly. I mean it must kind of remove a little bit of the chaos, I suppose, that might ensue otherwise when, you know, you've got a number of factors at play, whether it's the type of biopsy analysis work and whether that's in-house or needs to be sent out of province, and you know, the urgency of a stage III versus something that's lesser criticality.

I'm just, as you're talking, I'm appreciating the vital nature of the work and the importance of having good systems in place and the value of the auditor's recommendations in achieving that end and your efforts at ensuring their implementation in a timely fashion in the best way possible given also the amalgamation and, you know, that also under way at the same time. So I think that bears mentioning, particularly as we've seen the added challenges of a pandemic and patients who aren't necessarily presenting to their physicians in a timely manner.

And I'm thinking of a friend of mine who went through a situation of, you know, a cancer diagnosis which was identified too late in the process, and ultimately she passed away at Christmastime. So these are real important matters and considerations to ensure we have good process.

So with that, I do want to kind of back up and go to a more sort of practical question around . . . I mean, first of all, great to hear that we've got such a fantastic genomics lab at the College of Medicine. I'm curious to know what sort of — and maybe I'm off script here but it is kind of a line of questioning — what sort of service model with . . . Like, I assume if they're with the college or the University of Saskatchewan, like, what that interaction is like and how that's achieved.

Mr. Miller: — The Advanced Diagnostic Research Lab at the College of Medicine is . . . The College of Medicine and the Saskatchewan Health Authority have a critical partnership. Many of our clinicians are also faculty members within the college. So specifically the advanced research lab is led by Dr. John DeCoteau, who's a hematopathologist. So a lot of the work . . . He designs tests. He designs genomics tests. And there's a network across Canada, because it's really complex work, that they share their tests that they design. So Dr. DeCoteau might have designed three or four breast cancer tests that his colleagues in Vancouver haven't done. He shares those with them so they can run those tests. So what they specifically look for in that lab is genetic mutations.

So when you hear more and more about customized drugs for people a lot, you'll hear more and more in the years to come, and so will our colleagues at the ministry, around companion testing. I'll use breast cancer as an example. We're working quite closely right now with the new gynecological surgeons to design some new gynecological tests where they will do genomics testing on your cancer tumour before they administer your chemotherapy, because they know that this genetic mutation of cancer will work with this kind of chemotherapy but not this kind. And when we're talking $50,000 doses of chemotherapy, the $2,000 or $3,000 genomic test, we would call that a companion test. You should be doing this test before you decide which chemotherapy to give. That's the type of work that's done at that lab. So yeah, that's the type of work that's done there for many different tumour types and diseases.

Ms. Ritchie: — Great. Thank you for that. That's exciting developments within the field for sure. You kind of touched on it in the early part of your answer, and I'm hoping that you can elaborate a little bit more though just in terms of, you know, what that service agreement is like between the college and the Health Authority.

Mr. Miller: — I can't speak specifically to the service agreement that we have with them. The members that work within that lab are all members of the department of lab medicine within the

Saskatchewan Health Authority. And they do partner also . . . We are in the process of expanding that genomics testing at Roy Romanow Provincial Lab with our partners at the Saskatchewan Cancer Agency, but it's preliminary right now. So all of those physicians are also members of our department.

Mr. Hendricks: — And as Corey mentioned, a number of them have joint appointments, and we fund them through the College of Medicine and through the clinical services fund. And we do provide clinical funding for the department of pathology as well. So be it through the SHA or the Ministry of Health, that is funded in Saskatoon.

Ms. Ritchie: — And then I'm curious to ask, for those that are out of province, how does that work, where specimens have to go out of province?

Mr. Miller: — So I mean we do have agreements with certain labs for certain tests. Not all labs, as I pointed out, have capacity or specialists in certain areas, so that we do have agreements with the Mayo Clinic, would be an example. BC Children's, we send some samples out there. I don't have the comprehensive list with me, but we do have arrangements where we do send specimens out of province and out of country.

Ms. Ritchie: — And in the cases where samples go out of province according to those agreements, can you explain how those priorities are set? How do we ensure that we're getting . . . where we're ending up in the queue, I suppose, you know, and the responses back?

Mr. Miller: — Yeah, I don't have the specifics on the process for how we end up in the queue. Certainly our clinicians recommend to our department that this sample, we would like to send it out of province to this specific lab for a second read or a second opinion. And then that is sent up through our lab leadership for approvals, and that is the process. After that, as far as where we go in the queue there, I would have to get that detail from our department.

Ms. Ritchie: — And so then as it relates back to the operating procedures, how is that accounted for in those cases where it might be indeterminate, the time frame with which samples come back and how that's tracked, monitored, ensured going forward?

Mr. Miller: — So to just address the process and the procedures for sending samples out of province, compared to the overall number of lab, pathology, surgical samples that we have in process, at any given time the takt number that we have in both Saskatoon and Regina is in around 750 a day.

So that's how many would be in motion any day. So that would be whether they're just still in the Rubbermaid tubs — they almost look like lunch kits that are coming from the O.R. [operating room] all the way to the pathologist's desk — at any given day we have about 750 in process. Our long waiters are very small, and these are ones that go out of province. But every sample is important so I do take your question seriously. Just because it's a number of one or three, that's still one or three patients. It's not . . . But they're relatively small numbers that we do send out of province for secondary reads.

And I would also point out that that is often done in consultation with the referring clinician so that that feedback and input can be given to the patients that know they are waiting. So the preliminary read . . . There can be a preliminary report that goes out to the surgeon. The surgeon is aware that the sample is being sent out. They can often act on it, but they still need to know what was that in order to ensure that they have definitive treatment plans, etc.

As far as the operating procedure of how we fit into the samples being set out, I don't think I have anything specific to share with you on that today.

Ms. Ritchie: — So okay. So you're saying that . . . I guess when we began this sort of line of questioning, I kind of was left with the impression that samples were being sent out of province on some frequency that's, you know, not insignificant, I'll say. And you know, I assume that might explain why we had samples taking as long as 222 days, based on the sample that the auditors had taken. And now it sounds . . . I think I'm hearing something a little bit different.

But I guess what I want to sort of ask next is, I mean, like is it the case that, you know, that with all that complexity and need in some cases to go out of province and the tracking process that's in place to ensure that things are moving forward in a timely manner and the right decisions are being made in terms of what's receiving priority in that list, I think the audit recommendations are trying to address sort of process improvements there to ensure timely service. But I'm wondering, you know, what other kinds of factors might be contributing to a longer turnaround time?

Mr. Miller: — Well I can't speak specifically to the case of the 222 days, but I do know that, you know, the recommendations that the provincial auditors have made since the original audit, we do get our monthly report turnarounds sent to our executive team. We would have a flag if we're seeing something getting out to be 50 days, 60 days, 70 days.

I'm looking at the November '21, and the longest wait-out was 42 days. So to put that into perspective, that sample probably was processed and reviewed already in the Saskatoon or Regina lab, and then the decision was made to send out. Then it's sent out of province or out of country, processed there. So it could be on day 7, 8, 10, 12 before it's even sent out of the province, and it's sent to the Mayo Clinic for their review. So that's why we would have a longer wait period like that. I think there's some . . . There's time to deliver, time to process, time to make the decision on sending it out of province. So I think those would be some of the delays that would add up into that 42 days.

[10:45]

And it's not an electronic interface when we send things out. They do send the blocks back to us because we do have a responsibility to keep as much of the samples as possible. And then the report would come with that, and then we would interface that report into our system, which would give us that. That would be the complete where it would no longer be in process.

Ms. Ritchie: — I do have several more questions, Mr. Chair. I'm not sure kind of where we're at in terms of timing.

The Chair: — No, the questions are important. It's a serious report. I'm just looking. That's wonderful. I want to make sure you're getting, you know, the questions in that are needed. I'm looking to other committee members just to break it up a bit. Is there anyone else that has a question right now? Or should we kind of . . . I'll just ask one just to give you a breather and a glass of water.

Just with respect to the Regina lab, it states that there's the assessment going on as to the factors that were causing some of the challenges around the timeliness of the reporting. And it said that the recommendation's been implemented, that the assessment there was some needed equipment and renovations, which is wonderful that that's been addressed. Were there any other factors that were identified there? Were resources a question? Were, you know, the access to the professionals there, the pathologists, or the staff that are required?

Mr. Miller: — So obviously any major operation like this, there's a number of factors and there's always opportunities for improvement. And that's why we're always grateful for outside eyes like the Provincial Auditor to come in at any of our services to help us identify opportunities for improvement.

It spoke specifically in our response to the renovation of the grossing room. And you know, like, you can't look past the entire process in pathology. And the grossing room is exactly what it sounds like. It's a gross room. That's where the specimens are cut into pieces and that's where the outside edges are taken off. And one of the factors that definitely contributes to wait times in the province is that around the grossing room and the people who work in the grossing room, which are called pathology assistants.

We've struggled with pathology assistants for a number of years in our province. And when we're short there, it often means that the pathologists have to go in and do the prep work. They can do it. They're trained to do it. It's part of their training. But it's not the best use of their time because other people can do it. We have worked to train other people within our labs, so some of our senior lab techs are trained to do grossing work. It's not fun work and not a lot of people like working in there.

The Saskatchewan Health Authority, over the last year, we've entered into an agreement with the University of Calgary. They do have a training program for pathology assistants and we have agreed to fund four pathology assistants to go to the University of Calgary for their practicum. And they will be doing their clinical practicums in both Saskatoon and Regina, so we have funded those students with return-for-work contracts. So we will pay for their training if they agree to come back for a return for service in both Saskatoon and Regina. And we're at that point now where those students are doing their practicum training in both Saskatoon and Regina, which will be of huge long-term benefit. So it's not adding to our pathology numbers but it's allowing them to have more time available to be reading slides instead of preparing slides. So I think that's a major factor.

I mean we always do have turn in our pathology numbers, like any part of our business. We have approximately 55 FTEs [full-time equivalent] for pathologists in Saskatchewan and we currently have 47 of those filled. I know we have one coming who's already signed a contract; he's coming in July. And I know we have a number that are being site-visited right now, but they are looking at more than one opportunity so I'm not going to shine extra light on it. We do have candidates that we are looking at, but I would say they are looking at us as well. So that's sort of where we're at from a recruitment perspective, but I think that that pathology, the work that we did in Regina to expand the grossing rooms as well as to renovate them, was much needed and will improve the efficiencies in the Regina lab, and have already. Thank you.

The Chair: — Well thanks for those responses and thanks for the work around recruitment, and as well the piece around the assistants, you know, the pathology assistants. I would want to say if any of them are ever looking at the record here, just thanks to everyone involved in that work — all of the pathology assistants and all of those pathologists — and the expertise that we're so privileged to have in this province. Certainly the report highlights, you know, the continued needed focus on these fronts. Thanks for your comments.

I know Deputy Chair Young has a question. We'll see if we burn through your questions. If not, you can do an audit and we'll come back to you with the questions.

Ms. C. Young: — Mine are in regards to recommendation no. 3 and recommendation no. 6, both of them which are at this point supposedly partially implemented, and the one on the standard operating procedures for the lab services in the five different labs, as well as on no. 6 with regards to the general surgical requisition form. Where are you at in rolling those out? And could you tell me why it would take till December to have everybody on board with making sure that those forms are done right?

Mr. Miller: — Thank you for the question. So the forms specifically, it's taking the 12 different health authorities and having our committee — so it's our provincial department — come together and decide on what is important and needs to be on the forms. Making it electronic, so it's both paper and electronic, so that it can be sent to us both ways because the samples come to us sometimes from the community and sometimes from within our buildings.

And then the standard operating procedures, the example that I'll use is, because I went there a little bit earlier, it's ensuring that all five of our hospitals that do lab have the same way in which we prioritize, so that in the future we can load level. And we do that often. If one lab is falling behind, we can move samples to another lab.

So the example that the Provincial Auditor's office pointed out was Regina having a big backlog. Let's say Moose Jaw doesn't. We could move simpler samples to Moose Jaw. When I say simpler, that's ensuring that those physicians can read them; they have the competencies and experience to read them. So the standardized operating process is to ensure that we are ranking and evaluating things the same in all five of our pathology labs so that they can be moved between. And what we say is, an urgent is an urgent in all five places, and it's not different in Moose Jaw from North Battleford, from P.A. [Prince Albert], Saskatoon, and Regina.

But I understand your question, and I take it, of why would it take so long to make that change. It's just a process that our team has to go through to implement change and to change processes that

are instilled into their work every day.

Ms. C. Young: — So they wouldn't necessarily take a best practice and ensure that everyone just follows that same best practice regardless of where it's coming or going to?

Mr. Miller: — I mean I think best practice is instilled into the work that they're working to standardize.

Ms. C. Young: — Okay.

The Chair: — I see Mr. Skoropad has a question.

Mr. Skoropad: — You know, actually it's a follow-up to that. That was kind of where my head was. First I want to say thank you for the work you do on this. I think I certainly speak for all folks here that either directly or indirectly, I think most people in Saskatchewan have been touched by this and the work that the labs do here. So the timeliness is so important.

Yeah. Regarding the consistent forms and best practice, I guess a couple questions. One, would some of that best practice be driven then from the labs, moving up, or from the physicians, down?

Mr. Miller: — I think a lot of the best practice comes . . . and again, it's embedded in some of what we've spoken about today around the accreditation processes that we have to have our labs go through. And you heard today the decision was made of the executive to actually follow both the Western Canadian accreditation as well as the American pathology. There's a lot of overlaps, but I just want to be clear the standard operating processes built into accreditation are rigorous, and when a lab says it has accreditation, it has a lot of standard operating procedures which are best practice. That's why they're embedded into the accreditation standard.

So you know, the fact that we have accredited labs and the lab has made the decision to follow both, some of that was because members of the department had strong feelings that we need to belong to the American college. There's some that felt like we needed to belong to a Canadian college, or the Western Canadian college. So we made the decision we would have our labs meet both accreditation requirements. So it's extra effort, but I want to be clear that there's a lot of overlap, and best practices are instilled into the accreditation standard operating practices that are required in accreditation.

So I hope that gives you some assurance in your question. We wouldn't be passing our lab accreditation if we weren't following best practices which are embedded into those standard operating practices that are a requirement for accreditation.

Mr. Skoropad: — I guess this is a bit of a follow-up. I was just taking it a little bit further. You spoke how, and really educated us, how all the pieces have to work together or certainly it creates delays in the process. So to that effect, I'm looking at the plan to educate physicians, surgeons to be able to fill out those forms in a consistent, accurate manner. And what kind of a, I guess, what are you looking at to get everyone up to speed?

Mr. Miller: — I mean, obviously when I spoke earlier about electronic forms, the value of an electronic process and an electronic form, it doesn't let you go by without marking is this elective, urgent, emergent. So an electronic form would allow us, you know, you can't just be sloppy and scribble something and expect that the person five steps down the chain can read your writing and understand and read into what is needed. The electronic form allows us to put rigour into it.

We can do that though also through manual process. It's going back to that person and saying, we can't process this until you fill it out right, and keep doing that and training them to do it correctly.

Mr. Skoropad: — Thank you.

The Chair: — Questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. I'm glad someone brought up the . . .

The Chair: — Oh, we'll come back to . . . That'll be a good question too. Keep going, Ms. Ritchie.

Ms. Ritchie: — I have a follow-up question to just this last line of questioning here, because I did find that a little bit interesting, the fact that, you know, you guys decided at the end of the day to sort of keep both accreditation systems. I can appreciate how that would come about. But I'm wondering though, in terms of what you were saying earlier about service loading and, you know, making those decisions, how does this impact on your ability to compare and prioritize if you're not necessarily dealing with an apples-to-apples comparison? Or is that not the case?

Mr. Miller: — I mean, I just need to be clear. Our processes are completely different everywhere. Like, we do have the ability to move samples and we move hundreds and hundreds, even probably thousands of samples between our labs every day in this province because we have the Roy Romanow Provincial Lab here in Regina, which is a state-of-the-art laboratory. And we're privileged to have such a tool for our patients.

And today we're talking about pathology specific, but we have chemistry. We have microbiology. We have all kinds of laboratory tests that happen, but today we're talking specifically about pathology. And you know, I want to be clear: it's not a hodgepodge of different processes happening in all of our different labs. They're very similar. But what we're saying in lab terms is to have things standardized is, you know, to the fourth decibel. Within lab, the people are very specific.

And you know, we do have work to do. That's why I think our team said it's partially implemented. There is work to do to standardize our operating practices between our different laboratories, and some of that is because our set-ups are different. Our equipment is different. We are in the infancy of standardizing what our labs will look like. We don't have all the same equipment. We don't have all the same set-ups, and we'll be working that direction together as a provincial team in our new structure.

[11:00]

Ms. Ritchie: — Okay. Yeah, I appreciate that little bit of colour and explanation. So when you're moving samples around from

lab to lab across the province, do you have a service provider? How is that done?

Mr. Miller: — Some aspects we do. We have contractors through procurement, but we do have different contracts in place that move our samples. So LifeLabs is an example. You see their labs around Regina and Saskatoon. They are one of our service providers that move samples from our community collection sites too. We do work with Robbie's team in procurement that have contracts with many courier companies that move samples from small towns to the larger labs or between the major labs.

And we certainly saw a great deal of that happen through COVID. We were moving, you know, thousands of samples every day from around the province to both the Roy Romanow Provincial Lab as well as the Royal University lab. So yeah, we have a number of different contractors who provide transportation of our samples.

Ms. Ritchie: — Is it possible to track those costs through the accounting process? I'm just wondering. If memory serves, my vague understanding was that some of those services previously might have been provided by the former STC [Saskatchewan Transportation Company].

Mr. Miller: — Some of the samples would have come through STC, no question, over the years. But I mean we obviously . . . The show needs to go on, so we've procured couriers who do that work. So yeah, I mean we pay those vendors for that service, so we could track and monitor the cost of transportation. It's a big part of our lab service, transportation of the supplies to where they need to be processed.

Ms. Ritchie: — Right. So I'm just wondering, is it possible to be provided with some of that information in terms of the costs? I know I'm a little bit off track here, but it opens up . . . I'm kind of curious to know, you know, the costs involved to perform that function over the years.

Mr. Hendricks: — At the time the decision was made around STC, we did actually receive some questions at committee about some of the transportation costs. And if my recollection is correct, I think it was mostly actually CBS [Canadian Blood Services] on blood products that was using STC. But we can dig up that information and provide it to the committee. I don't have it handy and, like honestly, that's too long ago.

Ms. Ritchie: — Okay. Thank you. I just wanted to ask.

The Chair: — Thanks for that. Just like any other undertaking, the information, you can provide it back to our committee Clerk and they'll share it out.

Ms. Ritchie: — Okay, so I'd like to go back to some of these more pertinent audit findings here. I've just got one last little line of questioning to go through, Mr. Chair. So what is the current backlog in assessments?

Mr. Miller: — I don't have the current backlog number on me today.

Mr. Wyatt: — Yeah, we don't have the current backlog number but we can speak to the average time, which would be comparable to what the auditor had reported, if you're interested in that information.

Ms. Ritchie: — Yeah, that would be helpful. Is that something you could provide in the course of this discussion right now?

Mr. Wyatt: — I mean, so Corey had mentioned earlier that, you know, the most recent data he was looking at was from November of 2021. And so at that point, the average time for cases that were signed out of the Saskatoon lab was seven days, nine hours. And comparing that to, I think the auditor's finding was in the 12-day range. Regina was five days, 16 hours, which is significantly reduced from the 18 days, seven hours' time frame. So the changes, you know, that Corey has described, particularly in Regina, which was seeing much higher wait times for processing samples, has really decreased significantly to that point in November of '21.

Ms. Ritchie: — Okay. And so on page 142, there's a number of good practices suggested for diagnostic timelines. Are these consistent with what's in place to date?

Mr. Miller: — Urgency. So urgent biopsies within 24 hours, small biopsies within three hours. Yeah, I'd have to get a report back on how our current wait times are in these urgency classifications for those specific disease types.

Ms. Ritchie: — And then I guess I would have a question for the auditor. Is it in the opinion of the auditor that the variance in practice between Regina and Saskatoon is leading to inequitable patient outcomes and standards?

Ms. Clemett: — So I guess in terms of what we did recommend was the right . . . developing some sort of consistent approach. From our perspective, when we did the audit we felt like five business days was almost what — and we would have been consulting an expert during the course of our work as well — was almost what a routine biopsy should take in terms of completion and diagnosis. And so a more complex case could take, as Corey indicated, up to sort of 15 business days. So hearing that to some degree, Regina and Saskatoon are closer whereby they're, you know, at seven and five now, is good to hear.

We will be following up on the recommendations we have made. I believe we anticipate doing that work this coming fall or for sure by the spring. So we will be circling back to these recommendations and then obviously providing a report back to the committee in terms of the status of these recommendations and whether we do agree and concur that they have been implemented to date.

Ms. Ritchie: — Thank you for that. Then on page 145 there is a mention of a cost-benefit tracking system. Sorry, I'm just going from my notes. Is this something that can be provided? Am I understanding that correctly?

Mr. Miller: — I think we spoke of the tracking system a little bit earlier where we have implemented one in Saskatoon. And we have procured one for Regina through another procurement process. It just hasn't been implemented yet. And a little bit just on the backlog of IT implementations, some of that due to COVID. But we do have that system procured, and certainly that specimen-tracking system will be of benefit for the overall

turnaround as we spoke about a little bit earlier.

Ms. Ritchie: — Okay, and I'm just wondering, is there examples . . . and maybe this is a question back to the auditor, if there were examples in other jurisdictions that were considered, just to get an idea of what the expectations were in terms of what it would look like?

Ms. Clemett: — So if you're talking about the electronic tracking system, we never like to tell an agency that, like, you must purchase. So hence why we said, you analyze, make sure on that cost-benefit side that this would make sense.

We were aware at the time of the audit that Saskatoon had received some funding at that time and was probably going to be pursuing that alternative, which was a good thing because, as you indicated, during the course of our work with the independent consultant that was utilized, having a tracking system, the bar codes, the samples so that you very much know where that sample is during the stage of the, you know, I guess during the analysis, is a good thing. It doesn't get misplaced. It doesn't have to be found. It doesn't take hours to round it up.

So happy to hear, I guess, at the end of the day that Regina and Saskatoon have now implemented such a system. And I think it allows you to do a better analysis to figure out those different stages of the process of almost the biopsy, to figure out is there any delays or gaps as such that we need to address.

Mr. Miller: — Yeah, I do think it's important to understand that our laboratory information system itself is a bit of a tracking system as well. The tracking system that the Provincial Auditor talked about is even a more detailed tracking system, where it will track where it is in the process. But the provincial laboratory systems that we have are great. So the example I could give you is, surgery could call us to say, where is my sample. And we can tell them, we've never received it; you didn't bring it to us because it hasn't been received in the labs. So when a specimen, whether it's pathology or anything, is received in the lab, it is entered into the lab information system so we know it's in the system.

We are still struggling, similar to what Robbie spoke of earlier, with many, many different systems and at different levels. So we do spend an enormous amount of time entering data into our systems. So a system might be collected in Nipawin, entered into the Nipawin lab system. When it's received at RRPL [Roy Romanow Provincial Laboratory], it has to be entered into their lab system.

And we do have a project under way with our partners at eHealth to standardize us to one provincial lab system. We do have many FTEs every day that are re-entering data that has already been entered. And that's just part of our transition to a single entity, and we'll get there. We do have a project plan and I'm confident that that will make our laboratories far more efficient in the province of Saskatchewan.

Ms. Ritchie: — Okay, good to hear on that front. I mean obviously anything that can optimize the work of front-line workers, ensuring that they can do their work more effectively, efficiently, you know, we all benefit from that. And I guess I'm kind of imagining, you know, like a UPS [United Parcel Service of America Inc.] where you can jump in and track your package with a bar code number and that sort of thing. So yes, certainly that kind of technology exists.

So you mentioned that Saskatoon has such a system already, but Regina was in the process. And so just some questions there around, you know, has that budgetary allocation been approved, and where is it in the process?

Mr. Miller: — It has. It was part of a procurement process that we had for immunohistology, so the funding was in place, the purchase has been made. We're now waiting for the system to be implemented. And whenever you implement a system like that, there's multiple integrations, and that needs to happen. And there's an IT project waiting for that to happen. There's been tremendous benefit of efficiencies in Saskatoon, and we are grateful for the support that we received from the City Hospital Foundation for that donation that they made to prioritize that for us.

Ms. Ritchie: — So when you say there's been an IT project identified for that implementation, has it been . . . is it also sort of in the queue, or does it have to wait for a new budgetary or . . .

Mr. Miller: — No, it's in the queue.

Ms. Ritchie: — Okay.

Mr. Miller: — Yeah, it's in the queue. We're just waiting for those resources to be available. When I say resources, it's just the IT infrastructure ready to help us with that implementation.

The Chair: — Thanks for that clarity and that response as well. Just that I know Mr. Goudy had a question I want to move over to.

Mr. Goudy: — Sorry. First of all, the way that you answer, we're loving it. Honestly, the way you can almost see what goes on in the background, I appreciate that.

Just seemed like the bottleneck you mentioned in the grossing room there, is that sort of one of the main bottlenecks in the whole process?

Mr. Miller: — I mean it has been one of our bottlenecks, because we've had to redeploy pathologists to be working in the lab in the grossing area. We've used both technologists and lab assistants in that. Pathologists don't particularly like working in the grossing room either. So it's not necessarily something that they long to do. And when we're short there, we can't have four pathologists waiting for samples and nobody processing them. So you know, they do step up and go in there as needed, but it isn't something their career longs to do.

Mr. Goudy: — It seems like Alberta's the training place for the . . . So how many, like you said we have five seats?

Mr. Miller: — Four seats.

Mr. Goudy: — And how long is that program?

[11:15]

Mr. Miller: — It's a two-year program. They will be . . . So it's a post-graduate program, so it's a master's degree program. So those candidates, we had them come to our sites because we didn't want to train them and then they leave. It's one thing we were giving them a return of service but they have to like where they're going to work at. So we had them both to Saskatoon and Regina for site visits, no different than recruiting a physician, to make sure they and their family wanted to stay in the city, they liked the facilities they were going to be working in. And we're confident that the candidates that we have accepted into the program will want to and will stay in both Saskatoon and Regina.

Mr. Goudy: — I just wanted to say, for MLAs [Member of the Legislative Assembly], it's just so nice to be able to confidently say to people when they phone, you know, we're waiting for my grandma or my father is in the hospital, to honestly be able to sit in here and be able to say, we do know where there are some bottlenecks, we do know what . . . To be able to say that the kind of work you're doing to make things more efficiently and cutting costs and all that you're doing, we just really appreciate that. And it's a privilege for us to sit in this room and hear.

Mr. Miller: — I want to thank you for saying that. I think one comment that I would share with all of you, no different, my phone rings too because people know you're the health care guy. You know, one tremendous benefit of COVID has been we have over 400,000 people who have signed up for MySaskHealthRecord. And your lab results, your pathology results are on there.

And we talked today about the system's waits. Sometimes the waits are not the system; it's our partners. So you know, no news is not good news. I would say that to any patient. No news is not good news. If you haven't heard, phone, because the results might be sitting there for 25 days before you're given those results. Your physician is a business, right? And that business might not be calling you because there might a stack of papers on their desk that high that they have to phone all of those patients.

So now with this MySaskHealthRecord, it has empowered patients to look at their results and get timely information on their health care. And that's been a benefit of COVID. So that's a powerful thing putting information to the patients.

The Chair: — Very good questions, and again just thank you so much for all the work on this front, and to all those involved in that work in the labs and the commitment to the further improvements. With respect to chapter 23, I'd look for a motion that we concur and note compliance with recommendations 1, 2, 5, and 7. Moved by Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. Moving along to recommendations 3, 4, and 6, I would look for a recommendation to concur and note progress. Mr. Skoropad has moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried as well. We will now turn our attention to another really important chapter, and that's chapter 24 of the 2018 report volume 2. And I'll kick it over to the Provincial Auditor.

Ms. Lowe: — Chapter 24 of our 2018 report volume 2, on pages 151 to 167, reports the results of our audit of the processes that the Saskatchewan Health Authority used to prevent and control hospital-acquired infections in the Regina General Hospital and Pasqua Hospital. This chapter includes four new recommendations.

A hospital-acquired infection is an infection that a patient acquires while in a hospital that was not present or incubating on admission. Such infections can extend a patient's hospital stay and may lead to increased complications and costs for treatment. In the most serious cases, hospital-acquired infections can cause or contribute to the death of a patient.

We concluded that for the 12-month period ended August 31st, 2018, the Saskatchewan Health Authority had, other than the areas highlighted in our four recommendations, effective processes to prevent and control hospital-acquired infections in the Regina General Hospital and Pasqua Hospital.

In our first recommendation on page 158, we recommend the Saskatchewan Health Authority give hospital staff responsible for patient care formal training updates on infection prevention and control practices at least annually. The authority gives new staff that provide patient care in the Regina General and Pasqua hospitals infection prevention and control orientation training. However, contrary to good practices, it does not provide them with formal, periodic refresher training on infection prevention and control practices.

Infection Prevention and Control Canada recommends providing staff with education on infection prevention and control at least annually. We found new staff at the Regina General and Pasqua hospitals receive about a one-hour orientation shortly after they start work that sufficiently covers key aspects of infection prevention and control. However, the authority does not require staff at the Regina General and Pasqua hospitals to receive refresher training on infection prevention and control.

During the audit, we observed 15 units in the two hospitals and found staff did not always follow good practice for general cleaning, such as clean linen carts were not always covered or were in close proximity to garbage cans and soiled linen. Our observations suggest additional reminders to staff to follow good practices for infection prevention and control may be warranted.

Periodic refresher training helps keep staff up-to-date and provides an opportunity to reinforce the importance of key activities to prevent and control hospital-acquired infections. Not having periodic refresher training can lead to inappropriate practices that may increase the risk of infection transmission and compromise the wellness and health of patients and staff.

In our second recommendation, on page 161, we recommend the Saskatchewan Health Authority use external observers to conduct regular blind direct-observation hand-hygiene compliance audits in its hospitals. While the authority routinely monitors staff compliance with established infection prevention and control practices, it needs to do more. Management in environmental services or housekeeping completed regular

audits to determine whether staff followed established cleaning standards. We observed that the environmental services unit keeps track of its daily audits and immediately addresses identified deficiencies in cleaning.

Hand hygiene is one of the main ways to prevent and control the spread of infections. Audits determine whether staff use appropriate hand-hygiene practices. In blind audits, staff observe a unit staff's compliance with the hand-hygiene policy when they are unaware of being observed. In direct-observation audits, staff openly observe other staff's compliance with the hand-hygiene policy.

Consistent with good practice, the Ministry of Health guidelines for hand hygiene indicate staff external to a unit or facility should observe compliance with hand hygiene to decrease the potential for bias. However, we found the Regina hospitals do not complete blind audits of hand hygiene on a regular basis or use staff external to the unit for direct-observation audits.

The department did one series of blind audits during our audit period and found significantly lower compliance rates than those of their direct-observation audits. Some units had a 60 to 70 per cent difference, suggesting that actual compliance rates for hand hygiene may be significantly lower than the reported during the monthly direct-observation audits.

Not routinely conducting blind audits of hand hygiene or using staff external to units to observe compliance with hand-hygiene practices increases the risk that compliance rates may not be representative of day-to-day hand-hygiene practices. Not having accurate compliance rates may increase the risk of the authority not taking sufficient or timely action to improve hand-hygiene practices of staff. This in turn places patients and staff at greater risk of hospital-acquired infections.

In our third recommendation, on page 163, we recommend the Saskatchewan Health Authority actively monitor actions taken by Regina hospitals' patient care units with lower-than-acceptable hand-hygiene compliance rates. The authority does not actively oversee the implementation of hand-hygiene corrective action plans for units with low compliance rates to ensure staff improve hand-hygiene practices. Not all patient care unit managers are doing enough to improve hand-hygiene practices.

Management expects unit managers to post monthly hand-hygiene compliance rates on the unit's visibility wall to remind staff of the importance of hand hygiene. During daily wall walks, managers are to remind staff about hand hygiene and reinforce compliance. Also, when compliance rates are low, unit managers are to develop and post corrective action plans on their unit walls.

For 4 of the 15 patient care units we observed, the hand-hygiene compliance rates were not posted on the visibility wall. The average compliant rates for those units between April and June 2018 ranged from 43 per cent to 87 per cent. For four of the eight patient care units we observed with compliance rates below 90 per cent in August 2018, none of them had developed corrective action plans.

We found that the authority was not actively holding patient care units accountable for the results of hand-hygiene audits. We noted that the infection prevention and control department did not have authority to ask units whose compliance rates remained below target over a longer period to make improvements. We further noted hospital management was not actively overseeing whether their units developed or implemented corrective plans or improved hand-hygiene practices as expected.

Without posting hand-hygiene audit results and corrective action plans, unit managers may not actively reinforce the importance of good hand-hygiene practices or take sufficient steps to improve hand-hygiene activities of staff in their unit. Not actively holding patient care units with unacceptable hand-hygiene compliance rates accountable increases the risk of not taking timely corrective actions, and places patients and staff at increased risk of hospital-acquired infections.

In our fourth recommendation on page 166, we recommend the Saskatchewan Health Authority regularly give senior management a written analysis of emerging risks and causes based on trends of hospital-acquired infections.

We found active monitoring of infection rates were reduced during reorganization of the authority's infection prevention and control departments. Analysis of trends in the Regina hospitals in emerging risks and causes of hospital-acquired infections is limited. While the infection prevention and control department continues to compare infection rates to its internal historical data to identify trends, since February 2018 neither it nor the authority formally analyzed trends or determined root causes for changes and reported on them.

In addition, reports on hospital-acquired infections did not identify the types of patients infected, potential causes of trends, or outline actions to reduce infection rates. Also they did not link locations of incidents of hospital-acquired infections to the hand-hygiene compliance rates of those units. Without routine analysis of infection trends and linkage to results of audits of infection prevention and control practices, the authority may not sufficiently protect staff and patients from infections acquired in its facilities. The authority also may miss identifying opportunities for improvement at the hospitals, and units therein with higher-than-normal rates of hospital-acquired infections.

I will now pause for the committee's consideration.

The Chair: — Thanks for the presentation and the real important focus on this work. We know how important this is to people. I'll turn it over to the deputy minister to respond, then open it up for questions.

Mr. Hendricks: — Okay. With the auditor's first recommendation, on page 158, that the ". . . Authority give hospital staff, responsible for patient care, formal training updates on infection prevention and control practices at least annually," the SHA considers this partially implemented.

The development of a provincially standardized infection and prevention control training and education for onboarding and orientation has now been completed. An annual infection prevention and control education module is now online and available for all SHA staff.

Once the administrative information management system,

AIMS, is implemented, steps will be initiated to make this training mandatory for all staff, with managers tracking completion.

The second recommendation, on page 161, that the ". . . Authority use external observers to conduct regular blind direct observation of hand-hygiene compliance audits in its hospitals." The SHA also considers this recommendation partially completed.

The SHA approved a hand-hygiene policy in 2020 and implemented a standard hand-hygiene auditing program in the former Regina Qu'Appelle Health Region that includes blind audits. Beginning January 2022, employees in Regina will trial a new hand-hygiene audit platform that, if successful, is intended to be implemented across the SHA. This new platform will utilize direct observation by auditors with all efforts made to conduct direct observations as blind as possible.

Recommendation no. 3, on page 163, that the ". . . Authority actively monitor actions taken by Regina hospitals' patient care units with lower-than-acceptable hand-hygiene compliance rates." Again the SHA considers this recommendation partially implemented. Leaders in the former Regina Qu'Appelle Health Region were reminded to continue hand-hygiene auditing, reporting, and improvement initiatives. The hand-hygiene policy was approved as described above and includes accountabilities and reporting. Hand hygiene continues to be strongly emphasized during the COVID-19 response.

[11:30]

The accountability and reporting structure within the policy includes measures and mechanisms for continuous improvement. And as part of the trial of the new hand-hygiene platform, compliance with the provincial hand-hygiene policy will be monitored and managed accordingly.

And the last recommendation, on page 166, that the ". . . Authority regularly give senior management a written analysis of emerging risks and causes based on trends of hospital-acquired infections," the SHA considers this implemented. The infection, prevention, and control epidemiologist is providing quarterly updates on trends and the risks associated with transmissions to the director of infection prevention and control, as well as the regional medical microbiologist. The report highlights emerging risks and causes based on data trends, areas of concern that have been shared with the executive directors for the clinical and support services in Regina, as well as those related to provincial oversight, and these are addressed as appropriate.

This concludes our response.

The Chair: — Thanks for the response, and I'll open it up to committee members for questions. Certainly this is important stuff. Looking to committee members. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. Thank you to the audit department and Deputy Minister Hendricks for that update on status of the recommendations. I find this a fascinating area. You know, we're clearly way, way, way outside my area of expertise, so that's partly why I have a fascination. It's something I'm completely unfamiliar with, but obviously it's something that, you know, we can have an appreciation of as any member of society who's had a loved one who's undergone a surgery and experienced complications resulting from an infection post surgery. And so the importance of this isn't lost on me either, and eager to sort of delve into the subject matter.

And yeah, so I've just got sort of a high-level question to just maybe start out with, in terms of . . . It would appear to me that, you know, this is a bit of a cultural issue, when you have something that I would assume would be, you know, just like basic standard operating practice within a hospital setting. And it's sort of almost like job number one. It's like safety.

You know, you're making sure that you are taking all those necessary precautions within a hospital setting to control infection and provide an environment that's free from infection as best you can, all things considered of course. And that would be necessarily on the radar of all employees that work within a hospital setting, regardless if they're performing surgeries or patient care post-op or the environmental services — I believe that's what they're called; something like that, right? — and the vital work that they do in terms of, you know, the cleaning and ensuring that we're preventing infection. So none of that's lost on me for sure, and I appreciate how critically important it is.

So given all of that and the need for a strong adherence and compliance to systems and processes that will ensure an environment free from as much infection as possible, can you speak to . . . I don't know; it's a hard question to answer. You know, I want to say that from the get-go. But there is a cultural component to this, so could you please explain to me how that is addressed as part of the work, broadly speaking, and that as part of the infection and control detection group?

The Chair: — Thank you so much for joining us at the table. Just before you speak, if you could just introduce yourself.

Ms. Vachon: — Sorry, yes. I'm Beth Vachon, VP for quality, safety and strategy with the SHA. So you're right. That's a really big question around the cultural issues of this. And it seems really simple that we just always wash our hands, but that's, you know, we know that when we do audits that we don't always . . . either it's not observed, it doesn't happen in the way that we know is the safest way to do it.

So when we talk about the cultural issue, I do have to say that going through a pandemic I think has really shone a spotlight on the need for good infection prevention and control and different sort of measures. So not only, you know, donning and doffing properly our PPE [personal protective equipment], but handwashing being a really significant part of what we do to keep people safe. So I actually see that there is more attention now to hand hygiene, infection control, more so than probably at any other time in the past number of years.

So that might be part of the culture change that we need to move forward. You can go into any room in a health care facility and there's reminders to wash your hands. When we design new buildings we're making sure that hand-wash stations are in the proper places, that we've got enough of them. So you know, as time has gone on I think that there's a number of things that will help to shift the culture when we talk about things like, you know, good hand hygiene. Making it easy for people to do the right

thing too is also, I think, a big part of that.

Ms. Ritchie: — Thank you for that. Yeah, I mean obviously I can see that, you know, the pandemic really would have put a spotlight on it. However, you know, there was SARS [severe acute respiratory syndrome] prior to COVID, and maybe there's a bit of time in there between that, you know, things kind of change a little bit. So it's not that there haven't been these previous opportunities for lessons to be learned and improvements to be made, so all to the good of course now.

And maybe as you're talking about how there is more attention, can you speak to sort of current outcomes, results in terms of, you know, where you're seeing those improvements and the way that you're tracking them?

I've always got a little bit of a follow-up. My apologies. I think it is going right to the fourth, I think the last recommendation because you do talk there about . . . Oh okay. So yes. So you haven't done . . . You're still in the process of implementing that final recommendation on sort of the tracking and monitoring emergent risks. Correct? So maybe you could just tell us a little bit about the status of that.

Ms. Vachon: — The recommendation on page 166?

Ms. Ritchie: — I believe so, yes. Yeah, I appreciate that it's in implementation. Okay, so twofold question. First of all, since the time of the audit, what improvements, in terms of measured outcomes, are you seeing? And where are you at in the implementation of that recommendation?

Ms. Vachon: — So one of the things that we've standardized is how we're testing people for things like VRE [vancomycin resistant enterococci], MRSA [methicillin resistant Staphylococcus aureus], some of the antibiotic-resistant infections that we see, which we know cause significant harm to some people.

So we've started doing some testing in Saskatoon and Regina where we're only testing people when they come in in high-risk situations. Because what we know is that people who are, you know, cancer patients or in ICU [intensive care unit], those are our most vulnerable. And those are the people that are often impacted most significantly by things like antimicrobial, you know, resistant micro-organisms.

And so how we've started to do that is, when we look at units like oncology for example, ICU, we do see, like a significant number. But we're testing and doing that screening on admission, so that people may be coming in with it, and we know that they're . . . So that we can take the proper precautions to be able to isolate, do all of the right gowning, doffing, infection control practices.

So when we look at this, sometimes the numbers might look significantly high on a particular unit. It's because we're actually testing and screening for that, where we wouldn't do that on a general medical ward or, you know, other units where we don't have the same level of risk and vulnerability of the patients.

Ms. Ritchie: — Okay. And so how does the hospital adjust though for some of the things that are identified in this audit in terms of hand hygiene and observations and those sorts of things?

Ms. Vachon: — So Max had noted that we are starting a new . . . we're testing a program right now. And I think part of our challenge has always been coming together, bringing 12 health regions into one authority, is again how people have been collecting data, how that gets translated is part of that.

So in Regina, starting in January we're doing a three-month trial on a hand-hygiene audit program. If it meets the needs that we have, then we will implement that throughout the whole province. The key to that is that we can start to compare, you know, numbers between different facilities. We can determine things like what's that epidemiology? What's causing it? How do we start to link hospital-based infections with hand-hygiene practices?

So part of the challenge when you're doing everything manually is being able to track, trend, link, and then use that as an education tool as well to help change that culture of good infection control.

Ms. Ritchie: — In terms of the resources within the infection prevention control, is that like a division that operates right across, kind of system wide, and are those dedicated positions? If so, how many of them and how has that changed over the past few years?

Ms. Vachon: — I think we saw some pretty significant inconsistencies in how, you know, infection practitioner staff were hired throughout different organizations within the health sector prior to. So we do have in Regina — I'll speak to Regina because that's what the audit is requesting information on — currently we have nine and a half FTE infection control practitioners in the former Regina Qu'Appelle.

Along with this we also have, at a provincial level, a manager, an admin support, and then two positions that provide that provincial-level support. That's an epidemiologist and a provincial infection control coordinator who again ensures things like standardizations, consistent practice, education. So delivered locally at the local level, but provincial support to ensure again that consistency and standardization.

[11:45]

Ms. Ritchie: — And so I notice that it said online modules were being developed. And so I'm just wondering about when you talk about a manager that is responsible for the oversight of these front-line health care workers and overseeing infection control, you know, how that's actually delivered? Because I mean, obviously you can do an online module, but I'm wondering what sort of the managerial human component is to that to ensure, you know, that the learning is occurring, that the behaviours are being adopted, you're seeing the outcomes that you want in terms of, you know, conformance and performance and eventual outcomes. How is that going to be achieved?

Ms. Vachon: — So, many of the education programs that we have that are online — and we have moved to that, you know, for the most part over the last two years — they all have a component, a test component. So you do the module, you go in, you do the test. If you get even one thing wrong, it takes you

back. And you know, you re-review and then you go back and complete the test again. So that's one way.

The other thing that we've been doing, you know, significant resources have gone into other ways of interacting with people and really stressing the importance, doing the education. And I'll say, in the beginning, it was that real focus again back on PPE, proper use of personal protective equipment; so ensuring that people knew how to safely, you know, don the PPE, safely take it off. And you know, one of the probably the most effective ways to do that is staff members watch their colleague put it on, take it off safely. And they just kind of watch each other's backs to make sure that that's happening. So that's one really effective way. It's peers, you know, peers helping peers.

The other thing that we've done are things like town halls where we open up a Webex to all staff. Anybody can participate; they have the opportunity to ask questions. If we need to get back to them, you know, there's personal interaction that goes back.

We have newsletters. So we have daily rounds within the SHA, and every single day everybody in their inbox gets whatever new resource material. It provides the link, so if there's something you have an interest in or a need to know, you click on the link and it takes you directly to the resource material. So that's been really effective. And then we also have leader resources, which is for out-of-scope staff. So it provides, you know, coaching tips, tools, all of those kinds of things.

And then the other thing that is published on a regular basis are things like safety bulletins, safety talks, huddle talks. So we have cascading huddles that have been implemented within the SHA, literally from the front-line huddle reports up to the CEO. And then we're able to escalate anything that hasn't been able to be solved at the appropriate level within the organization, so a way to remove barriers. That happens every single day within the SHA. Safety is a big component of that, so if there are issues we do have that ability daily to be able to really focus and remove the barriers. You know, that's a leader's responsibility to be able to do that and then go from there.

So those are a few examples of some of the ways that we're trying to address safety culture, create information, and the ability for our staff to be able to be safe on the job and ensure that our patients are safe.

Ms. Ritchie: — I guess I'm wondering about sort of how that is playing out in terms of, like are you seeing that there is certain areas or departments where you're experiencing lower levels of conformance with hygiene practices, the handwashing and that versus other departments, for example custodial staff versus nurses, and if you could just sort of maybe explain how that might be addressed.

Ms. Vachon: — I can't give you for the entire SHA what that would look like. What I will say though is that hand-hygiene audits, for example, are collected manually at the unit level or the department level, which is why we're looking at a more of an automated program to be able to track and report on those things exactly. I would say at this point we don't have the ability to look at the entire SHA with that information because it all has to be compiled manually.

But that really is the goal of implementing this new system, is to be able to report effectively trends, comparisons, all of those things. So the trial for that program completes the end of March, and then we'll make the decision that it's either meeting our needs or not. And from there I think we'll be able to provide better information.

Ms. Ritchie: — And I'm glad you're doing that. I mean are there, like, feedback mechanisms from front-line employees in terms of, you know, like, well a reason why there is this non-conformance is because of this reason or . . . You know, how do you account for some of the practical challenges, constraints? And if so, you know, maybe some examples of what those look like as part of the process.

Mr. Hendricks: — So you're saying, like, do we solicit formal feedback from providers about . . .

Ms. Ritchie: — Formal feedback from front-line employees.

Mr. Hendricks: — On the audit process or on just, generally on . . .

Ms. Ritchie: — On conformance. Like, are you getting feedback in terms of what might be getting practically in the way of the hygiene process and that?

Mr. Hendricks: — Oh.

Ms. Vachon: — So one of the ways that we would seek feedback is that when an audit is completed and those numbers are taken to the huddle or put on the wall, you know, when they do their wall walks, that would certainly be an opportunity for feedback on what does staff think is root causes or something they need to dig in further, is there, you know, other information. And so, you know, audit is a really effective way to be able to show the numbers and to start those conversations.

So that is one of the ways that we would do that, is to have those discussions at the safety huddles in the morning to talk about, you know, how do we improve these rates. Often you know, you'll see the run charts so that people can start to compare month to month, if things are improving, getting worse, what's working, what's not, and then . . . So when you say formal feedback, I'm not sure if that is what you meant, but that would be the types of ways that we would seek that feedback from staff.

Ms. Ritchie: — Just one final question. I know we're wrapping up here before lunch, and thank you for your responses thus far. And if I misspoke, I apologize. It wasn't necessarily formal but just, you know, what processes and how are you interacting to get the feedback. And you know, that's great what you're talking about in terms of, you know, the daily walks and so on and so forth.

The follow-up question to that is, what are you hearing from those discussions? What might be the things, from what you've heard, that might be getting in the way of conformance?

Ms. Vachon: — I think there's lots of different levels and many different things that . . .

Ms. Ritchie: — From the employee level?

Ms. Vachon: — Yes.

Ms. Ritchie: — Okay.

Ms. Vachon: — So it might be . . . You know, again, we've got audits for things like the environmental services and how they're doing their cleanings and, you know, checking that and doing some coaching perhaps in that area. Same with our, you know, our staff. Like I just don't think there's anybody who can say, nobody told me I had to wash my hands. I mean that's something we learn right from the time we're small.

I think what does happen sometimes though is that staff get busy. They get, you know, distracted. So when I say it's really important to make it easy for people to do the right thing, I think that's a big part of it. So again, our staff know they need to wash their hands. Are they doing it properly? Because it's not just, you know, this. It's definitely . . . There are certain things that you need to do to wash your hands properly to prevent infection. So have they been taught to wash their hands properly? You know, what are those reminders?

Ms. Ritchie: — Yes. And you know, I guess one can imagine that when one is busy, you know, shortcuts and things kind of get cut or not done as well as they should be. And so I guess I do kind of . . . You know, the broader question in my head is, like okay, is this a symptom of something else? Is this pointing to, you know, things like staffing levels being too inadequate, you know, workloads being too high, things of that nature? I mean seriously . . .

The Chair: — And this is, you know, it's an appropriate question to be asking, and I hate to maybe interject. I hope that sort of root-cause analysis is going on. I suspect it is. We certainly know the health system is short on resources, but it's critical that things like hand washing are happening. And I commend officials and folks that are working to make that happen and all those front-line folks and workers and professionals that are making that commitment and making sure their colleagues are doing the same. So thanks for the systems. Thanks for the work on this front.

I'm mindful just of time and I'm happy to take a question that hasn't been satisfied or asked. I'm not seeing any here right now. Good questions. Thanks for the responses and work on this front.

At this time then I would seek a motion that concurs and notes compliance with recommendation no. 4. Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. I would seek a motion to concur and note progress with respect to recommendations 1, 2, and 3. And Mr. Nerlien moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried as well.

So just as an update to anyone watching us at home and officials tracking along and all of us around the table, we will obviously be bumping the other chapters into the afternoon. We'll just keep the order that we've got here, so when we come back we'll deal with the 2019 report volume 1, chapter 12. And for anyone thinking that looks like a lot of chapters we're going to be covering this afternoon, that is true, but off the top are the chapters that are primarily new recommendations which certainly require greater scrutiny and engagement from this committee. So I think we're going to be able to get through our program by midnight tonight. I'm certain of it.

And I'd like to say thanks to Chris Bayda, our assistant provincial comptroller, for joining us here this morning as well.

This committee stands adjourned until 1 p.m. Let me correct that for Hansard. This committee is recessed till 1 p.m.

[The committee recessed from 11:58 until 13:00.]

The Chair: — Okay, folks, we'll reconvene the Standing Committee on Public Accounts. We'll turn our attention . . . We had a brief break. I don't know if there's others, well I know there's others. I'm sure everyone in this room sort of looked at the world around us as we step away from this table. And you know, I just thank everybody that's here and all these folks that are at this table for your attention and your diligence.

But you know, it's hard to even get your mind around when you look at what's going on in Ukraine right now. Civilian assets and civilians and atrocities with human rights that, you know, I think that most of us thought we'd never see again. But anyways, I know it's hard. Yeah, I guess as the Chair I'm struggling to make sure you've got my full attention. And you have it. But it would be wrong of us as well, I think, not to recognize that each one of us, you know, our minds are in part, I think, tracking the horrors and atrocity that's playing out right now.

Anyways, thanks for everybody's time and attention here today. And I'll turn it over to our Provincial Auditor to focus in on chapter 12.

Ms. Lowe: — Chapter 12 of our 2019 report volume 1 on pages 187 to 205 reports the results of our audit of the Saskatchewan Health Authority's processes to maintain health care facilities in the city of Saskatoon and surrounding area. This chapter includes 10 new recommendations.

Over 50 health care facilities located in the city of Saskatoon and immediate surrounding areas serve over 360,000 Saskatchewan residents in more than 100 communities, which includes cities, towns, rural municipalities, and First Nations communities. Facilities located in the city of Saskatoon and surrounding area include 9 hospitals, 28 long-term care facilities, and 19 health centres and other health care facilities. Facilities include buildings and significant components, for example, boilers and air filters.

The health care facilities located in Saskatoon and surrounding areas accounted for about $1.5 billion of the authority's estimated deferred maintenance with an average facility condition index of 26 per cent, which is a poor condition. Maintaining facilities to acceptable conditions helps ensure they meet service delivery requirements. Deferring maintenance can reduce capacity to provide services, increase future repair costs, and potentially reduce overall service life of facilities, for

example, having to replace a building or components earlier than intended.

Proper operation and maintenance of a health care facility and its key components, such as nurse call systems and boilers, is essential not only to the safe and effective delivery of health services to patients and long-term care residents but also for providing safe work environments for health care providers.

We concluded for the 12-month period ending November 30th, 2018, the Saskatchewan Health Authority did not have effective processes to maintain health care facilities located in the city of Saskatoon and surrounding area. We made 10 recommendations.

While the authority has qualified staff and relies on their professionalism to conduct maintenance, it needs to make improvements in the various areas to effectively maintain its Saskatoon-area facilities over their entire lifespan. The authority needs complete and consistent information about each key Saskatoon-area facility and component subject to maintenance to provide a basis for maintenance planning decisions. It needs a comprehensive risk-based maintenance plan to guide maintenance decisions of those facilities and components over the long term. This would include setting desired conditions of key facilities and components and consistently setting the nature, extent, and expected frequency of regular maintenance.

In our first recommendation, on page 193, we recommend the Saskatchewan Health Authority establish measurable service objectives for its key health care facilities and critical components located in the city of Saskatoon and surrounding areas. Having minimum condition standards enables taking a risk-informed approach to maintenance planning. It facilitates comparisons of assets' current conditions to those standards to identify particular facilities or components at risk. This supports determining the extent of resources needed for maintenance and deciding where best to focus maintenance efforts over the short, medium, and long term.

In our second recommendation, on page 195, we recommend the Saskatchewan Health Authority control the accuracy and reliability of maintenance data in its IT system for key health care facilities and components located in the city of Saskatoon and surrounding areas. Insufficient controls over user access to the maintenance IT system and insufficient program change controls may result in system data being inaccurate or incomplete. Inaccurate and incomplete maintenance data may result in inappropriate maintenance decisions or using additional time unnecessarily.

In our third recommendation, on page 196, we recommend the Saskatchewan Health Authority maintain complete information on each of its key health care facilities and components located in the city of Saskatoon and surrounding areas to enable the preparation of a comprehensive maintenance plan.

Having a complete listing of key facilities and components provides the basis to decide on which types of assets to do preventative maintenance and on which to do only reactive maintenance. Not identifying all of its key facilities and components increases the risk that the authority may not effectively prioritize maintenance activities or make inconsistent decisions about approaches to maintenance. This could lead to increased future repair costs or replacing facilities or components earlier than intended.

In addition, not basing planned, preventative maintenance decisions on current and complete information increases the risk of maintenance inefficiencies. We found the authority needs documented guidance on prioritizing maintenance to support completing maintenance within scheduled time frames. Timely maintenance reduces the likelihood of failure or breakdown which reduces the risk of harm to residents, patients, visitors, and the staff.

In our fourth recommendation, on page 198, we recommend the Saskatchewan Health Authority consistently set the nature, extent, and frequency of preventative maintenance activities for similar categories of key health care facilities and components located in the city of Saskatoon and surrounding areas. For five of six preventative maintenance requisitions we tested where the maintenance IT system identified a reason for the preventative maintenance, such as a requirement per a manufacturer manual, relevant Saskatoon-area maintenance staff was unable to provide us with the related manual or other support for the basis of these preventative maintenance decisions.

In addition, our testing of 30 preventative maintenance requisitions found the authority did not make consistent preventative maintenance decisions on the same equipment types. For example, facilities management decided to maintain nurse call systems located in Saskatoon on a monthly basis, whereas for two systems located in rural facilities it decided to maintain them only when they failed.

Not making consistent decisions and aligning the frequency and maintenance activities with standards — that's manufacturer and code requirements — increases the risks that key facilities and component assets are not maintained appropriately, or conversely, resources are used inefficiently. Inadequately maintained assets may put patients, residents, visitors, and staff at risk of injury if an asset fails.

In our fifth recommendation, on page 199, we recommend the Saskatchewan Health Authority use its planned maintenance activities as an input to setting its Saskatoon-area maintenance budget. Since the authority has not set measurable service objectives, it has not estimated the cost to maintain its Saskatoon-area assets to a desired condition or asset availability over its useful lifespan. As a result, the authority does not know whether it's doing maintenance at appropriate times or if not, what the impact of deferring maintenance is on the delivery of health care, safety, and costs.

In our sixth recommendation, on page 200, we recommend the Saskatchewan Health Authority complete preventative maintenance on its key health care facilities and components located in the city of Saskatoon and surrounding areas within expected time frames. For 30 preventative maintenance requisitions we tested, 14 were not completed within the time frame set out in the maintenance IT system. Staff completed expected maintenance tasks between 11 and 251 days after the scheduled maintenance date.

For four of six roof inspections included in our sample, staff completed the inspections between 14 and 251 days after the

scheduled inspection date. Not completing timely preventative maintenance increases the risk that an asset may fail and cause harm to residents, patients, visitors, or staff. This could also lead to increased future repair costs or the authority maintaining assets earlier than intended.

Our seventh and eighth recommendations, on page 201, are related. We recommend the Saskatchewan Health Authority have written guidance for classifying and prioritizing requests for demand maintenance on key health care facilities and components located in the city of Saskatoon and surrounding areas. In addition, we recommend the Saskatchewan Health Authority complete demand maintenance in line with priority rankings for key health care facilities and components located in the city of Saskatoon and surrounding areas.

For 7 of the 10 demand requisitions we tested, staff did not complete the demand maintenance work within the time frame consistent with the priority rating. For example, we tested one demand requisition with a priority ranking of 3, that being more urgent than other requisitions based on the urgency scale of 1 to 12. This requisition was for the installation of security at a lab exit for safety reasons, but maintenance staff did not complete it until 184 days after the initial request.

In addition, 3 of 10 demand requisitions we tested were not repairs of components or equipment that did not work, rather the work was more of the nature of a capital project to replace or renovate components. Completing capital projects as a demand requisition allows staff to skip the prioritized process for capital projects. Not completing timely demand maintenance increases the risk that an asset may fail and cause harm to residents, patients, visitors, or staff.

In our ninth recommendation, on page 202, we recommend the Saskatchewan Health Authority consistently document the priority of capital maintenance projects undertaken in the city of Saskatoon and surrounding areas. Failing to score projects consistently or documenting rationale for selecting projects can lead to an increased risk the authority is not prioritizing and completing capital projects that best address its needs. In addition, it increases the risk of not using resources, for example, staff and the budget, effectively.

Finally, we found senior management need to receive reports and results of Saskatoon-area maintenance activities. In our 10th recommendation, on page 204, we recommend the Saskatchewan Health Authority report to senior management the results of maintenance activities for its key health care facilities and components located in the city of Saskatoon and surrounding areas.

Without sufficient analysis and reporting of maintenance results, the authority cannot assess if effective maintenance of its key facilities and components is occurring, or if maintenance funding is sufficient and efficiently used.

I will now pause for the committee's consideration.

The Chair: — Thank you very much for the presentation and the focus of the work. I'll turn it over to Deputy Minister Hendricks for a presentation and then we'll turn it over for questions.

Mr. Hendricks: — Okay, thank you. With respect to recommendation no. 1 on page 193, the SHA considers this recommendation implemented. The SHA infrastructure team performed a high-level assessment of the Saskatoon-area critical infrastructure in the fall of 2018, which informed the development of a capital budget for 2019-20. Work to develop it was delayed due to COVID-19. By December 31st, 2021 a provincial capital asset plan with measurable service objectives for all assets, including Saskatoon facilities and critical components, was completed.

With respect to the second recommendation, on page 195, the SHA considers this recommendation partially implemented. The SHA is currently implementing processes to control system access and utilization based on roles and job function. In addition, the SHA is implementing a software update to track all changes made in the system. Work on responding to this recommendation was put on hold as the SHA focused on responding to the COVID-19 pandemic. Responses to a request for proposals for a computerized maintenance management system are under evaluation. The contract is expected to be awarded by March 31st, 2022, and implementation is planned to be complete by March 31st, 2023.

On recommendation no. 3, page 196, again the SHA considers this recommendation to be partially implemented. The SHA has created a work standard for entering facility information into its maintenance system and has verified that the information for 19 critical systems within the Saskatoon facilities is complete. The SHA will verify all information for key facilities and components in the Saskatoon area.

[13:15]

Recommendation no. 4, on page 198. Again the SHA believes that this recommendation is partially implemented. A project is under way to develop a standardized written procedure to describe the preventative maintenance of key facilities and components, including frequency, manufacturer instructions, and code requirements. Members of the project and working group are from across the province. In addition, the SHA will implement a work standard for preventative maintenance that includes assessing the condition of the asset and updating the asset record accordingly. Work standards will be validated and approved by building services directors each month. The project team expects to complete the work standards by October 31st, 2022.

On recommendation no. 5, on page 199, again the SHA believes that this recommendation is partially implemented. It is developing a risk-based maintenance plan for its Saskatoon-area key facilities and components, expected to be complete in the summer of 2022.

Recommendation no. 6, on page 200. The SHA considers this recommendation partially implemented. The SHA is developing standardized procedures for completion of preventative maintenance within the expected time frames as well as a tracking-and-escalation system to monitor the performance of their maintenance staff. The work is expected to be completed in summer 2022.

Recommendation no. 7, on page 201. The SHA considers this

recommendation to be partially implemented. The SHA is developing guidelines to help its Saskatoon-based maintenance staff prioritize, respond to, and complete demand maintenance work requests.

Recommendation no. 8. The SHA considers this recommendation to be partially implemented. The SHA will use priority ratings for key health care facilities to plan daily work activities of its maintenance staff in the Saskatoon area. In addition to developing a reporting system to monitor completion rates and compliance to priority ratings, an escalation process for complete demand maintenance requests will be implemented.

Recommendation no. 9, on page 202. The SHA considers this recommendation to be implemented. In addition to consistent criteria and evidence to support decisions, the new capital intake process includes a review committee to ensure that the plan addresses complexity of issues and is aligned to investment strategies. This process helps to formalize and consistently document capital budget planning, including prioritization of projects.

And finally recommendation no. 10, on page 204. The SHA considers this recommendation implemented. Monthly reports about capital budget execution and preventative and demand maintenance performance are provided to SHA senior management on a monthly basis beginning on December 1st, 2019. Thank you.

The Chair: — Thanks for the report and all the work on this front. I'll open it up to committee members for questions. Ms. Ritchie.

Ms. Ritchie: — Well that was a surprise, I bet. Okay. Well thank you both to the audit team for their presentation and responses from the deputy minister on the current status and the planned actions for each of those 10 recommendations.

And I think, just as a comment, it's not often that I see audit reports that start off with "did not have effective processes." Typically it's more in the case of, they do but here are some deficiencies. So that's concerning. And I guess my questions will try to understand what's behind some of that lack of effectiveness while at the same time also appreciating that you've obviously taken a number of steps here to address any deficiencies moving forward.

So maybe I'll start with page 192. It discusses the overall average facility condition index, and the 2018 numbers are noted. Is it possible to get updates for 2019, 2020, and 2021, and in addition to that also a breakdown by facility? I note that in the listing of the Saskatoon and area facilities . . . I did see that here somewhere a moment ago, you know, a very comprehensive list of acute care hospitals, health centres and other facilities, and long-term care homes that are part of the facilities that are, I assume, to be included in the scope of this audit, and noticing in particular that a number of these are long-term care homes. Curious to know the extent to which these maintenance deficiencies are impacting on more, sort of, acute care hospitals and health centres versus long-term care facilities.

Mr. Hendricks: — Maybe I can start and then I don't know if Andrew can maybe pick up where I leave off. And so your first question was regarding the facility condition index and if that would be available for more recent years by a facility in Saskatoon. I believe we have the information to 2019. After that we're looking at transitioning to a new facility condition system that SaskBuilds is rolling out. And so we don't have it more recently than that.

With respect to the other questions, I'll maybe turn it over to Andrew.

Mr. Will: — Yeah, so if I remember right, you're also interested in a breakdown by facility FCI [facility condition index], and I think that does exist for the previous study, as Max indicated. In terms of the long-term care facilities, I'll just say like some of those in Saskatoon are operated by affiliate organizations as well, so there is a separation there.

And maybe just a general comment to your point, your opening comment on, you know, the lack of standards. And I'll just say across the province, maintenance services, you know . . . I think the description that the Provincial Auditor gave was a good description in terms of really relying on kind of the professional judgment and work of maintenance leadership in terms of, you know, caring for the buildings that they're looking after. And I really do see an opportunity here to, you know, approach this in a more methodical, documented, consistent-with-standards way.

I really see that the formation of the SHA really lends an opportunity here for us to create that sort of professionalism in terms of how maintenance services are provided across the province. And in terms of how we've organized ourselves, you know, maintenance services literally report up through maintenance leadership, specifically that have expertise now in that particular area.

So while we had lots of variation before, we're working to standardize that. And as Max had mentioned, you know, there's good work happening across the province to standardize our maintenance processes, and each week they're working through more and more types of equipment and establishing those standards. And then we're real excited about the procurement of the computerized maintenance software because that will allow us to really quantify and track and make visible where we are behind on maintenance. Yeah, those would be my comments there. I think we'll be in a better place once that work is complete.

Ms. Ritchie: — And just for clarification, can I take from that response that data up to 2019 can be provided as requested?

Mr. Hendricks: — Yes, we'll provide that to the committee.

Ms. Ritchie: — Okay. So you mentioned that post 2019 that SaskBuilds would be providing some sort of a role. Could you please elaborate?

Mr. Hendricks: — So the purpose of the facility condition index and that software was to track facilities across the province so that we had a mechanism by which to allocate maintenance funding to various facilities, determine when a facility needed to be replaced, that sort of thing. I think the interest is in moving to something that will allow a more universal system across all public sector capital.

So right now the challenge is we have one that we use, or did have one that we use in the health system, but we need to be able to have a common platform to be able to compare that to education and highways and whatever so that the government can make those decisions across all areas. And so you know, as Andrew mentioned, they have software in the SHA to kind of do this at that level as well. And so you know, our ability to actually track maintenance priorities and efficiencies and that sort of thing is improving and to actually manage them both at a provincial level and at an SHA level.

Ms. Ritchie: — And so if that is carrying . . . If you're going to be dependent on another agency, i.e. SaskBuilds, for that piece of the work here, I'm just kind of curious to know how that might impact on the progress now that you've got to sort of feed into another process, operated by another agency, and if you've got . . . Can you just maybe explain to me how you'll be able to monitor progress?

Ms. Morrissette: — Thanks. Good afternoon, everybody. Billie-Jo Morrissette, assistant deputy minister with the Ministry of Health. So maybe just a couple of things. I'll maybe let Andrew speak to the piece around the software that he's talking about, kind of at that SHA level, some of the more detailed information that they're going to implement that will really assist them at that level.

But when it comes to the role of SaskBuilds, some of the conversations we've been having with SaskBuilds is really exploring the options for what is an appropriate, you know, asset management kind of approach, and like Max said, trying to find out if it does make sense to have a standard kind of approach across the public sector to allow for better information, you know, in a more consistent manner for decision makers across.

Having said that, any solution or any option that we'd explore where we would take a consistent approach wouldn't change, you know, kind of the data ownership or the responsibility or the roles of the various agencies. So the SHA would continue to maintain, you know, they would be the keeper. It's their data. You know, they would be expected to kind of input the key data into that system and certainly would be using that information to, I think, supplement what they might have in their own systems to help them make decisions as well. So it really doesn't . . . I don't think it would affect the ability of this work to progress. I think it can complement it.

And just with respect to the VFA, you know, we continue to maintain that system. So until we have sorted out the appropriate option to move forward, we'll continue to maintain that in a way until we have that, so that we do, you know, continue to have good information available to us to make those higher-level funding decisions at the ministry level.

Ms. Ritchie: — Thank you for that further explanation. Next on page 193, it states that as of November 2018, facilities management had not identified categories of critical assets, and ventilation systems were used as an example. Can you provide any information on what type of ventilation systems are used, the status, and what sort of improvements? I think ventilation systems obviously have become, you know, a priority area with COVID. And just looking to understand how that's being approached.

Mr. Will: — So in Saskatoon, as a follow-up to these recommendations, they did do an assessment of all of our critical building service components. And they have sort of applied a risk assessment, you know, to those components, and we are using that to make decisions about where we're making investments in terms of improvements to those facilities.

[13:30]

And actually I'll use that example. I know through that process, for example, for Royal University Hospital, though our exhaust system was one of the improvements that was made, just knowing kind of where it was in its life cycle and the impact on patients if that were to go down, it would disrupt surgeries.

So, yes, that would be my example and I think we've progressed in that area to, sort of, proactively make that assessment and then make investments where required.

Ms. Ritchie: — On page 201 it states that "Not completing timely demand maintenance increases the risk that an asset may fail and cause harm to residents, patients, visitors or staff." Just curious as to whether a critical incident has ever occurred due to a maintenance request not being completed in a timely manner.

Mr. Will: — I don't know the answer to that question. But if I could maybe just speak a little bit about demand maintenance?

Ms. Ritchie: — Yes.

Mr. Will: — So demand maintenance is a little different than preventative maintenance. Preventative maintenance, you have a schedule and you're regularly doing service. Demand maintenance is more when, you know, something is broken, not working, and staff report that and then the maintenance team follows up.

And I'll just say in response to this recommendation, they have put in place a process to . . . Well I would say the smaller, quick-fix kinds of demand maintenance, they flow through real time. If it is something that requires a more significant time commitment on the part of maintenance to address the issue, they do have a risk matrix that they apply and then make a decision, you know, which items that they address more urgently and then others that could wait.

So you know, I would just say certainly, you know, your question is I guess just connecting the impact that that can have on patients. And you know, the teams have put a good process in place to make sure we're getting to the most important things first when they do break. And you know, our goal is that we've got preventative maintenance to a level where those things are not breaking unexpectedly, but it does happen for sure.

Ms. Ritchie: — I think in the first recommendation, you made mention that there was a high-level assessment of critical infrastructure and that there were maintenance activities that had to be deferred. I think that was because of COVID; I'm not sure. But if you could maybe speak to what ended up having to be deferred.

Mr. Will: — I'm sorry, which recommendation is that related to?

Ms. Ritchie: — No. 1.

Mr. Will: — I believe no. 1 was implemented.

Ms. Ritchie: — Yes, and just when you were talking about the actions taken to implement since the Provincial Auditor's report and you mentioned . . . I may have heard wrong, but I believe you had said that there was some deferred works. And I was just curious to know what those were.

Mr. Will: — So it sounds like that was completed but not to the deadline that was expected.

Ms. Ritchie: — Oh, okay. I see. All right, thank you for that.

And then — sorry if I'm jumping around a little bit — under recommendation no. 5, so Health Authority use its planned maintenance activities as an input to setting its maintenance budget, you mentioned that this is partially completed and that you're developing a risk-based plan to maintain Saskatoon-area facilities. So yeah, just a little bit curious there to know, obviously, yeah, there is a need for setting some sort of priority and what the factors will be in doing so.

Mr. Will: — Yeah, you know, thanks for that question. So I don't have the specific criteria with me, and we could sure provide that. But we basically, all of the sort of maintenance requests from across all of our facilities within SHA do feed in, and we do score those according to objective criteria. And it would consider things like, you know, impact to patient and resident safety, or impact to operational availability or other criteria. You know, it could consider the current condition or age of the element that's being requested. And then, you know, we prioritize those and then those projects are ultimately approved. And then during the year the team implements those.

And I should also mention that another improvement that has been put in place is a process for monitoring weekly the implementation of those approved projects so that we complete those during the year. And we've made a significant improvement in terms of delivering those projects in a timely way. And that same process also is overseeing our demand maintenance. I should have made that comment when we were talking about that area as well.

Ms. Ritchie: — Okay. Thank you. Under recommendation no. 8, you indicated that you're developing a reporting system to monitor completion rates and compliance to priority ratings. And you mentioned an escalation process as part of that one.

Mr. Will: — Yes.

Ms. Ritchie: — Again it's a similar kind of a question just in terms of understanding what would . . . Maybe you could explain the escalation process for me and how it applies.

Mr. Will: — So as I understand it, the teams are tracking their preventative maintenance log. And then, you know, as in the weekly monitoring that I described, they're looking at how long each of these different requests are outstanding.

Ms. Ritchie: — And then if they sort of fall behind, then they get escalated. Is that the idea?

Mr. Will: — Yeah. And I think one of the points that I was wanting to make earlier is, you know, previously across the province, in some cases maintenance staff would report to a general health care administrator at a site. In other regions they might have reported up to, you know, someone that had responsibilities for a maintenance program within the former region.

The way we've designed our structure now is that all of the site facility managers that might have a team reporting to them report up to an area director that's accountable for maintenance. So it's those area directors that are monitoring, you know, the completion rates of the work, whether it be demand maintenance or the more significant facility improvements that are approved to be done during the year.

Ms. Ritchie: — So what sort of things would contribute to a project needing to be escalated? Why would a project fall behind? Not hypothetically, but in real terms.

Mr. Will: — Yeah, that's a good question. So one of the challenges we have in health care is many of our spaces operate 24 hours a day, 365 days a year. So you know, at times it's challenging to get in and do that work because it means literally disrupting a service for a period of time. So you know, certainly there are times when our clinical teams will maybe be facing a peak in health care demand and say, hey, it's not a good time to come in and do that work. So that might result in a delay to the work being done.

But ultimately, you know, an escalation might be required if the issue is not getting addressed, and I would say communication that needs to happen between the maintenance people and the clinical people in terms of when can the work be done. So that would be a real example.

Ms. Ritchie: — Right. And is that something you're assessing in an ongoing manner to sort of understand what's causing escalations?

Mr. Will: — Yeah. Well like I, you know . . .

Ms. Ritchie: — As a management function.

Mr. Will: — Yeah. So I think that's where I was describing. Like the area directors that have accountability for maintenance, they are having regular meetings with their teams to monitor the work. And I'll say in Saskatoon for example, I know that they have visibility walls where they're literally tracking, like, the issues of the day. And if something is breaking down, then the team will kind of all kind of redirect, maybe change the plan for the day so that they could address that issue that's there.

And so those conversations, for sure, it's a part of our improvement process so that staff can say, here's the challenges that I'm having. And they can problem solve and share ideas in terms of, like, how do we get into that space that, you know, we're having trouble getting into because it's too busy, and they can kind of work through that. And it might be someone that's more senior may be helping to kind of problem solve that issue.

Ms. Ritchie: — And so a final question on that. You know, recognizing that this is sort of a partially implemented

recommendation, I mean I'm just kind of wondering about what happens, say at the end of a year where you haven't quite met the targets for, you know, planned maintenance, preventative maintenance. You've managed it all the way throughout, through your escalation process and what have you. But at that point, like, do you have a way of assessing and understanding the overall limitations and improvement opportunities?

Mr. Will: — I think the CMMS [computerized maintenance management system], or the computerized maintenance management program, is really going to help us have some good data in terms of how effectively are we completing our planned maintenance. And I think that will also support kind of resource allocation in terms of, you know, do we need to reallocate some staffing resources from one part of the province to another to be able to meet the requirements of the facility?

I also think as we populate the preventative maintenance requirements into the computerized maintenance management system, it will allow us to actually quantify like how much work is involved in completing that preventative maintenance. And I think that also will help us in terms of resource allocation decisions.

Ms. Ritchie: — You know, I guess I also recognize that because there has been an amalgamation and a transition is under way, and then you layer COVID on top of that, it's not like you're operating in normal times. But nevertheless, you know, just in terms of how it's been going overall, is there a sense that these annual maintenance plans have been sort of realistic in scope and been achieved?

Mr. Will: — Well I appreciate your initial comments there because these teams, like maintenance staff across the province have really had to, you know, go above and beyond to try and accommodate some of the COVID requirements. And I'll use Saskatoon as an example. You know, they literally expanded ICU capacity and it was, you know, all hands on deck to be able to do that work. So you know, the improvements that I've described, they've done these in addition to responding to the demands placed on them through COVID. So yeah, that certainly is a, you know, a real concern.

Sorry, and the last part of your question again? I just lost my train of thought there.

Ms. Ritchie: — Well it was, how realistic have you found the plans to be? And then looking back to see sort of like what's been . . .

Mr. Will: — Yeah, thank you for that. So in terms of, you know, the budgeted initiatives for facility improvements that we've done, as I mentioned, we really made some strides forward. We're delivering those projects now more effectively than we ever have.

Part of our improvement there is we've now moved to a two-year budgeting process that allows us to do planning, design, and procurement prior to the initiation of the next year once those dollars are approved. It also, by doing that, it also allows us to take better advantage of summer months for some of these projects that do have some weather implications to them.

The other change that we've put in place is the weekly monitoring that I mentioned of all of our projects. So we have project managers that are literally tracking all of the approved projects and ensuring that we achieve those during the fiscal year. And it's definitely helped us deliver our projects in a more timely way.

[13:45]

Ms. Ritchie: — Okay, thank you. No more questions.

The Chair: — Thanks for the questions. Thanks for all the work on these important fronts. Looking for any further questions. Not seeing any with respect to this chapter, I would welcome a motion to move that we concur and note compliance with recommendations 1 and 9. Mr. Goudy moves. All agreed?

Some Hon. Members: **—** Agreed.

The Chair: — That's carried. I would look for a motion that we concur and note progress with respect to recommendations 2, 3, 4, 5, 6, 7, and 8. Moved by Mr. Friesen. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried also. Oh, we have recommendation no. 10. We should include it. And that was also one that was implemented. Sorry for not identifying it. I'd welcome a motion to concur and note compliance. Mr. Skoropad moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — All right, that's carried. Okay, we'll move along to chapter 24 and I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 24 of our 2019 report volume 2, on pages 197 to 222, reports on the processes the Saskatchewan Health Authority uses to treat patients at risk of suicide in northwest Saskatchewan. This chapter includes eight new recommendations.

The rate of suicide has been consistently higher in northwest Saskatchewan than the rest of the province for the last three years. In 2018 the average suicide rate per 100,000 was 27.9 in northwest Saskatchewan compared to the provincial average of 18.7. This higher rate increases the importance of the authority appropriately treating patients at risk of suicide in this part of the province.

Healthcare services can offer a significant role in preventing suicide by screening for suicide risk and appropriately following up on positive screens. The public health system failing to assess suicide risk may result in missed opportunities to identify suicide-prone individuals and to provide timely treatment to help them address contributing factors. Not doing so may subsequently result in fatal consequences.

We concluded that for the 12-month period ended August 31, 2019, the Saskatchewan Health Authority had, other than the areas highlighted in our eight recommendations, effective processes to treat patients at risk of suicide in the northwest integrated service area.

In our first recommendation on page 207, we recommend the Saskatchewan Health Authority work with others, for example the Ministry of Health, to analyze key data about rates and prevalence of suicide attempts to rationalize services made available to patients at risk of suicide. The Saskatchewan Health Authority has not sufficiently rationalized whether services available to patients at risk of suicide in northwest Saskatchewan address the demand for services in this area. This in part because it does not have complete key data. Also we found its analysis of existing key data was limited.

To assess services provided to patients at risk of suicide, good practice suggests focusing on four key measures: suicide rate, hospitalization rate for self-injury, emergency department rate for self-inflicted injury, and prevalence of suicide attempts. We found complete data is largely available for some of these measures. Specifically our analysis of data found northwest Saskatchewan has higher rates of suicide and self-injury hospitalizations than the provincial rates.

The authority and the ministry do not have any coordinated efforts to analyze data related to services to patients at risk of suicide. We found funding for suicide prevention programs fragmented across provincial government agencies, the federal government, and First Nations agencies. Better coordination and analysis of multi-sector suicide prevention strategies may identify duplication or absence of services in certain communities.

Systematic trend analysis of key measures by hospital and by geographical region would inform the planning and implementation of treatment programs. It would help the authority determine whether it gives individuals at risk of suicide in northwest Saskatchewan sufficient access to services. Such analysis would help the health sector determine if its programs are making a difference.

In our second recommendation, on page 211, we recommend the Saskatchewan Health Authority give suitable training to staff located in northwest Saskatchewan caring for patients at risk of suicide.

The authority is not giving staff at facilities in northwest Saskatchewan, working with patients at risk of suicide, sufficient training on caring for these patients. We found the authority has not determined its training needs for staff in the area of caring for patients at risk of suicide. Rather, the authority allows staff at individual facilities to determine and coordinate their own training needs other than for staff training on new clinical-related IT systems.

We also found the nature and extent of training varies significantly, and the training provided did not meet the foundational training expected in the Saskatchewan suicide framework. Training helps keep staff up to date. Not providing sufficient ongoing training for staff treating patients at risk of suicide increases the risk staff may not follow practices the authority expects and may provide patients with inconsistent care.

In our third recommendation, on page 214, we recommend the Saskatchewan Health Authority follow its established protocols to provide psychiatric consultations to patients accessing emergency departments in northwest Saskatchewan who are at high risk of suicide.

Staff and facilities located in northwest Saskatchewan consistently followed established protocols to screen patients for risk of suicide, but emergency department staff did not always seek psychiatric consultation for patients with a high risk of suicide. We found the authority had clear protocols for handling patients who came to the emergency department and indicated a plan to attempt suicide. It expected health care providers to rate those patients who attempted suicide, or had a plan to attempt, as high risk. It also expected the staff completing the preliminary screening to consult with an emergency department physician to validate the assessed risk of suicide. Where an emergency physician agreed with a high level of risk, it expected the emergency department to consult with a psychiatrist for further assessment and determine next steps.

We tested 23 files of patients who attempted suicide and came to emergency departments, and found staff did not always follow the protocols to consult with a psychiatrist prior to discharge. We identified three instances where patients with intention of self-harm did not see a psychiatrist prior to their discharge. Emergency department health care providers not consistently following the authority's protocol to consult with a psychiatrist prior to discharge of a patient with a plan to attempt suicide, increases the risk of those patients not receiving support and treatment. In addition, it may open the authority to litigation if it did not provide the patient with appropriate care.

In our fourth recommendation, on page 215, we recommend the Saskatchewan Health Authority address barriers to using video conferencing to provide psychiatric services to communities in northwest Saskatchewan. The authority has not analyzed why patients at greater than a low risk of suicide are not showing up for scheduled Telehealth, that is by video conferencing, appointments. Its provision of psychiatric services through Telehealth also remains low. We found the authority's use of Telehealth for providing psychiatric services depends on whether it has a sufficient number of psychiatrists available.

We also found patients poorly utilized Telehealth to access psychiatric services in northwest Saskatchewan. For example, in both 2017 and 2019 the rate of patient no-shows for Telehealth appointments with North Battleford psychiatrists was at least 50 per cent. The authority recognizes no-shows result in a significant amount of unproductive time for psychiatrists.

Research shows psychiatric consultations and short-term follow-ups can be as effective when delivered via Telehealth as when provided face to face. Given the geographic spread and size of communities in northwest Saskatchewan, use of video conferencing can help patients and psychiatrists minimize travel time and costs to attend face-to-face appointments. Not determining reasons for poor use of video conferencing for psychiatric services in northwest Saskatchewan communities reduces the authority's opportunities to identify and address barriers to its use.

In our fifth recommendation, on page 217, we recommend the Saskatchewan Health Authority analyze reasons patients at risk of suicide miss appointments for mental health out-patient services, to help address barriers. The authority actively follows

up with patients who received out-patient and in-patient services but does not know why certain patients do not show up for scheduled appointments. We tested 22 patient files and found the authority followed its follow-up protocols for patients at risk of suicide receiving mental health in-patient and out-patient services. However we found patients often miss appointments, which disrupts the continuity of clinical care.

Not knowing why patients miss appointments reduces the authority's opportunities to identify and help patients overcome barriers to attending appointments. Such information would help the authority assess the appropriateness of its services for patients at risk of suicide.

In our sixth recommendation, on page 219, we recommend the Saskatchewan Health Authority follow up with patients who attempted suicide, discharged from emergency departments in northwest Saskatchewan, to encourage treatment where needed.

In northwest Saskatchewan, the authority's follow-up protocols for patients at risk of suicide accessing services through emergency departments differ from those for patients accessing services through mental health out-patient services. Research supports that contacting people and providing support after discharge from emergency departments reduces suicidal behaviours and deaths. For four files tested of patients who attempted suicide and were discharged from emergency departments, we did not find any evidence of the patient being referred to mental health or addiction services.

Having differing follow-up protocols for patients who attempted suicide accessing health services through emergency departments, from those accessing services through out-patient services, may result in not providing patients with consistent levels of care. Proactive follow-up care promotes continuity of care and continues the assessment and management of suicide risk.

In our seventh recommendation, on page 220, we recommend the Saskatchewan Health Authority conduct risk-based file audits of patients at risk of suicide in northwest Saskatchewan. The authority does not use a risk-based approach for conducting patient file audits in the northwest Saskatchewan health care facilities. Patient file audits can determine whether staff follow policy and provide appropriate care to patients at risk of suicide.

The Saskatchewan suicide framework expects former health regions to audit 10 per cent of mental health in-patient and out-patient files monthly to determine whether files document the various items, for example suicide screening, discharge plan. The authority did not conduct monthly mental health out-patient file audits since April 1st, 2018 or in-patient file audits since March 31st, 2019 in northwest Saskatchewan health care facilities as the framework expects. We also found the past in-patient and out-patient file audits conducted in northwest Saskatchewan did not cover all of the framework's requirements.

Conducting systematic risk-based audits of patient files would help supervisors and management actively monitor staff and help identify areas needed for improvement. Not following policy may result in inadequate services provided to patients at risk of suicide.

In our eighth recommendation, on page 221, we recommend the Saskatchewan Health Authority periodically inspect the safety of its facilities in northwest Saskatchewan providing services to patients at risk of suicide. The Saskatchewan suicide framework requires annual facility safety inspections of in-patient facilities to identify obstructions to staff observation of high-risk patients in physical structures that patients could use in attempting suicide.

We found the authority does not formally inspect the safety of facilities periodically in northwest Saskatchewan used to provide mental health in-patient services or emergency department services to patients at risk of suicide. Not doing periodic robust inspections of facilities used to care for patients at risk of suicide increases the risk of not sufficiently identifying and addressing safety risks.

I will now pause for the committee's consideration.

The Chair: — Thank you for the presentation. Thank you for the focus of the work as well. I know this impacts so many lives, not just in the region that you speak of but so many across the province. I'll turn it over at this point to Deputy Minister Hendricks for a response, then we'll open it up for questions.

Mr. Hendricks: — Okay. Recommendation no. 1, on page 207, the SHA considers this recommendation implemented. Key data has been acquired and analyzed in collaboration with the Ministry of Health and Saskatchewan coroner's office. This data serves to rationalize the alignment of resources and provision of suicide prevention initiatives that are currently in place.

[14:00]

Analysis shows that in the former Keewatin Yatthé Health Region, suicide rate is higher per capita than other areas of the greater northwest area. Rates are highest amongst Indigenous males between the ages of 18 and 31, with the highest rates in the La Loche area. Although rates of suicide have seen a decline in the 2015 to '19 period, compared with the 2010 to '14 period, prevalence in this geographic area continues to be higher than average compared to other northwest areas.

The SHA's objective is to continue to review and update data annually to ensure that resources are targeted to the area of highest need. Resources have been realigned in La Loche, Buffalo Narrows, and Ile-a-la-Crosse.

For recommendation no. 2, on page 211, the SHA considers this recommendation partially implemented. The SHA has provided an up-to-date suicide risk assessment and intervention training for all new and existing mental health and addictions staff in the Northwest who were previously not trained. This skill training has been provided through the suicide response policies and/or other related training such as applied suicide intervention skills training, critical incident stress training, violence threat risk assessment, and traumatic event systems.

Ongoing work continues with the Ministry of Health and other partners to develop a full standardized menu of suicide risk assessment and intervention training options that will be tailored to meet the needs of all staff, both mental health and addictions and those working in areas including primary health care,

emergency rooms, and community partners and agencies. A process for tracking the completion of required training is being developed and implemented.

Recommendation no. 3, on page 214. The SHA again considers this recommendation to be partially implemented. A process for referring from emergency departments to psychiatry for consultation for patients at high risk of suicide has been developed. An algorithm for emergency room physicians and clinicians for direct and immediate consultations to LINK [Leveraging Immediate Non-urgent Knowledge] — which is the provincial on-call consultation service for a specialist, including psychiatry — or 24-hour on-call psychiatrists for patients at high risk of suicide, has been discussed and shared at some but not all northwest sites to date.

Recommendation no. 4, on page 215. The SHA has not implemented this due to the pandemic.

On recommendation no. 5, on page 217, the SHA considers that this recommendation is partially implemented. Work standards have been developed that clinicians follow to track no-shows of clients deemed to be at risk for suicide. Mental health and addictions clinicians provide follow-up phone calls to all clients who do not show up for appointments in order to find out what are the reasons, if any, for missed appointments and to discuss barriers they experience in regards to attending their scheduled appointments.

Standardized processes to analyze reasons clients miss appointments are not fully developed yet. The former Keewatin Yatthé Health Region is still in the process of fully implementing the mental health and addictions information system, so the proposed mechanism for research needed to analyze reasons for missed appointment services is delayed.

Recommendation no. 6, on page 219. The SHA considers this recommendation implemented. Each site in northwest Saskatchewan has now implemented a process to follow up with high-risk clients after they are discharged from the emergency department. The process and standards are designed to meet the needs of their respective communities.

Recommendation no. 7, on page 220. The SHA considers this recommendation to be partially implemented. Auditing procedures for remote and northern sites continue to require some fine tuning; however auditing of client files has been expanded to other sites in northwest Saskatchewan as a mandatory process. The former Keewatin Yatthé Health Region is in the process of fully implementing a mental health and addictions information system and will initiate file auditing and reporting with that implementation.

Recommendation no. 8, on page 221. This is not implemented. Primary health care executive directors in northwest Saskatchewan planned to ensure annual safety inspections were completed and results were received in a timely manner beginning in March 2020. The implementation of this recommendation was delayed as a result of new safety protocols limiting access to facilities during the pandemic. Consultation, on-site meetings, and site visits will occur as soon as reasonably possible. In the meantime, managers and staff of in-patient units, particularly in-patient mental health units where patients with higher suicidal risks are admitted, would regularly monitor their units for safety risks.

The Chair: — Thank you for the presentation. Thanks to folks that are involved in, you know, life-saving efforts and work on this front. I'm going to turn it over to committee members for questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. And I want to first of all start off by thanking the Provincial Auditor and her staff for the important work you have been undertaking to highlight deficiencies within the delivery of services for suicide prevention. And I just want to acknowledge, you know, the importance of that work, the vital nature of that work ensuring that we are addressing what is an unacceptably high level and rate of suicide in this province, in particular in the northwest part of the province. So again I want to thank you all, and your team, very much for that work.

Next, Deputy Minister Hendricks, thank you for your status report and in particular your response on the first item, where you've provided some updated information on that need for analyzing key data and the results that you have found from that work. I think that's very important. The auditor has stated in 2018 the average rate per 100,000 being significantly higher than the provincial average, so 27.9 per 100,000 compared to the 18.7 provincial average. I'm wondering if we can be provided with updated numbers for 2019, 2020, and '21.

Ms. Morrissette: — Good afternoon. So the 2019 data in the suicide rates per 100,000 residents as was reported in the auditor's report: for 2019 the updated numbers for the provincial rate are 17.6; and in the former Prairie North RHA [regional health authority], 23.77; in the former Keewatin RHA, 31.9.

The numbers for 2020 and 2021, we don't have those resolved yet. So the coroner's data is typically a little bit lagged. It takes a little bit of time for those to be confirmed, but as Max mentioned in his statements, certainly as the information becomes available on an annual basis we would continue to be looking at those rates.

Ms. Ritchie: — All right. Thank you very much. On page 210 it's noted that full-time psychiatrists in northwest Saskatchewan as of 2018 are predominantly found in larger centres like North Battleford. I'm wondering if you can tell me if that is still the case. And I would also like a breakdown of the number of psychiatrists by location in northwest Saskatchewan and if there are any vacancies currently.

Mr. Hendricks: — Yeah, we can provide a list of the number of physicians in those communities. So in North Battleford there are five full-time psychiatry positions, and then we contract with four psychiatrists on a fee-for-service basis to provide services in Lloydminster as well. But the next-closest larger community where we would have psychiatry is Saskatoon. What you, I think, would strive for in a lot of these northwestern communities is to have, you know, other mental health workers and that sort of thing have strong connections with psychiatry in those larger communities as a referral service. But yeah, those are the numbers and we can provide them as you need them historically.

Ms. Ritchie: — Based on what I've been able to take in so far today, I get the impression that there's a heavy reliance on the

video conferencing system to deliver psychiatric care in much of or all of the North, and there's been, I think, some also identified challenges with that approach. There was one recommendation around missed appointments at sort of a 50 per cent success rate. I wonder if someone can help me find the number that refers to, Mr. Chair. You know, anyways I guess what I'd like to know is if the service delivery mechanism or method is seen as succeeding, what is being done to address the deficiencies with it, you know, increase the rates of attendance and address any other barriers, and maybe you could speak to what those barriers are.

Mr. Hendricks: — I'll start and then Andy — sorry, Andrew McLetchie is northern integrated health — can join in.

So one of the things that we had relied on for a lot of northern specialist consultations is Telehealth. And you know, I guess it works well in psychiatry ideally, but the challenge with Telehealth is it required the provider to have a suite, and oftentimes for the patients to move to a suite to actually receive the consultation. One big plus of the pandemic is I think we've come a long way on virtual care, where we've looked at using technologies that we wouldn't have thought maybe of using before, and we're continuing to expand those because we're realizing the value in that.

So obviously telephone is the primary mechanism that was used during the pandemic. But we're looking at other technologies that are more basic, that people can use on their phones and that sort of thing, that are secure and should provide increased opportunities for many northern residents to access psychiatry and other specialized services without leaving their community or their house for that matter. I think this can go a long way in terms of mental health, but you know, there has to be somebody on the other end of the line. And that's maybe probably the more challenging part, is providing the access through either psychiatrists . . . But there are also a number of other mental health staff that are very qualified. It doesn't always have to be a psychiatrist.

So maybe, Andy, if you want to say anything?

Mr. McLetchie: — As Max said, I'm Andy McLetchie, the vice-president of integrated northern health for the Saskatchewan Health Authority. And Max is right that there are sort of challenges with accessing suites where Telehealth exists. We also in a sense have challenges for a number of residents, particularly in the far North, being able to have the phone that has access to data, and so using some of the other tools to connect with professionals at a distance.

[14:15]

I think the other thing to point out here is I do think there's a lot of in-person kind of visits. Psychiatry out of Saskatoon travels to places like La Loche and Ile-a-la-Crosse usually twice a month to provide in-person services in those communities, and so the Telehealth services are there to kind of provide follow-up support. As well, the local mental health clinicians are often the ones who are following up and connecting clients in need with psychiatry.

Ms. Ritchie: — So when you talk about some of those challenges with the client or patient being able to utilize the service through Telehealth . . . Yeah, I know we're short on time. But I am really curious to know, you know, if there is any work or effort being undertaken to improve access, address that reality.

Mr. Hendricks: — Yeah, you know, Telehealth is maybe . . . You know, I shouldn't say it . . . Like, it has been utilized in certain jurisdictions very successfully. In northern Ontario, they've had much better success with it than we have here in Saskatchewan. But you know, I think when we step back, you know, for specialties like psychiatry, whether they really require a fully automated Telehealth suite. And one of the biggest impediments with the Telehealth suite was that the provider had to leave their office to go to the Telehealth suite to connect, which was as big a problem getting them to. Because, you know, that takes time out of their day and that sort of thing.

It's just that technology has advanced. We don't require that big set-up to do this. We can carry images and allow consultations to be conducted remotely without having to have all that equipment. And even in some other specialties that rely on more than just, you know, a discussion and face-to-face contact, there are other diagnostic instruments that can be plugged into your home computer, right, that allow people to monitor you remotely, your health professionals to monitor you remotely. So I think we're just seeing the evolution of the technology, and I think it is opening some opportunities for this.

Ms. Ritchie: — Maybe just one more question then. Yeah, you mentioned the location of psychiatrists in Lloyd and North Battleford, Saskatoon. Is there any effort under way to retain and recruit qualified mental health practitioners to be situated in communities in the northwest area of the province?

Mr. McLetchie: — Yes, there's been a number of positions — through some of the funding that the province has provided for mental health and addictions — that have been created in northern Saskatchewan. Unfortunately there's been challenges with recruitment and retention to places like La Loche and Buffalo Narrows and Ile-a-la-Crosse. But there's an ongoing effort to try and find people that want to work in those northern communities and to provide services to the people there.

Ms. Ritchie: — And can you describe what some of those challenges are and what's being done to address them?

Mr. McLetchie: — I think there's a number of challenges that probably exist. Some of it is wanting to live and work in a northern remote community. Housing is often kind of brought up as a challenge in these locations. It's also, I think with some of the challenges with recruitment that we've seen in those communities, people are bringing up that not having consistent people that they're working with becomes a barrier to being able to provide as good a service as they'd like to. And it speaks to the need for ongoing retention of staff once we hire them.

Ms. Ritchie: — And in relation to that . . . So I guess what I'm asking then is, also on the retention side, are there incentives, programs? How are you approaching that from a strategic angle?

Mr. McLetchie: — In the far North there is northern incentives that are built into most of the collective agreements, and those include both weekly kind of cost-of-living benefits as well as an

annual retention bonus, if you will, that is given after each year of work there. And those are largely the mechanisms by which we kind of support northern people or incentivize working in the North. There is also housing that's made available in a lot of our communities that although the staff pay for it, it is subsidized to some degree.

Ms. Ritchie: — And I think I was sort of lumping together psychiatrists and mental health professionals, so I understand probably that the psychiatric teams do this fly-in that you mentioned twice per month. And I wonder if . . . Apologies if you've mentioned this already, but you know, what is the current level of vacancy rates in the North for mental health?

Mr. McLetchie: — For mental health positions or for psychiatry?

Ms. Ritchie: — Mental health.

Mr. McLetchie: — I would have to get that for you. I don't have that information.

Ms. Ritchie: — Okay. Well I appreciate that. Thank you very much. No more questions, Mr. Chair.

The Chair: — Thanks for the questions, and thanks for the work. I just have a question with respect to, I guess it relates to recommendation no. 6 about those people that have arrived at emergency who have attempted suicide. And then to maybe broaden that category, those that are presenting at an emergency room that have suicidal ideation or are presenting a serious risk of suicide, that they're expressing that.

Is there follow-up? I guess first of all on northwest Saskatchewan, is there follow-up then with all of those patients, or only those who have attempted suicide? Would that also include those that are showing up and stating that they're at risk of suicide and expressing suicidal ideation?

Mr. Hendricks: — So each site in northwest Saskatchewan has implemented a process to follow up on high-risk clients, not just those that have attempted. But I guess that would include people that have suicidal ideation. So anybody that's discharged from emergency, there is a process now and standards to follow up with them in their respective communities.

The Chair: — Well I think that's really important, so thanks for the work that's, you know, been taken on to make that happen. I guess my question is — you know, this pertains to northwest Saskatchewan, and this is a matter of concern across the province — is that standard practice now? Is that same follow-up occurring province-wide for anyone who's presenting to emergency rooms across Saskatchewan?

Mr. McLetchie: — Yes. It's intended to be the standard across Saskatchewan, and I think part of the follow-up to these recommendations is to make sure that that's occurring across the province.

The Chair: — Thanks. It's a point of concern that at times there seem to be some gaps on that end, and I really appreciate the focus and the work on this front. So thank you for that. Any other questions from committee members with respect to this report? Mr. Friesen.

Mr. Friesen: — I just had a quick question for the auditors. When you were talking about the Telehealth versus in person, you're saying they're . . . I just want to confirm that I heard it right, but pretty much an equal outcome? Doesn't matter which way it was? Is that kind of where you were going with that?

Ms. Clemett: — Yeah, so what we did find is that research does seem to indicate, and yet I would say during the course of the audit we did find that basically when a patient does . . . it's almost that initial meeting with a psychiatrist, like building that relationship, being in person is obviously preferred and better.

As the deputy minister indicated, I think things have evolved now with COVID, and patients and a lot of us are more acceptable of different types of technology mechanisms in which we are able to receive care. But yeah, research did indicate to some degree, you know, sort of talking and meeting in person or over video is the same. I guess it's much like us auditing now, right? Like, if I'm talking to you through a camera or talking to you in person, hopefully it'll be relatively similar results.

Mr. Friesen: — Wow, that's really neat. Thanks for that.

The Chair: — Further questions at this point? Not seeing any right now, I'd welcome a motion to concur and note compliance with respect to recommendations 1 and 6. Moved by Mr. Nerlien. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. I'd welcome a motion with respect to recommendations 2, 3, 5, and 8 that we concur and note progress. Mr. Goudy. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. And with respect to recommendations 4 and 7, I'd welcome a motion that we concur. Mr. Friesen. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed. Just a note to folks that might be following along here as well, just a reminder of the thorough follow-up process as well that the auditor's office has. We hear the undertakings and the commitments that are being made and the actions that are being taken. The auditor then follows back up, reports out publicly to the people of Saskatchewan. That comes back to this table as well.

What we'll do now is move along with our agenda and turn our attention to chapter 39 of the 2019 report volume 2. And I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 39 of our 2019 report volume 2, on pages 293 to 301, reports the results of our first follow-up audit of the former Cypress Regional Health Authority's processes to deliver accessible and responsive ambulance services.

By April 2019, the Ministry of Health and the Saskatchewan Health Authority had implemented one of the seven

recommendations we made in our 2016 audit. The authority implemented a process to confirm ambulance operators, either owned or contracted, hold a current ambulance licence. All ambulance operators in the former Cypress Health Region held current licences at April 2019.

While the ministry did not analyze whether it needs to change *The Ambulance Act*, it worked with the authority to develop a performance-based contract template for contracted ambulance service providers. The new performance-based contract template clearly sets out service quality expectations, for example, response time targets, and requires regular reporting on specific measures, for example, the volume and quality of services provided.

As of April 2019, the authority continued to work to implement new contracts with private ambulance operators using the template over the next two to three years. Through the new performance-based contracts, the ministry and the authority should obtain better performance information to use in conducting a future comprehensive review of patient demand relative to ambulance services across the province.

Also collecting better performance information like delayed response times should also support the authority in assessing the success of its ground ambulance services and determining actions to take when ambulance are not responding to service calls within the targeted 30 minutes in rural locations.

I will now pause for the committee's consideration.

The Chair: — Thank you, thank you very much for the focus of this work. Thank you to the ministry and folks that have been involved in implementation on these fronts. There's a lot of work that's occurred. We've got a status update here, I know, with respect to these recommendations. They've come to this committee already. We've concurred on them and we have the report out here today that demonstrates implementation. So I think our scrutiny can be a little more expeditious at this table. I would maybe kick it over to the deputy minister to see if he has some brief remarks with respect to this chapter and then I'd open it up for committee members.

Mr. Hendricks: — Thank you. So maybe I would just go through the status of the recommendations fairly quickly. So on page 295, which is the first recommendation, the SHA considers this partially implemented. So the SHA emergency medical service portfolio has developed a proposal to stabilize rural and remote ambulance services. This has come forward to government for budgetary consideration and will be part of our annual budget cycle.

No. 2, on page 296, the SHA considers partially implemented. All contracted services in the Southwest except one have been converted to new performance-based contracts. The remaining performance-based contracts are expected to be executed by the end of 2022.

[14:30]

The auditors' third recommendation, on page 297. The ministry considers this recommendation implemented. The ministry has conducted broad EMS [emergency medical services]-sector consultations in 2017, and at the conclusion of the consultation process, consideration was given to legislative amendments.

It was determined that the focus for enhancing contract management's practices would be through the introduction of a standardized performance-based contract as mentioned. And last, the contracts will also support greater consistency across EMS services and improve quality of service.

No. 4 on page 298. We also consider this implemented. I think the auditor agrees with us on that one.

On no. 5 and 6 on page 298, the SHA considers these recommendations implemented. They're monitoring progress on monitoring response times against targets with monthly and quarterly reports being provided to the Southwest manager of EMS and the director of EMS South. The reports include the reasons specific calls did not meet response times.

Recommendation 7, the SHA considers — on page 300, sorry — the SHA considers partially implemented. Reporting against performance metrics is expected to be implemented with the new computer-aided dispatch system planned to begin in October 2022.

The Chair: — Thank you for the report out, and I may have misspoke just with respect to one of the recommendations. That was the one that you just identified, recommendation 7, where you've laid out the timeline that's coming around to full implementation.

I'll open it up if there's questions from any committee members. I do want to say thanks for, you know, providing the report on all the actions and implementation because it allows us to cut to the chase at this table. Not seeing any, again . . . Oh, Deputy Chair Young.

Ms. C. Young: — Are there currently any open contracts that you're working on and using this new template with, and if so, what concerns or challenges that have come forward with the new template?

Mr. Miller: — Thank you for the question. Corey Miller, vice-president of provincial programs for the Saskatchewan Health Authority. We've worked with the operators in developing that performance-based agreement. So there was a collective group of SHA leadership, ministry leadership, and members of the professional association of paramedics, and owners of . . . So we worked with them in developing what was a fair and reasonable performance-based agreement.

As Deputy Minister Hendricks mentioned, we haven't got everybody to sign them yet. I would say we have a few, but it is targeted by the end of '22 for that to happen. I wouldn't say there's lots of challenges with it. Just some operators like *The Ambulance Act* and the accountabilities and performance measures that they do and don't have to report in it. But I'd say we're getting there and it is an expectation that they sign that or we won't be renewing their agreements.

So specifically there's a requirement for them to report response times, and I would highlight we're being reasonable in it. We are a large geographic province and with the response times for

emergencies being 9 minutes and 59 seconds, it's not possible for some services to reach an accident in that time frame. So we're being reasonable with them and asking them to report the distances between their base, and we time them on that 9 minutes and 59 seconds from that distance.

So in this area I'll give you the example, you know, the provider in Ponteix responding to Cadillac — that's a 15-minute drive — the expectations are they report any time it's more than 15 minutes and 9 minutes and 59 seconds to that site. That allows us to measure their performance at a standardized way. Some people don't like the fact that they're going to have to report those types of variances in their performances.

Ms. C. Young: — And *The Ambulance Act* itself has different numbers in it and I'm assuming that they're . . .

Mr. Miller: — We've always had response times. It's the reporting of the response times.

Ms. C. Young: — So it's the reporting part; it's not with the standards that are there. Okay, thank you.

The Chair: — Good questions. Thanks for the responses. Not seeing any other questions at this time, I'd welcome a motion to conclude consideration of chapter 39. Moved by Deputy Chair Young. All agreed?

Some Hon. Members — Agreed.

The Chair: — That's carried. Moving right along, I'm going to turn it over to the Provincial Auditor to focus on chapter 35 of the 2019 report volume 1.

Ms. Lowe: — Chapter 35 of our 2019 report volume 1 on pages 323 to 327 report the results of our second follow-up on recommendations we first made in 2014 about Prince Albert Parkland Regional Health Authority's processes to provide timely and appropriate home care services in the city of Prince Albert and surrounding area.

By February 2019, the Saskatchewan Health Authority had implemented the three remaining recommendations. The authority improved its compliance with established policies and procedures for completing required needs assessments — for example, an in-home safety assessment — and began conducting monthly audits to monitor compliance with its needs assessment policy. Tracking compliance rates helps the authority monitor the work done. Completing each of the required needs assessments help ensure clients receive all the required home care services and reduce the risk of injury to clients and staff.

The authority also formed a home care approval committee for Prince Albert Home Care to review and approve all clients' home care plans. We found staff work schedules aligned with approved home care plans. Consistent review and approval of home care plans confirms the appropriateness of assessed needs for home care services. Having schedules that align with approved home care plans helps ensure clients receive the services based on their assessed needs.

I will now pause for the committee's consideration.

The Chair: — Thank you for the report, the focus of the work. I'll turn it over to the deputy minister and we'll go from there.

Mr. Hendricks: — All of the recommendations, I believe, are implemented so no further comments from the ministry or the SHA on this item.

The Chair: — Ms. Ritchie, you have about 10 or 15 questions on the matter? Thank you to the ministry for the work. And looking to committee members for questions.

Ms. Ritchie: — Thank you, Mr. Chair. Thank you to both the Provincial Auditor for that report and the deputy minister for the current status and completion of the audits. I do have some questions. Can you tell us the number of clients or patients that are served within this area?

Mr. Hendricks: — Unfortunately we don't have that with us right now. We can provide that to the committee through the Chair.

Ms. Ritchie: — Okay, thank you. I was also interesting to know, for comparison purposes, also what the provincial-wide numbers would be?

Mr. Hendricks: — We can provide that as well.

Ms. Ritchie: — Okay. Also the number of nursing visits for the past number of years — I guess this audit was in 2019 — and so just wanting to know the number both . . . that as well as home support services, and in order to get an idea on the trends and if you had any comments on that.

Mr. McLetchie: — Sorry, the question was on the trends for homes?

Ms. Ritchie: — Number of nursing visits and home support visits.

Mr. McLetchie: — I don't have those numbers on me right now.

Ms. Ritchie: — Okay. So it's also nice and good to learn that the home care approval committee for the Prince Albert care home. I'm just wondering if there's any . . . Is this specific to the Prince Albert area or are there similar kinds of committees operating in other parts of the province? Is this a standard practice?

Mr. McLetchie: — The answer to that is there are committees, and they're sort of being pulled under each area within the province. So there'd be six different committees within each of the six areas that would be looking at that service provision.

Ms. Ritchie: — And just one follow-up question. I'd just like a little bit more information on the membership on those committees and the kinds of matters that they're considering.

Ms. Earnshaw: — I'm Karen Earnshaw, the vice-president of integrated rural health with the Saskatchewan Health Authority. The home care committees would be made up of various classifications of licensed providers, primarily nursing, so registered nurses and registered psychiatric nurses. But there also would be representation representing therapies, predominantly occupational health therapy and physiotherapy. And then there

also would be representation of social work. So essentially the scope and the range of services that would be provided to home care clients would be represented on that committee.

Ms. Ritchie: — And the other part of that question was the scope of their agendas, the matters that they're discussing, and I guess the mandate for the committees, if you could sort of speak to that.

Ms. Earnshaw: — Well the mandate for those committees has really shifted to a provincial standardization. The committees would have had been mandated by their former regions to ensure consistency and application of care protocols across the former region. But really the work of those committees now that would sit under the new six integrated health areas would be really to be focused on standardization provincially.

I will tell you that the committees have been less focused on home care throughout the past, you know, 20-plus months simply because those primary health care committees in general have been very focused on, you know, things like prevention, immunization, etc. But that is the work of those committees to look at. Our care is access, so access to home care, is that standardized? And then, is the delivery of the care standardized provincially?

Ms. Ritchie: — I'm wondering how patient concerns might come to that committee, like what sort of input. Do patients or their representatives have any input?

Ms. Earnshaw: — They do, but it would be through the same advocacy of the patient. Each former region has got access to hear and bring forward patient concerns, which would be no different than if that concern was raising out of long-term care or acute care or any other community-based program.

Ms. Ritchie: — Thank you for that. No further questions, Mr. Chair.

The Chair: — Good questions. Any further questions? Not seeing any. Thanks for the work on this front. I'll welcome a motion to conclude consideration of chapter 35. Mr. Skoropad moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll move along, and I believe chapters 40 and 33 are going to be . . . They're related. One's the follow-up. They're going to be dealt with together. I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 40 of our 2019 report volume 2 on pages 303 to 308 and chapter 33 of our 2021 report volume 2 on pages 241 to 245 report the results of two follow-ups on our 2017 audit about processes to deliver provincially funded childhood immunizations in La Ronge and surrounding area.

[14:45]

By July 2021 the authority strengthened its processes to deliver provincially funded childhood immunizations in La Ronge and surrounding area by implementing each of the five recommendations we first made in 2017. We note that this follow-up audit did not include processes around delivering the COVID-19 vaccine.

While within La Ronge and surrounding area, we found the authority annually analyzes and reports on childhood immunization coverage rates by community and properly stores vaccines as required by the Saskatchewan Immunization Manual. The authority properly managed and protected its vaccine inventory by regularly reconciling its on-hand inventory to quantities recorded in its records and completing emergency event recovery plans. In addition it provided periodic reports to senior management on coverage rate information as it related to provincially funded childhood immunizations to help determine whether immunization services are effective — that is, providing the right level of services in the right locations. I will now pause for the committee's consideration.

The Chair: — Thank you very much for the presentation and the focus of the work. Thanks to the ministry for their work and for reporting out their efforts on this front. I'll kick it over to the deputy minister for brief comments and then open it up to the committee.

Mr. Hendricks: — Like the last chapter, all of the recommendations have been implemented, so we have no further comments.

The Chair: — Thank you very much for the implementation, the efforts on this front. It's certainly a real important area of work that impacts so many people's lives. Any questions from committee members with respect to these two chapters? Ms. Ritchie.

Ms. Ritchie: — Yes, thank you. I think as it relates to chapter 33, we see that regional versus provincial childhood coverage rates on page 245, that there is a lower than average rate of immunization for two-year-olds for pertussis and measles. What is SHA doing to increase those rates?

Mr. McLetchie: — I think we're doing a number of things. Predominantly there's work — because this area includes both a lot of Indigenous communities with services delivered by those First Nations as well as ours — there's work happening between the northern population health unit and the Northern Inter-Tribal Health Authority to basically kind of look at what are the causal agents kind of behind people or children not getting immunized. When they identify different communities with lower rates, they often kind of come up with strategies, working with local leaders to look and see how they can increase the uptake. They also will shift resources within kind of the northeast area 1 and 2 to meet the needs of the various communities to do sort of immunization pushes and that to improve the access for individuals who might not otherwise have good access.

Ms. Ritchie: — Maybe as a follow-up to that, and appreciating also that these recommendations have been implemented, can you speak to that more sort of in a systematic fashion? Like are there ranking and tracking and management oversight?

Mr. McLetchie: — Yeah. So basically on a monthly basis there's a review of immunizations that are due as well. Because every month new children that would hit the two-year mark would in a sense be eligible that weren't previously. And so the team reviews both who are the children that are coming on that

require immunization and how well have we done in the past month on immunizations that have occurred in that previous month. And based on that, the public health teams come up with strategies to try to continue to increase the number of vaccines that occur.

Ms. Ritchie: — And one final question. Has La Ronge and area, the SHA, dealt with staff absenteeism or shortages in the last year? And if so, can you expand on the impact, if any, on service delivery.

Mr. McLetchie: — Yes. There's been shortages of staff in the La Ronge area, in some ways impacted both by pressures with the pandemic where they've required more staff, particularly in the public health area to help with vaccination for COVID, and their process by which they've looked to say how did they meet the needs of the population as a whole. They tried to remain very consistent with that process in looking to say what's needed in the next month or weeks ahead in order to meet the needs of the broader population as it relates to immunization or other public health concerns.

Ms. Ritchie: — That's all the questions I have for now, Mr. Chair. Thank you.

The Chair: — Okay. Thank you for the questions. Any further questions? Not seeing any, again a reminder to anyone following along that we've had these recommendations fully considered at this table and scrutinized, and now we've had the report out on the actions that have, you know, caused the implementation to respond to these recommendations.

I'd welcome a motion to conclude consideration of chapters 40 and 33 respectively. Moved by Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's moved. We'll move along now to chapter 41, and I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 41 of our 2019 report volume 2, on pages 309 to 312, reports the results of our second follow-up of the Saskatchewan Health Authority's actions on three remaining recommendations we first made in 2015 about processes for the safe and timely discharge of hospital patients from its two acute care facilities in Regina: Pasqua Hospital and Regina General Hospital.

The authority implemented one recommendation and partially implemented the other two recommendations. By June 2019 the authority's two acute care facilities followed its policy of documenting its patient discharge instructions and discussing those instructions with patients before discharge. However, those two facilities often did not follow the authority's policy to conduct medication reconciliations before discharging patients. Only 2 of 30 patient files we tested contained completed medication reconciliation. These reconciliations help to reduce drug-related incidents. As of June 2019, the authority was in the process of automating medication reconciliations.

We also found those two facilities inconsistently documented consultations with health care providers in a central and comprehensive manner to facilitate a coordinated, informed approach to individual patient care. In our testing of 30 patient files, we found 27 files that required consultations with other health care providers but did not incorporate the results of documented consultations in the nursing care plan. Rather, the patient files only noted that the consultations occurred. Consistently documenting consultations between health care providers in one central location — for example, nursing care plans — provides complete information to help health care professionals make informed decisions about a patient's care while in hospital and promotes a coordinated approach to patient care.

I will now pause for the committee's consideration.

The Chair: — Thank you very much for the follow-up and the report. I'll turn it over to the deputy minister and then open it up for questions.

Mr. Hendricks: — So the first recommendation, on page 310, the SHA has partially implemented that recommendation. The SHA, Regina area, is in the process of implementing the accountable care unit model of care at the Regina General Hospital. Next steps include formalizing physician commitment to participate in daily multidisciplinary rounds at the patients' bedside, resulting in patients and families being part of an understanding of the daily care plan.

The second recommendation, on page 311, the SHA considers implemented. Medication reconciliation has been implemented on all medical and surgical in-patient units in Regina. Processes are consistent with Accreditation Canada requirements. And then the third recommendation, on page 312, I think the auditor acknowledges it's implemented.

The Chair: — Thank you very much for the presentation, for all the work. I'll open it up if there's any questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. So as it relates to the first outstanding recommendation and the accountable care unit model of care, it's mentioned that there's still the need to formalize physician commitment to participate in this daily multidisciplinary rounds at patients' bedsides. And I apologize, I know probably this has been discussed at previous committee meetings, but just given the status of where that's at, what's needed to sort of move that to completion? Or what might be getting in the way of moving that to completion?

Ms. Garratt: — Sharon Garratt. I'm the vice-president of integrated urban health and the chief nursing officer in the Saskatchewan Health Authority. The model of care that's described is an integrated, team-based model of care. So in order to have the physicians present on the unit, we have set up teams of physicians, and they're rostered and contracted. So there has been work under way over the last couple of years to finalize the contracts to support the physicians to be engaged in the units with the teams. So that's the work that's been under way, and it has taken us a bit longer to implement at the General Hospital with COVID, as the physicians were engaged in COVID care versus working, moving forward with the model of care.

Ms. Ritchie: — So are you suggesting that, or is it the case that it's a contractual negotiation issue that is needing to be resolved?

Ms. Garratt: — It's a model-of-care change. So there's work with the physicians and the integrated team to finalize the model and then ensure that the contracts are integrated with and aligned with the model. So it's a two-part process.

Ms. Ritchie: — I see. Okay. You have December of this year as the deadline or date for completion. All things considered, how is that anticipated to be completed within that time?

Ms. Garratt: — Yes, I believe it should be.

Ms. Ritchie: — Okay. All right. I did have a few other quick questions I wanted to ask on a few other points.

So on page 311 I'm just looking for an update on the move to electronic health records. The auditor noted in June 2019 that the SHA had not decided when it would make this move, so I'm just wondering where that's currently at.

Ms. Garratt: — So the SHA independently can't move to an electronic health record. So we work with our partners at the ministry and eHealth to support rolling out of an electronic health record within the health system and across the health system.

Mr. Hendricks: — There is a budget proposal that has been submitted by the SHA. The move to an electronic health record in our acute care facilities is a massive IT project from both, I guess, a complexity and a cost perspective. So it will undergo the budget review process and we'll see where it ends up.

Ms. Ritchie: — Well okay. I think I'm going to just leave that there. That sounds like it could be a fairly long discussion. Maybe we'll get some follow-up at a later point. As it relates to the expansion of . . . No, I think I'll scratch that one.

Just in terms of the pandemic, what changes, if any, have staff made to ensure patients are discharged in a safe and timely manner?

Ms. Garratt: — The process to ensure safe and timely discharge wouldn't change due to the pandemic. So what you've seen described as the work is the same work. So our teams continue to communicate with families, do team-based rounds where patients and families are there and ensure that they're aware of the discharge plan and have written communication to follow up. So the recommendations that you see here, that work continues, and we would apply those same processes to safe, timely discharge during COVID as we would if we didn't have COVID.

Ms. Ritchie: — Right. So in the current state with hospital capacity, can you tell us what current capacity levels are at the Regina hospitals?

[15:00]

Ms. Garratt: — At the Regina hospitals today — we get daily reports — they are at, I guess, at a reasonable capacity. They had a small number of individuals waiting for beds this morning that I was aware of, so the hospitals are full. We continue to transition patients onto units, care for them, and transition them to other areas of care on an ongoing basis.

Ms. Ritchie: — And when you say the hospitals are full, I think I've heard numbers reported by percentages and sometimes even over 100 per cent. Can you tell us what that percentage would be today?

Ms. Garratt: — If I could get my phone, I can tell you the report from this morning. Is that . . .

Ms. Ritchie: — Thank you.

Ms. Garratt: — It might take me a minute to find the . . . So at noon today — we talk about the geographically protected beds which would be most of our medical and surgical beds — the Regina General Hospital was at 87 per cent occupancy and the Pasqua Hospital was at 102 per cent occupancy.

Ms. Ritchie: — Thank you very much. No further questions, Mr. Chair.

The Chair: — Thanks for the follow-up questions as well. Any further questions? Not seeing any, I would welcome a motion to concur and conclude consideration of chapter 41. Moved by Mr. Goudy. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll move along to chapter 24, and I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 24 of our 2020 report volume 1, on pages 245 to 246, report the results of our follow-up of the Saskatchewan Health Authority's actions on the last outstanding recommendation from our 2013 audit about processes used to manage and administer medications in the Weyburn General Hospital and St. Joseph's Hospital in Estevan.

The authority implemented our last recommendation. As of November 2019 we found the authority consistently records and reviews patient medication profiles before administering medication to patients within its Weyburn and Estevan hospitals. A medication profile includes a patient's name, gender, age, known allergies, and a comprehensive list of medications taken in the past. This supports giving each hospital patient the right medication at the right dosage.

I will now pause for the committee's consideration.

The Chair: — Thank you for the follow-up and the presentation. I'll turn it over to Deputy Minister Hendricks and then open it up for questions.

Mr. Hendricks: — Nothing to add. This recommendation has been implemented as noted by the Provincial Auditor.

The Chair: — Thanks for the work and thanks for reporting that out. Questions? Ms. Ritchie.

Ms. Ritchie: — No, my apologies. No questions.

The Chair: — A bit of a hair-trigger on the questions, but I can understand how you'd kind of get into habit with these, and very good questions through the day. Not seeing any other questions at this point, I would welcome a motion to conclude consideration of chapter 24. Mr. Friesen. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That is carried. And I'll turn it over to the Provincial Auditor to focus in on chapter 25 of the 2020 report volume 1.

Ms. Lowe: — Chapter 25 of our 2020 report volume 1, on pages 247 to 255, reports the results of our first follow-up of the Saskatchewan Health Authority's actions on seven recommendations we made in 2017 about the efficient use of magnetic resonance imaging, MRI, services in Regina. By January 2020 we found the authority implemented three recommendations and made progress on the other four recommendations.

We found the authority developed work standards to have staff track the actual completion dates of each stage of MRI services and reasons for rescheduling MRI appointments in its IT system. The authority also implemented an audit process to validate the accuracy of data in that system. We found the authority began to regularly analyze MRI volume data on a weekly and monthly basis to identify significant patient waits for MRI services, but more work remains.

Consistent with previous years, the authority did not meet demand for MRI scans in 2019 in Regina, which resulted in patients waiting more days than the MRI guidelines suggest. For example, there were 143 patients waiting more than three months for an MRI scan at December 31st, 2019. The authority needs to analyze the dates of the different stages of MRI services that it now tracks to determine causes and ways to address significant delays.

The authority did not yet formally assess the quality of MRI interpretations radiologists provide. However we found the authority began working with eHealth to develop an IT system to help assess the quality of radiologist interpretations of MRI scans. It plans to use this system to have formal peer reviews of their scans performed.

While we found the authority appropriately monitored the selection and volume of MRI scans sent to contracted licensed private operators, it had not yet developed a process to monitor the timeliness and quality of MRI scans performed by these operators.

The authority requires private operators to follow the wait-time guidelines for public MRI scans. Under the one-for-one model, a private operator is to schedule a second scan within 14 days after completing the privately paid scan. We tested 10 scans provided by private operators and found three scans where a private operator took longer than the 14-day requirement. Lack of timely MRI scans performed at private operators may indicate a concern with the prioritization methods or capacity. This impacts how long patients are waiting for MRI services.

Once the authority implements processes to assess the timeliness and quality of all MRI scans, it needs to determine the nature and timing of additional information senior management and the board will need to receive to better monitor MRI service delivery. Having timely and quality MRI service delivery alleviates patient stress, avoids unnecessary referrals, and reduces costs. It also facilitates timely and appropriate diagnosis or treatment to help improve patient outcomes.

I will now pause for the committee's considerations.

The Chair: — Thank you for the work, the follow-up, and the presentation. I'll open it up to the deputy minister for comments and then to the committee.

Mr. Hendricks: — Okay, thank you. First of all, I believe Mr. Miller has a clarification on something earlier, Mr. Chair.

Mr. Miller: — Yes, Mr. Chair, I'd just like to address to the committee on chapter 39, the ground ambulance service, the example that I used, I used the wrong numbers. So my apologies, ma'am. On the rural response for emergencies is not 9 minutes and 59 seconds; it's 29 minutes and 59 seconds. So my apologies. I don't think it changes . . . The difference would still be plus the 15 minutes to drive that distance, but I just wanted to make sure that that clarification was given. My apologies.

The Chair: — Thanks so much for correcting that information. And I'll open it up to . . . Deputy Minister, do you have some comments at this time?

Mr. Hendricks: — Yes, just a couple. So the Provincial Auditor has acknowledged that recommendations 1 and 2 on page 249 are implemented. The third recommendation on page 250, the SHA views this as implemented. Robust weekly reporting of MRI services is provided to operational leaders on a weekly basis to allow real-time changes to be made to address concerns. This reporting includes analysis of the nature and causes of the wait times and is being continually reviewed and enhanced via an iterative evaluation process. And then reporting for senior leaders is provided on a monthly basis using reporting created by the Ministry of Health in collaboration with the SHA.

Recommendation no. 4 on page 252, the SHA views this as partially implemented. The SHA and radiologists are developing a peer learning program that will be dependent on technology updates to the provincial information system. Although this initiative is a priority for the SHA, the implementation of peer and learning review systems has been delayed from the targeted, and is now targeted for implementation on March 31st, 2023.

The fifth recommendation, on page 252, the auditor has acknowledged is implemented. The sixth recommendation, on page 254, the SHA believes is partially implemented. Monthly analysis reports on MRI services, including contract to private services, are provided to operational and senior leaders. The report is continually being reviewed and enhanced through an iterative evaluation process, and the enhancements will be implemented and this recommendation are expected to be in place by the end of 2022.

The seventh recommendation, on page 254, the SHA believes is implemented. Monthly and weekly analysis reports on MRI services are provided to senior leadership. Since SHA's amalgamation in 2017, reporting of these types of reports are submitted to senior management rather than to the board. That concludes my remarks.

The Chair: — Okay. Thank you for the work. Thank you for the presentation. And I'll open it up now to the committee for

questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. So I've got a few questions here on some of the partially implemented recommendations, and I just note that the peer learning program is awaiting or is dependent on some technology updates to the system. I presume that's through eHealth. Okay, yeah. Yeah, maybe you could just help me understand what the delay or what are the things that could affect that moving forward.

Mr. Miller: — Corey Miller, vice-president of provincial programs again. The peer learning is a way in which the radiologist will reread something that's already been read by one of their peers, and it would be a percentage of the total number that are done. It will require some software changes to our PACS as well as our RIS [radiology information system] system, so that will require IT support.

I would stress, because I think this is an important point, that oversight and quality . . . There is a process through the College of Physicians and Surgeons of Saskatchewan through what we call the ACMI committee, which is the Advisory Committee on Medical Imaging, where they do grant the licence for private clinics but they also do review of the radiologists' quality of work.

But would agree fully with the auditor's recommendation that the more we can do quality rechecks of peers, et cetera, in a professional manner, that's how we build a culture of quality, where people can review each other and have a process to give feedback to a peer. That's what we're looking to promote. But I will give you assurances there are oversights of quality through the College of Physicians and Surgeons of Saskatchewan. This will be supernumerary to that.

Ms. Ritchie: — Okay. And I appreciate that further context. Just sort of drilling down though a little bit here, what is the nature of the technology updates that need to be performed?

Mr. Miller: — So what it will do, it will create a work list for the re-review. So the peer review system . . . Our radiologists read, whether it be an MRI, X-ray, CT [computerized tomography], on a workstation and they have a work list that they read through. A peer review would be a separate work list that somebody is assigned today that will be a reread of a percentage, whatever the department and us decide is the percentage that should be reread from a peer perspective.

So it'll be the creation of a work list in the PACS system and in our radiology information system so that we can track and report the percentages of the peer review. So that's what we're looking to build into the software of both the radiology information system as well as the picture archive communication system.

Ms. Ritchie: — So you're saying that there isn't an app for that presently?

Mr. Miller: — Like we would want to build it into the existing workflow that the radiologists do. So some of them might be scheduled this morning in CT or in MR [magnetic resonance] or in ultrasound. There would be a peer review period where they would take their turn each in the schedule, where they would be doing peer review.

Ms. Ritchie: — Okay. That was actually a poor attempt at a joke.

The Chair: — I got it.

[15:15]

Ms. Ritchie: — Okay. Okay, thank you. A couple of other quick rapid-fires here. What is the current wait-list to access MRIs in Saskatchewan and the average number of people on the wait-list for previous years going back to 2018?

Mr. Wyatt: — Hi. Mark Wyatt, assistant deputy minister. So in Regina right now the average wait-list, based on data up to December 2021, for a patient who received an MRI was 77 days. And if you were to look at sort of the 90th percentile, which is another way that we will often measure, 90 per cent of patients received their MRIs in Regina within 188 days.

Right now Regina is comparable in terms of the number of patients waiting for an MRI at 4,980 which is just slightly above Saskatoon. But of interest, the number of patients who are waiting greater than 90 days is significantly lower at 1,917 which is about 700 below where Saskatoon is at. So we are seeing wait-time numbers performance in terms of the number of patients waiting over certain periods of time actually in a better position in Regina than what we would see in Saskatoon right now.

Ms. Ritchie: — How many private operators of MRI services are there in Saskatchewan?

Mr. Wyatt: — You would have . . . [inaudible interjection] . . . four? Okay.

Mr. Miller: — There's four clinics. There's four clinics, three providers.

Ms. Ritchie: — Private clinics?

Mr. Miller: — Correct.

Ms. Ritchie: — And versus . . .

Mr. Miller: — Publicly administrated, privately delivered. So we give them the patients, funded from our . . . through contracts.

Ms. Ritchie: — Okay. Thank you. And what is that compared to the number of public clinics?

Mr. Miller: — So in Saskatoon there are four MRIs in the hospitals: one at St. Paul's, one at City, two at RUH [Royal University Hospital]. There's one at the Moose Jaw Hospital, and there's two at the General Hospital in Regina.

Ms. Ritchie: — Okay. I greatly appreciated timely access to those services when my daughter fell and bumped her head on the playground when she was small, and it can be very scary. There's a whole range of reasons people, I understand, use MRIs but I know I certainly appreciated having that timely access. That was many years ago now, but these questions are making me think of that.

So can you expand on how the pandemic has impacted delivery of MRIs in Saskatchewan?

Mr. Miller: — Yes. For sure. I mean it touches a little bit on what you questioned us this morning and one of the comments that you made where people haven't accessed health care in the way that they should have, or because people were at home and not accessing primary care and their family physician the way they would have.

So we actually saw a reduction in the amount of referrals for many of our imaging modalities. I'm quite proud to say I think our imaging facilities within our health care did a great job of continuing to move and do urgent and semi-urgent patients. We did see reductions. The process of doing imaging throughout COVID was impacted with socially distancing, right? We've leaned our processes. We have waiting rooms which we now had to separate patients.

But I would say, all in all, the health care system certainly saw a reduction in our referrals and a small reduction in our throughputs of our imaging. But I will say, you know, as COVID has drawn out and patients have been going to their specialists, we've certainly seen a larger increase over the last six months of referrals for specialty imaging tests. For sure we've seen an increase.

Mr. Wyatt: — I can maybe just add one thing to that. When it comes to wait times, it was interesting because you saw the reduction in the number of new referrals coming in, and particularly elective referrals during that first sort of three, four months in the spring of 2020.

The wait times actually dramatically dropped in terms of how quickly people were getting their MRIs because you were dealing primarily with higher urgency cases. And then as the services ramped up, what you then saw was the wait times increasing because people who had been waiting for whatever amount of time, plus with no or very few elective cases going through during that spring of 2020.

Then you saw the wait times that people were . . . you know, the time that they had waited to get their MRI jumping pretty significantly. And then since then we have both, by virtue, as Corey said, in restoring service levels but also investing in some . . . an in-year investment that was provided last year to increase the number of CTs and MRIs in both public and private facilities has also helped to really stabilize the wait times. And that sort of takes us to where we are today.

Ms. Ritchie: — Okay, well that's good to know. And maybe just one follow-up on that. If you could speak to the systems that are in place to sort of help with, yeah, the prioritization and managing those service loads.

Mr. Miller: — Yeah, I can speak to that. So similar to the laboratory examples that we gave this morning, we receive requisitions from referring clinicians from all over the province which have a prioritization referral. They're also reviewed by our radiologists and prioritized. So they're reviewed by the clinical team and then placed into the urgency — level 1, 2, 3, 4 — and a level 1 is emergent. There really isn't a wait. It's the next available time we can get them reasonably in onto one of the tables. So that's how the prioritization process works.

Ms. Ritchie: — Okay, thank you for that. Finally, so in the status update, the SHA will regularly monitor private MRI operators as of December 31st. Can you expand on kind of what this will look like? What the plan will actually be?

Mr. Miller: — Can you repeat? I'm not sure I follow your question.

Ms. Ritchie: — I'm sorry. Yeah, I may have done a poor job of asking it. So section 3.5 and if you can, just . . .

Mr. Miller: — What page?

Ms. Ritchie: — 254.

Mr. Miller: — So I mean I can just explain to you as the leader of provincial programs, it includes medical imaging. On a monthly basis we review it with the leadership team of imaging, so the executive director and directors of imaging from around the province. We go through our wait times which includes the services now that are being contracted out to the private facilities. So that's part of that review that they provide to us. But I will say they're continually reviewing those data and making adjustments.

And you know, I think it's important to understand we hear about our MRI wait times every day. We have daily huddles with our teams and it's almost on a daily basis that we hear about the in-patient pressures for MRI. And that's why our out-patient partners are so important in the delivery of this. It's not uncommon for us to have . . . We have a computer monitor. We call it the whiteboard, but it's really an electronic monitor that's monitoring the amount of in-patients that are awaiting imaging. And that's reported on a daily basis to myself and Dr. Babyn as the leaders and responsible for those because it's important.

Those patients are waiting for testing which might be allowing them to be discharged or allowing a disposition for further care as needed. But the private facilities, the work that they do with us and for us is reported to us just like it is with our own facilities now because they're important partners of ours.

Ms. Ritchie: — Okay. Thank you for that. No further questions, Mr. Chair.

The Chair: — Important questions. And thanks for all the work on this front. These services are so critical to folks. I see Deputy Chair Young has a question.

Ms. C. Young: — Is there a certain percentage every year of out-of-province referrals to MRI? And if so, what would that percentage be?

Mr. Miller: — That's a good question. I can't think of a whole lot of procedures that we would refer out of province anymore. I think . . .

Ms. C. Young: — More coming in is what more, like . . .

Mr. Miller: — I mean on the Alberta side, certainly we get spillover from the Lloydminster and adjacent area. But I mean, we have people travelling through our province who require emergency care all the time.

Ms. C. Young: — Right.

Mr. Miller: — And that's for certain. We certainly get lots of referrals in from Flin Flon, from that Hanson Lake highway way. But I wouldn't see we see a huge amount of out-of-province referrals in for services within our buildings. It's not a major complement.

Ms. C. Young: — Okay. Thank you.

The Chair: — Not seeing any further questions on this chapter, I would welcome a motion to conclude consideration of chapter 25. Looking for a hand or a nod. Oh, Mr. Goudy. Boy, he's quick there. That's moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — All right. That's carried. We'll move along now to chapter 26.

Ms. Lowe: — Chapter 26 of our 2020 report volume 1 on pages 257 to 258 reports the result of our fourth follow-up of the Saskatchewan Health Authority's actions on the last remaining recommendation from our 2010 audit about processes to maintain medical equipment within health care facilities in Melfort and surrounding area. The authority implemented our last recommendation.

By November 2019, we found the authority maintained medical equipment within health care facilities located in Melfort and surrounding area within reasonable time frames and in accordance with manufacturer's requirements. In addition, future maintenance schedules set out in its IT maintenance system aligned with manufacturers' maintenance requirements. This decreases the risk of equipment not working properly or safely.

I will now pause for the committee's consideration.

The Chair: — Thanks for the presentation. Thanks for the update. I'll flip it over to officials if they care to offer brief comment, and we'll go from there.

Ms. Morrissette: — Thank you. As this one is implemented, no further comments from the ministry. Thank you.

The Chair: — What a great report. I'll open it up to the table for questions. Not seeing any there either.

Mr. Goudy: — No, no problems in Melfort.

The Chair: — I think the MLA for Melfort's trying to take credit over here. Not seeing any questions, I'd welcome a motion to conclude consideration of chapter 26. Moved by the member from Melfort, Mr. Todd Goudy. And all agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay, that's carried. We'll move along to chapter 27. There's a bit more to this presentation.

Ms. Lowe: — Chapter 27 of our 2020 report volume 1 on pages 259 to 262 reports the results of our second follow-up of the Saskatchewan Health Authority's actions on seven remaining recommendations from our 2014 audit of processes related to medication management in long-term facilities located in Kindersley and surrounding area.

By December 2019 the authority improved several processes for managing medication plans for long-term care residents in facilities located in Kindersley and surrounding area. We found it implemented five of the seven remaining recommendations we made in 2014.

The authority improved documentation in its residents' files by including quarterly medication reviews, prescription changes, and nurses' notes. This documentation decreases the risk of patients receiving incorrect medications, dosages, and frequency.

The authority also established processes to identify trends and issues related to medication management. It summarizes medication incident reports centrally for facility managers to identify trends in medication incidents and create targeted training to correct the incidents. For example, the authority identified fentanyl patch incidents where extra patches were found on residents and as a result delivered training to staff. In addition, the authority initiated the process to assess the appropriateness of antipsychotic prescriptions given to residents.

[15:30]

The authority still needs to document informed consent from long-term care residents or their designated decision makers for the use of medication as a restraint or when changes to high-risk medications are made. We found 47 per cent of the 17 resident files tested where medication was used as a restraint did not have informed consent on the file, while 31 per cent of the 13 resident files tested with changes to high-risk medications did not have documentation to support that decision makers or residents were informed. Decision makers or residents should be aware if medication is used as a restraint or has changed, as medication can significantly impact a resident's quality of life.

I will now pause for the committee's consideration.

The Chair: — Thank you for the focus in this work and then all the follow-up as well and of course all the actions that are reported out towards implementation here. I'm looking for any comments from officials, and we'll open it up.

Ms. Morrissette: — Thank you. We'll do a quick status update on this one. So for the first three recommendations, found on page 260, as noted by the auditor, these recommendations have been implemented. The SHA does utilize a multidisciplinary team approach to complete quarterly reviews of medications of residents in long-term care facilities located in Kindersley and surrounding area. Resident files include information on quarterly medication reviews, medication administration records, prescription changes, and as noted by the auditor, notes from the nurses.

With respect to the fourth recommendation, found on page 261, the SHA considers this recommendation implemented. A new education program was rolled out in 2020 to all registered nurses and licensed practical nurses for the least-restraint and consent for high-risk medication policies.

With respect to the fifth recommendation, found on page 261, the SHA considers this recommendation implemented as well. Staff are following a policy that was created that requires informed written consent from long-term care residents or their designated decision makers for changes in high-risk medication.

For recommendation no. 6, the Provincial Auditor has noted this recommendation has been implemented so no further comments there. Similarly for recommendation no. 7, no further comments on that one. Thank you.

The Chair: — Thanks again to all that have been involved in this very important work and to bringing about this change. I'd open it up for questions if there are any. Ms. Ritchie.

Ms. Ritchie: — Thank you. Thank you. I'm just taking a moment to catch up here. So just for clarification maybe to start with, the status of recommendations in the report on page 261 indicates that the two recommendations related to obtaining informed written consent not being implemented, but are you indicating that it has indeed been now?

Ms. Earnshaw: — Yes.

Ms. Ritchie: — Okay. Okay, great. Just wanted to make sure I had heard correctly on that point. So in that case I have no further questions. Thank you.

The Chair: — Thank you for the questions and the clarifications. Any further questions from folks with respect to chapter 27? Not seeing any, I'd welcome a motion to conclude consideration. Deputy Chair Young moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — All right. That's carried. We'll move along now to chapter 28 of the 2020 report volume 1, and I'll kick it over to the Provincial Auditor.

Ms. Lowe: — Chapter 28 of our 2020 report volume 1 on pages 263 to 267 reports the results of our first follow-up of Saskatchewan Health Authority's actions on five recommendations we made in 2017 about processes to minimize employee absenteeism in Kindersley and surrounding area.

By November 2019, we found the authority implemented one recommendation. It implemented a checklist for managers in Kindersley and surrounding area to use in meetings with employees who have excessive absenteeism. However additional work remains on the other four recommendations.

We found the authority is in the early stages of expanding the role of human resources staff in promoting employee attendance. Involving human resources personnel is a way to reduce the workload for managers responsible for managing staff attendance. Human resources personnel can provide more timely absenteeism management, particularly when a large number of employees have excessive absenteeism. Authority management indicated a plan to implement a new electronic case management system in 2020-21 to better support attendance management. However we note the capacity of human resources personnel must be reasonable to provide necessary support.

We also found managers in health care facilities in Kindersley and surrounding area are not consistently documenting meetings with employees who have excessive absenteeism. For each of the seven employees with excessive absenteeism tested, we found the related manager did not complete a meeting checklist or alternate form of documentation to document discussions with or actions taken to address the absence.

Finally we found the authority's analysis in reporting on employee absenteeism remained virtually unchanged from our original 2017 audit. The authority's manual system in place does not collect sufficient data to complete adequate analysis. It has not yet gathered more information or performed analysis to enable periodic reports of its actions and progress in addressing the causes of employee absenteeism. Collecting necessary data and analyzing causes of absences would assist in the development and reporting of strategies to reduce employee absenteeism. Effectively managing absenteeism contributes to quality service delivery to the public, minimizes costs, and supports the well-being of employees.

And I will now pause for the committee's consideration.

The Chair: — Thanks so much for the report and the follow-up. And we've welcomed some new officials to the room. Just a reminder for all new officials or those that haven't been to the table, when you come just state your name before you speak. I'll flip it over to the DM for brief remarks and then we'll open it up.

Mr. Hendricks: — Sure. So recommendation no. 1, on page 264. This is partially implemented, or the SHA considers this recommendation partially implemented. Beginning in April 2018, the ability management coordinator within human resources was providing monthly reports on employees whose sick time exceeds the regional average, to managers for review and follow-up.

This functionality will be embedded in the administrative information management system development phase 2. Given there is not a timeline established for phase 2 implementation, the SHA will begin this analysis manually. This work has been paused throughout the pandemic to focus on accommodations work and redeploying staff to meet operational needs.

Recommendation no. 2, on page 265. As the auditor noted, this has been implemented.

Recommendation no. 3, on page 266, is partially implemented. Beginning December 2017, managers are expected to provide copies of the formal meeting guides to the ability management coordinator as evidence of the meetings. The coordinator was reviewing the completed guides and provides coaching to managers as required; however, this was paused due to COVID-19.

Recommendation no. 4, on page 266. The SHA considers this recommendation partially implemented. This will be addressed as part of the administrative information management system development where attendance support is planned for phase 2 of the project. The SHA will update processes to improve documentation of decisions to place an employee in an attendance support program or not, as well as documentation showing the types of supports offered and follow-up expected in

an action plan for the employee.

COVID-19 shifted SHA priorities in much of the AIMS project. As well as the majority of attendance support has remained paused during the past six months in order to shift resources to the COVID-19 response. As a result there will be no meaningful progress on this recommendation. Work will resume once AIMS is implemented. This functionality will be embedded in AIMS in development phase 2. Given that there is not a timeline established for phase 2, the SHA will undertake this manually.

Recommendation no. 5, on page 267. This is partially implemented again. The attendance management module of the new administrative management system will greatly improve the SHA's ability to report on attendance metrics, and a reporting framework will be developed as part of the process. Work to implement this recommendation was delayed due to COVID-19 and will resume once AIMS is implemented. We expect to be able to produce the report for the board once phase 1 of the AIMS is implemented. That concludes my remarks.

The Chair: — Thanks for the report and all of the work on this front. I'll open it up to the committee for questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. So yeah, I appreciate that the pandemic has gotten in the way of moving forward with the auditor's recommendations. And of course, you know, the capacity issues around health care workers throughout the pandemic is also duly noted. Certainly it's been a tremendously challenging time and other, I guess, pressures on the system as they relate to issues around sick leave. So just wanted to kind of note that situation.

But I guess, you know, it does also speak to some long-standing health care staffing issues prior to the pandemic. And maybe just a starting point, if you could provide a current status update in terms of the situation as it relates to absenteeisms and whatever those . . . I think I heard mention of some sort of maybe a threshold for when some sort of, you know, remediation is needed and where things are standing in relation to those targets right at the current time.

Mr. Matthies: — Kyle Matthies, executive director of organizational development and employee wellness with the Saskatchewan Health Authority. In terms of sick time throughout the pandemic, I'll just quickly go through the last few years: 2019-20 we averaged 84.1 hours per FTE; '19-20, 84.33; and in '20-21, the first year of the pandemic, 63.95; and as of '21-22 quarter 3, we're at 55.58. So over the course of the pandemic, we've actually seen a decrease in sick time amongst health care workers.

Probably a number of different factors at play there. With the reduction in surgeries in the health care system, we wouldn't have people leaving for surgeries like we would normally have. Likely the increase of PPE amongst health care workers probably played a factor here as well, and then just the remarkable dedication of our health care staff to be at work throughout the pandemic, supporting the citizens of Saskatchewan.

Ms. Ritchie: — In terms of the causes of the absenteeism, you know, going back to the time of the audit and forward to now, can you just speak to how that issue is understood? Have you been able to do any sort of data analysis? I know that was recommended as part of the recommendations. But generally want to just, kind of, hear your view on what the nature of the issue is.

Mr. Matthies: — I think, like we've responded in the report, until we have . . . We're still operating with 12 different systems capturing that data, and so to have any sort of a roll-up of that information, our plan is to wait for AIMS to be in place. Or we need to wait for AIMS to be in place to have a consistent case management approach that would give us that data. So I don't have an answer for you currently.

Ms. Ritchie: — But surely you must have some sense from what you're hearing from managers and staff.

Mr. Hendricks: — Yeah, I can maybe start. So I think prior to the pandemic, obviously our sick leave numbers are concerning in terms of our ability to manage the system. So there are a variety of factors.

Obviously, as health care workers, you're in an environment that exposes you to various things and so naturally, you know, there's probably a higher tendency for illness, and also the health care environment isn't without its stresses either.

And so obviously sometimes, a health care worker, you know, there will be other issues. Some of it will be WCB [Workers' Compensation Board]-related, some will be related to, you know, overtime. Obviously there are issues around workload and that sort of thing. But then, you know, there are employees, as there are in any sector, who treat sick time differently and don't use it only for sick time. And so those are the ones that I think need to probably be managed. And you know, I think the system will help us to more effectively manage those situations. I wouldn't say that they're regular ones, but you know, certainly there are those cases. So who would that be, that would . . .

[15:45]

Mr. Matthies: — All be accurate, yeah.

Ms. Ritchie: — And then in terms of, yeah, the added stress of working through the pandemic, it seems like perhaps it's kind of gone the other way, where perhaps people have had need for a stress day or, you know, a day off that haven't been able to take it. Because I mean obviously it sounds like those numbers have come down quite a bit, so it seems like you've kind of got the opposite issue, maybe, on the table now. I just wonder if you want to sort of speak to that.

Mr. Matthies: — Yeah, I would say for better or for worse, those numbers have come down. And again I think that there's a lot of factors at play there. One of them of course is that our health care workers are exceptionally dedicated throughout the COVID pandemic. That said, I think I'm concerned for our employees post-pandemic, and the mental health needs that we'll be facing at that time. We've been doing a lot of work to support our employees throughout the pandemic, supporting our leaders to better support their staff, but this is an area of concern for us and our organization for sure, and our health care organizations across the country as well.

So while it's good to see the dip in sick time, I don't think that's indicative of there not being concerns related to mental health amongst our staff.

Ms. Ritchie: — And so, given that sort of changing situation, then how is management responding and preparing for that eventuality?

Mr. Matthies: — Well there's probably been a few blessings related to COVID, but this has been one area where we've been able to put more focus. There's been more of a pronounced need for this, so we're doing a lot of work with our management team across the board, helping them to understand the mental health needs of their staff. We're doing a lot of promotion of the various supports that staff have access to, whether that's through our employee family assistance program, some of the other supports that we have available that they can access as they need to as well as their benefits program.

Recently we've begun providing mental health supports on site for staff, and that was in response to a lower uptake of the as-requested kinds of supports that we had available. And our thinking there was to eliminate any barriers to access that they might be having, perceived or real. And so in many of our major locations with ERs [emergency room] and ICUs, we've been having mental health supports available on site multiple days a week for our staff to take advantage of.

Ms. Ritchie: — Great. I want to acknowledge the fact that, I mean you've been operating through a crisis, and so under normal circumstances there'd be different capacity to monitor, adapt, adjust. With the current situation, you've kind of had to work under quite a bit of duress. And I appreciate, you know, the adjustments you've been making on the fly here through the on-site supports and so forth that you've mentioned.

But kind of putting my auditor hat on, I'm just wondering . . . You know, it's not really my job, but I do try my best in an unofficial capacity. I do want to ask the question in terms of what kinds of management processes are you using to kind of have that ongoing monitoring and tracking and adjustment to meet those employee needs? It's kind of flipped from absenteeism to something else but I think it bears the question.

Mr. Matthies: — Yeah, I appreciate the way you phrased that. I think it's an extension of the same, for many of our staff members who have excessive absenteeism, that we treat them as whole people. And there's invariably mental health-related issues at play when people are away from work excessively. So your question was . . . Sorry, I've lost sight of your question there.

Ms. Ritchie: — Sure. I was putting my auditor hat on.

Mr. Matthies: — I remember that part.

Ms. Ritchie: — Yeah. And so the question was more about, you know, sort of the system approach and the management reporting, the governance piece.

Mr. Hendricks: — Yeah. Earlier this week actually, Andrew and a few of his senior leaders and my ADM [assistant deputy minister] sat down and went over their Q4 [fourth quarter] priorities for this year, but also their priorities going into next year. And I think as a ministry and as a DM, I was pleased to see one of their number one priorities was basically the health of their staff. And so they have a number of initiatives that are training managers, you know, some interactively through online things, but to recognize stress and mental health amongst their employees and even amongst themselves.

And then going forward, you know, during the pandemic as Kyle mentioned, there were initiatives where we did go into the workplace to provide support to workers who might be experiencing stress in the workplace. But we recognize that that's not going to end right away, and that many of the, I guess, after-effects of the pandemic will linger for months, in some cases probably years.

And so we're also going into another busy period too here, where we have a health system who's been through one stress test, and we're putting it back out there again because we have huge wait-lists that have evolved during the pandemic, and pent-up services. So we need to focus heavily, and we're working with the SHA on this because they're taking care of the folks that we've got.

But also one of the challenges through the pandemic has been — and it's pan-Canadian; it's actually an international problem — is our whole HHR [health human resources] capacity. And so we're looking at strategies to bring additional workers in, to recruit more people. Nobody likes to work short-shifted, you know, and there were certain areas that put extreme pressure on people and on certain professions.

And so I think it's part of a comprehensive strategy that we're focused on with the SHA to try and alleviate some of this pressure coming out of this pandemic. Like I said, you know, looking after the workforce that's there, and who's done amazing work, but also bringing in the cavalry to help them out over the next several months.

Ms. Ritchie: — Thank you for that. Yes, part of my concern or question here is around, you know, the things that might get in the way of responding to these changing needs and to recognizing you're sort of on the other end of the spectrum with the issues facing health care workers. Is there anything further to add in terms of what might get in the way of addressing the needs and changing dynamic?

Mr. Hendricks: —You know, I think our biggest challenge obviously will be in the near term. You know, these solutions won't happen overnight that will immediately address the pressures on our workforce. And so we need to be mindful of that and we need to — and you know, Andrew can maybe speak more to this, or Kyle — we need to have strategies in place to maintain the health of our workforce and not to push them too, too far.

But you know, on the recruitment and retention front we can do some things that are immediate but, to be blunt, these will take some time to address some of these issues because we're competing nationally and internationally, as I mentioned. And some of it's around, you know, do we have enough training capacity, that sort of thing, and certain programs. And so there's a fairly long lead time to educate some health professionals.

And you know, we can look at international recruitment and who

we have here who might be able to be trained up to provide certain services or, you know, I think there are people out there that have educational qualifications from other jurisdictions, that sort of thing that we can look at. But you know, I think some of the reality is that this is going to take some time to fully address.

Ms. Ritchie: — I can appreciate that. What I'm hearing is, you know, attract and retain in a highly competitive environment coming out of the pandemic. So appreciate that insight. No further questions.

The Chair: — Any further questions from folks around the table? Certainly a real thoughtful exchange. I just want to say I really appreciate some of the remarks I'm hearing from leadership around the recognition of the whole person and the sacrifice and pressure and mental health and wellness of the legions of health care workers and professionals across this province. I think making sure that, you know, that's supported is really going to be critical moving forward. So I just really appreciated sort of the language and the culture that I heard from leadership here today.

Not seeing any questions, I'll look for a motion to conclude consideration of chapter 28. Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. We'll move along to chapter 29, and I'll turn it over to our Provincial Auditor.

Ms. Lowe: — Chapter 29 of our 2020 report volume 1, on pages 269 to 276, reports the results of our first follow-up of the Saskatchewan Health Authority's actions on recommendations we made in 2017 about overseeing contracted special-care homes in Saskatoon and surrounding area.

By November 2019 we found the authority implemented one of the six recommendations we made in 2017. The authority, along with the Ministry of Health and contracted private operators of special-care homes, clarified accountability relationships between all three parties. We found the authority started working with private operators to develop a new template contract. The authority planned to finalize the template by March 31st, 2020 and start work on signing new contracts with the 16 special-care homes in Saskatoon and surrounding area. It's expected new contracts may be signed over several years as current contracts expire.

The authority clearly expects homes to provide quality care and follow the ministry's program guidelines for special-care homes. However, it had not redefined performance measures or service expectations on which it expects special-care homes to follow. It also was not yet inspecting special-care homes' compliance with the program guidelines. At November 2019 the authority was waiting for the Ministry of Health to complete its revision to the program guidelines before it takes additional steps to improve its oversight of contracted special-care homes. Necessary steps include defining the quality of services the authority expects homes to provide, assessing each home's compliance with those expectations and the ministry's guidelines, and addressing identified non-compliance to mitigate risks to residents within homes.

At the time of our follow-up, contracted homes in Saskatoon and surrounding area continue to have performance issues. For example, 10 of the 16 contracted homes in Saskatoon and surrounding area had more residents than expected fall within the last 30 days. Not having a process to assess whether contracted homes provide quality care and take timely actions when necessary puts the residents of contracted special-care homes at risk of not receiving quality services.

I'll now pause for the committee's consideration.

The Chair: — Thanks so much for this, you know, very important focus and the report here today. I'll open it up to Deputy Minister Hendricks and then we'll get at the questioning.

[16:00]

Mr. Hendricks — Recommendation no. 1, on page 271, as the auditor noted, is implemented. Recommendation no. 2, on page 271, the SHA believes is partially implemented. Work continues on a principles and services agreement between the SHA and the Provincial Affiliate Resource Group.

The body of the principles and services agreement and the quality and performance schedule are in the final review phase, and so the shared services schedule and the funding and services schedule are in development. Progress on this initiative has been delayed due to COVID, but work is expected to be complete in the summer of 2022.

On recommendation no. 3, on page 273, the SHA considers this implemented. The Ministry of Health led a provincial review and revision of the program guidelines for special-care homes. The ministry has developed an inspection process and will lead inspections of special-care homes to assess compliance with guidelines. The inspections will report on the performance of each home's compliance with the guidelines. Corrective action plans to address any deficiencies will be reported and tracked by the ministry.

The fourth recommendation, on page 273. The SHA considers this partially implemented. The steering committee overseeing the development of the principles and services agreement form the quality and performance working group to establish minimum service expectations for high-quality, resident-centred care. Key performance measures and targets that define service expectations related to the quality of care will be included in the principles and services agreement schedules. Work again was delayed because of COVID, but will be complete in the summer of 2022.

Recommendation no. 5, on page 274. The SHA considers this recommendation implemented. The Ministry of Health began inspecting long-term care homes in December 2021. Inspections assess the home's compliance with the province's program guidelines for special-care homes and any related regulations and policies, focusing mainly on resident care and resident-centred work within the home. Routine inspections will occur on a three-year cycle and may occur more frequently should problems be identified.

And then recommendation no. 6, on page 274. The recommendation has not been implemented. A framework, as I

noted, for addressing non-compliance with agreed-upon key measures will be included in the new principles and services agreement which is expected to be completed in the summer of 2022.

The Deputy Chair: — Thank you, Deputy Minister. I'll open the floor to questions from committee members now. Ms. Ritchie.

Ms. Ritchie: — Thank you, Madam Chair. Yes, I'm very honoured to enter in here with a few questions on a topic that concerns, you know, our province's most vulnerable and their care within the special-care homes systems in the province. So I guess as it relates to some of the partially implemented . . . You mentioned that you're in the process of finalizing an agreement with the care providers. Sorry, I'm just having to try to find my place here. Yes, so you're working with the Affiliate Resource Group, which I assume means the organization representing care homes, private service delivery.

Mr. Hendricks: — It's an organization that represents all affiliate groups in the province.

Ms. Ritchie: — Okay. Good. Yeah, and so maybe if you could just elucidate for the committee what some of those outstanding items are. I think you might have referred to one in the last recommendation. But I'd just like to understand sort of what's getting in the way of crossing all the t's and dotting the i's.

Ms. Garratt: — Sure. Sharon Garratt, VP integrated urban health in the SHA. So the template agreement is with affiliated organizations and/or designated health care organizations. Special-care homes, some are operated by the SHA and some are operated by affiliates. So these recommendations relate to the homes operated by affiliates. And with those organizations, we have worked with them in the past. The Provincial Affiliate Resource Group, PARG for short, represents the affiliates. And we are negotiating with them to finalize a template agreement and then each individual affiliate signs their own agreement with the SHA. So it's a bit similar to the ambulance discussion you heard earlier except that the template agreement is actually negotiated with that group.

So we've been at the table. We've been disrupted. As you've noted, the residents of long-term care facilities have been the most vulnerable to the impact from COVID. So a lot of our time has been devoted to ensuring that the residents are safe, adequately protected, and that we're also balancing policies so that they have life balance. So there's been various points over the last two years where both the affiliates and the SHA have been busy with that work and not been able to sit down together to finalize the negotiation of the agreement.

So the body of the agreement has . . . So originally the template referred to regional health authorities and other things that, once the SHA came into formation, needed to be changed. So there's certain items in that agreement that we're working through and that are paused right now, but have a small list of items that we're working on with them, that we'll be going back to the table with them as soon as we're able to finalize the body. And then as noted here, there's schedules that define other parts of the agreement.

Ms. Ritchie: — Okay. Now I wanted to ask a question about, you know, I would assume that if, you know, negotiations on these template agreements are kind of where the rubber might be hitting the road, would be around things like service levels. Would that be fair to say?

Ms. Garratt: — Quite honestly, the language in the body of the agreements speaks to our relationship, so the body of the agreement is about how we work together. It's not specific to the service level because the service level and the funding provided is actually negotiated individually with each home. What we're doing in the negotiation with PARG is to find a way to describe those things in a way that's transparent and easily understood in the agreement. So yeah, we haven't . . . Yeah, that would be how I would describe it.

Ms. Ritchie: — And then you mentioned schedules. So what sorts of . . . Is this all part of the template, the schedules? And if you could give me a sense of the items that they'll cover.

Ms. Garratt: — So the schedules that are described in here: one describes the services that they're expected to provide; one describes the funding that they will receive in response to the services; one describes what's called shared services, and I would describe that as things that we will provide for affiliates such as HR supports, LR [labour relations] supports or payroll or scheduling.

So there's been various supports that previous regional health authorities provided to affiliated homes in the past and we're looking at what those services are. So those are described in a schedule. There's a schedule about the quality and performance. So there are quality indicators that are already measured, and those are measures that are reported up to CIHI [Canadian Institute for Health Information]. And they're nationally developed measures that look at quality of care in long-term care homes. So that there's a foundation that we're already measuring, but we're reviewing that as part of the process.

Ms. Ritchie: — Okay, so this sounds like a bit of a two-step process. It sounds like it's a lot of work on the front end with these template agreements, but then once you have that, then you have to move into negotiating with each individual service provider. So as it relates to item 2 and working with the group, I think . . . Maybe you could just clarify for me if, you know, those individual discussions with individual providers is also part of this time frame and the scope of the recommendation.

Ms. Garratt: — I think, as the auditor reported, we would be signing . . . Once we agree that we have a body that we've agreed to, the signing with individual care homes would follow from there. And it would take a period of time depending on when they've been . . .

Ms. Ritchie: — Right, yeah. So my question's sort of a timing question because it's indicated here that you're going to have these standard agreements by July 1st. And I'm just wondering when the ones with individual service providers would be occurring.

Ms. Garratt: — They would follow after that. So we'd have to have the individual conversations following that.

Ms. Ritchie: — Okay. Great. Thank you very much on that front.

I think I've got one more question here. Yeah, so no. 5 is indicated as implemented. I'm just kind of wondering though, with routine inspections, are there recommendations that will be part of that process? And then, I mean, are those binding? Or like when issues are identified, how are they going to be ensured that they're resolved?

Ms. Morrissette: —Thanks for the question. So certainly, you know, we are in the pilot stage still of this new inspection program. And certainly the intention would be, as there are findings we would share those with the home. And you know, as we would normally do in our system, you know, when we have evidence from other things like quality indicators or other things that we're measuring, we would work with the home to produce a continuous improvement program. So we would like to see, you know, plans in place to address the issues that are uncovered during the inspection process. And so that would be depending on the nature of the home and who is operating the home. So certainly for the SHA-operated homes, we would have that discussion with them.

As it relates to affiliates and other third-party related homes, we'd have the discussion of course with the SHA and the third-party operated home, as those agreements are between the SHA and that third party. So certainly an intention is to share those learnings and work with the homes to improve the conditions that we uncover.

Ms. Ritchie: — Are you saying that as part of this pilot though that there will be recommendations flowing from them? I mean, you talk about working with. But I think we've seen quite recently from other reports — by the Ombudsman in particular — where we've had . . . I'm not sure they were called recommendations. Maybe they called them something else. But you know, there wasn't the follow-through. So my question is, how do we ensure, regardless of what we call it or the process that we're using, how are we ensuring timely resolution of issues as they are identified? We don't risk them falling through the cracks.

Ms. Morrissette: — So maybe just to be a little more specific on the process. The home will receive a written report within 30 days of the visit. And so in that report it will outline, you know, issues that have been uncovered or expected plans that we'd like to see. And so certainly there will be a monitoring function that will come along with that where we will continue to — you know, much like we would do with other kinds of inspections, you know, public health inspections and whatnot — we would do the appropriate follow-up to make sure that those actions are being taken, and that we are tracking the progress of those in terms of safety and quality of care.

Ms. Ritchie: — Okay. That's all I have for now. Thank you very much.

The Chair: — Deputy Chair Young.

Ms. C. Young: — So on page 275 of your report, you provided a chart that spoke to, particularly Saskatoon and surrounding area, special-care homes not meeting performance targets. And it was during that 2019. Has there been an updated one?

I assume, even though you say they've been focusing more on ensuring that, you know, residents of our care homes currently during COVID have been paid special attention and they've changed their programming. But I'm assuming they still have to provide accountability reports, and if this chart has changed based on some of the performance standards not meeting targets in some of these homes. And some of them are significant as to what they were lacking.

[16:15]

Ms. Garratt: — So when we looked to update this particular chart, there's some challenges in terms of . . . There was a change in the system, so we had some challenges pulling it at the time of this report.

But what happens with each one of these, if they are not meeting a target, the homes are actually . . . develop a corrective action plan and then there's follow-up with the home again within three months about what the progress is. So there is ongoing feedback.

Ms. C. Young: — So every three months.

Ms. Garratt: — So there is actually ongoing feedback and review and looking at them. But I recall as we worked through this that . . . So I don't know if I have actually the updated data at this point in time in terms of that.

The other thing that we've been doing in response to the pandemic is regular safety review with our . . . actually our infection control and safety teams going into the homes to audit all of the measures that we put in place around COVID. And each one of those reviews would produce a report and follow-up. And our team would engage, and if needed, would actually help the homes meet the requirements around the measures that we're to put in place due to COVID.

So we've done a couple of additional things, but there was a challenge as I said. So I don't know that I have an updated chart, but it is a regular expectation.

Ms. C. Young: — Can you assure me that this has improved based on, like, what I'm seeing here on the seven different categories? And some were significantly higher.

Ms. Garratt: — I don't know that I can say that in response to that, so I wouldn't want to say that without the data in front of me.

What I can tell you is that this is viewed as a quality improvement process and some of these measures impact each other. So looking at residents and daily restraints, so we have a goal to not restrain residents in long-term care. If you don't restrain residents, there's some residents that will increase their risk of falls because of that, and then you need to have other measures in place in response to that. There's things like very low beds, padding, and other things. Sometimes you improve on one and then something else gets worse in response, so they're not always . . . They kind of flex. As you pay attention to one, something else changes.

Ms. C. Young: — Thank you.

The Chair: — Very good. Important questions. Thanks for the

responses. Any further questions, folks? Not seeing any, I would welcome a motion to conclude consideration of chapter 29. Moved by Mr. Nerlien. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. I'll turn it over to the Provincial Auditor to focus on chapter 22.

Ms. Lowe: — Chapter 22 of our 2021 report volume 1, on pages 241 to 254, reports the results of our first follow-up of the Saskatchewan Health Authority's actions on recommendations we made in 2018 about processes to provide timely access to mental health and addictions services in Prince Albert and surrounding areas.

By January 2021 the authority implemented 5 of the 10 recommendations we made in 2018. We found the authority implemented a provincial integrated health record system and a level-of-care assessment tool for out-patient mental health and addictions services. The authority also enhanced monitoring of wait times for access to out-patient mental health and addictions services. We found the authority put in processes to improve the proportion of clients showing up for scheduled appointments and documented discussions with addiction clients about the post-detox support available to them.

However we found the authority is not effectively documenting its follow-up with clients who have missed their scheduled appointment or treatment. We tested 30 clients and found five client files did not have documentation that any follow-up occurred with the client. Timely follow-up to assess health status can avoid future hospital visits and reduce overall costs to the client and the health care system.

The authority has not formally assessed whether mental health and addictions services are meeting client demand in Prince Albert and surrounding area. It continues to struggle to provide mental health out-patient services in a timely manner. For example, we found more than 90 per cent of children with moderate acuity level had to wait more than 20 business days to see a psychiatrist for their first appointment in 2019-20, a 10 per cent increase from 2017-18. Not doing a comprehensive reassessment of a client demand, relative to mental health and addictions services available, increases the risk of not providing those with mental health illnesses and addictions with timely access to service. Long waits can lead to people's health condition getting worse, and in some cases long waits can even contribute to death.

We found the authority has yet to develop a strategy to collect key mental health and addictions client service information in its health record system from health care professionals outside of the authority; for example, psychiatrists. Without a strategy to share and capture information on all mental health and addictions services provided by health care providers, the authority does not have a complete client history of services. A complete client history of services provided and their impact on patient health would aid all health care providers in determining appropriate courses of action for patients.

While the authority implemented a community support team to support mental health and addictions clients with complex needs in their community, the authority has not improved the hospital readmission rate for mental health patients since our 2018 audit. That is the average readmission rate of around 10 per cent. We found the community recovery team has not yet developed any measures to gauge their success.

Finally, the authority has not made progress in collaborating with the Ministry of Social Services to enhance access to housing options for mental health and addiction clients. Having organizations work together to provide stable housing can lead to better outcomes for people living with complex mental health and addiction issues.

I will now pause for the committee's consideration.

The Chair: — Thanks so much for the presentation and such an important focus. I'll turn it over to the deputy minister for remarks, and we'll open it up for questions.

Mr. Hendricks: — Okay, so the first recommendation on page 243 is not implemented. Mental health and addictions services, patient demand, caseloads, and appointment supply are reviewed on an ongoing basis. More work is needed to fully leverage the reporting features of information systems to better understand service supply in relation to demand. Progress on this important work has been delayed due to recruitment challenges, as well as the necessary focus on the pandemic.

Recommendation no. 2 on page 246, the auditor has noted this as implemented. Recommendation no. 3 on page 246 is not implemented. There is provincial work occurring regarding the integration of a provincial health record that will be inclusive of mental health and addiction client information.

Recommendation no. 4 on page 248, as noted by the auditor, is implemented. Recommendation no. 5 on page 249 is partially implemented. The SHA communication recovery team is tracking client episode of care for approximately 25 per cent of clients to better understand client needs. Once data collection analysis is completed, the SHA will use the information to better serve their clients.

Recommendation no. 6 on page 250 is not implemented. Work to implement the recommendation is ongoing. Due to the COVID-19 response, no further provincial work has occurred with the exception of the assisted self-isolation site work. The pre- and post-treatment beds and residential support beds for this area are set for implementation on March 1st, 2022. And the SHA is involved in a homeless research project where a number of community stakeholders inclusive of social services and health are present.

Recommendation no. 7, as the auditor has noted, has been implemented. Recommendation no. 8 has also been implemented.

Recommendation no. 9 on page 252 is partially implemented. Work standards are developed. There is consistent practice of documentation regarding follow-up when clients do not maintain a scheduled appointment. Management will develop monthly audit, metric, and processes to ensure measurement improvement regarding consistent documentation. Due to the COVID-19 response, the rollout of the standardized suicide protocol process

in the mental health and addictions information system and accreditation and the audit work have been delayed. SHA intends to have the new processes fully implemented by the 31st of December of 2022.

And lastly on page 253, recommendation no. 10 is implemented.

The Chair: — Thank you for the report. I'll open it up to the table for questions. Ms. Ritchie.

Ms. Ritchie: — Thank you, Mr. Chair. It seems there's quite a few recommendations stemming from this audit that are yet to be implemented still. I think on the first one, regarding assessing whether mental health and addiction services are meeting client demand in its northeast integrated service area, I believe I heard you say that there were some recruitment challenges. Is that correct?

Mr. McLetchie: — Yes.

Ms. Ritchie: — Yes, okay. Yeah, I just wanted to clarify that. So yeah, I mean, I can appreciate that wait times are being monitored and you're exploring options for increasing access in response to . . . [inaudible] . . . And if recruitment . . . Maybe you could just speak a little more to the recruitment question. What's driving that? What's getting in the way of recruitment?

Mr. McLetchie: — Andrew McLetchie, the vice-president of integrated northern health. I think that there's probably a number of factors. I think just provincially there's sort of been a shortage of nurses and social workers with mental health training, and so in a sense those staff can go wherever they want in the province to be employed. And so it's resulted in, you know, difficulty with recruitment as well as a degree of churn.

And I think in some ways we've also, through the pandemic, created positions that staff could apply to, temporary positions they could apply to. And so a number of staff have chosen to do temporary roles, which added to some of the recruitment challenges.

Ms. Ritchie: — And what is the current vacancy level then for these positions?

Mr. McLetchie: — You know, I don't have that information with me, but I can get it for you.

Ms. Ritchie: — Okay, yeah. Well similarly, it would be useful to know what sort of counselling wait times you're experiencing as a result.

Mr. McLetchie: — In terms of wait times, I kind of in a sense don't have the actual wait times, but I have information that basically talks to wait time per assessment and for a number of the different targets that we have. So this is kind of looking at kind of severe or very severe clients being seen immediately, severe clients being seen kind of within a number of days, moderate clients being seen within 20 days, and mild being seen within 30 days.

And basically we are seeing our child and youth addictions clients that need to be assessed within that target. We are seeing adult addictions within targets, with the exception of moderate clients, where 41 of 47 were seen within the 20 days. For child and youth mental health — and these are information from the past year — we weren't meeting the target for severe, where one of our clients wasn't able to be seen within the time frame. And for moderate, two of our clients, 15 of the 17 were seen within the appropriate time frame.

[16:30]

And then for adult mental health, for severe and moderate, we also weren't meeting the 100 per cent targets. There was one person that we didn't see who was listed as severe in adult mental health in the past year within the target, and there was nine people that were moderate that weren't seen within 20 days.

Ms. Ritchie: — When you talk about options being explored for increasing access, can you give me an idea of things you're looking at?

Mr. McLetchie: — For increasing access to any one of the services or just generally access?

Ms. Ritchie: — Let's go general.

Mr. McLetchie: — General. I think there's been a number of different services that we've kind of looked at within the community, and a number of these are from the mental health and addictions investments in the Prince Albert area. So having things like the police and crisis teams kind of allows for a response to a subset of the population that in a sense can be assessed and responded to quite rapidly and allows for that positive relationship with our police services.

We also in a sense have a mental health drop-in, kind of in the central part of Prince Albert, that allows for kind of clients to be seen, and there are physicians and nurse practitioners at that site that support those clients. As well there's a number of different relationships, the various community programs that are being explored and built on, that allow for us to broaden our service delivery and go beyond just what the SHA provides in terms of counselling.

Ms. Ritchie: — As it relates to the CBOs [community-based organization], I am somewhat aware that there is a lack of consistent funding for them to be providing those kinds of services. And if that is an option that's being explored, is continuing funding also part of that consideration?

Ms. Morrissette: — I would say one of the things that . . . Stepping back and looking a little bit at our CBO partners, you know, in the space of mental health and in addictions, we're seeing them take on a growing role in that service delivery. And through many of our new investments we have actually gone out to market to ask, you know, some of our CBO partners, you know, can you deliver some of our mental health? That's as an example some of these counselling services. And so certainly they have the opportunity to come forward through those formalized processes to tell us, you know, what is the cost of providing that service.

And so we are engaging with them in a little bit of a different way where, you know, we are looking for these services through those mechanisms. And they have ways of, you know, telling us, you

know, what are the costs of running those programs.

And so I do think that that has positioned us a little bit differently maybe to be working with this sector. And it is something that, you know, I think we're really conscious of moving forward. They're a big part of how our services are delivered and will continue to be. And so I think more and more we are thinking about them in terms of, you know, what kinds of training supports, what kinds of other things might they need in addition to, you know, some of our main delivery agents like the SHA.

So I do think that from both a funding perspective but a capacity and training and a kind of clinical perspective, they really are on our radar and we're looking very much to kind of strengthen those relationships. And I know, you know, when you hear us talk about health networks, certainly the SHA has a strong commitment to delivering service through the network model, which really contemplates strong partnerships between CBO organizations and other delivery agencies. So I think that, you know, I think that has been maturing over time, you know, a ways. . . some ways to go, but we do consider them a really valuable partner.

Ms. Ritchie: — Yeah. And well, and I think that . . . Well I guess my next question would be, are you consulting with them on program service delivery, support services, etc., as part of that sort of maturing relationship?

Ms. Morrissette: — Yeah, I know. I can speak to how that unfolds at the local level. But certainly, you know, when we undertake provincial initiatives there's different mechanisms of engaging with them. We use things like market sounding or we have them represented on a number of our different strategy tables, the Pillars for Life as an example. We'd have, you know, partners from the community there. So we have lots of different mechanisms of engaging those partners and are really trying to understand what role they can play and how they can be successful in doing that. Having said that, you know, Andrew might have more to share in terms of how that unfolds at the local level.

Mr. McLetchie: — Yeah, and I think what I'd add is adding to what Billie-Jo had said around network development. That really within the networks across the Saskatchewan Health Authority, our mental health and addictions leaders and our primary health care teams do reach out to the various partner organizations, depending on what projects they're working on. So an example in P.A., you know, one of the recommendations was around housing. And I know that our mental health and addictions team has had a lot of discussions with numerous community partners around what's feasible or what are the opportunities that can be explored for improved housing for at-risk populations in that community. And in a sense, those relationships don't always result in perhaps an action or it may not be the right time for some of these NGOs [non-governmental organization], but it is something kind of where they have a lot of advice and support that they can provide that then can be built into future planning.

Ms. Ritchie: — And I'm glad that you're using that example, because I did have one final question I wanted to ask about that in terms of progress on housing options. And it's my understanding that the auditor affirms that stable housing would reduce costs and improve outcomes. So is it . . . Can we make housing for mental health and addiction clients a priority?

Mr. McLetchie: — Well I do think it's one of the directions that the province has gone in in terms of looking to say, what are the opportunities around housing for mental health clients and clients with addiction? And I think Prince Albert has had some challenges in finding the right community organization to move forward on that, but definitely those discussions have continued despite those challenges. And I know within the community there's a lot of groups, including the city of P.A., that are very interested to see what can be done in terms of housing.

Ms. Ritchie: — Final question related to that. I understand there had been a meeting in December 2019 between the Ministry of Social Services and SHA on that topic. I assume they've probably been meeting since. But in relation to that one, can you tell us what outcomes arose from that if anyone can recall it? I know I'm going back a ways.

Mr. McLetchie: — I'm not sure that I have that information off the top of my head there. I know that there's been ongoing conversations with a number of different partners, and definitely the Ministry of Social Services along with the SHA has been working with a number of community partners. But as to the specific outcomes there, other than knowing that they continue to discuss kind of how to build options for housing, I'm not aware of the specific ones from that meeting.

Ms. Ritchie: — All right. Thanks very much.

The Chair: — Any further questions from committee members?

Thanks to those that are involved in this work. I mean, it's critical in people's lives and it's about our future, these sorts of interventions and priority that we place on these things. And I was sort of watching it as the Chair here too. I sort of wanted to interject on certain pieces, but I think some of those are best left for the budget debate as well and the estimates debate and the policy field debate.

But you know, from my perspective to the province and to the, you know, to the cabinet, these are very important things that need to be prioritized and then resourced so that the good folks can get out there and the partners can close those gaps.

I'm not seeing any further questions. I'd entertain a motion to conclude consideration of chapter 22. Deputy Chair Young moves. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried. Which takes us to our last chapter, last item of the day and that's chapter 23, and I'll turn it over to the Provincial Auditor.

Ms. Lowe: — Chapter 23 of our 2021 report volume 1, on pages 255 to 260, reports the results of our third follow-up of the Saskatchewan Health Authority's actions on three remaining recommendations we made in 2013 about processes to triage patients in hospital emergency departments in Saskatoon.

By February 2021, the authority implemented two of the three remaining recommendations we made in 2013. Changes the

authority made better support staff in routinely assessing patients in emergency department wait rooms, and improve patient flow in and out of emergency departments at the Saskatoon hospitals. These improvements resulted in emergency department patients seeing physicians, on average, sooner.

However the authority needs to resume its work about tracking and reducing the incidence of patients who could be seen outside of the emergency department to ensure it makes optimal use of its emergency departments. Tracking the incidence of patients who could be seen outside of an emergency department provides key information necessary to formulate strategies to focus the use of emergency department resources on patients requiring emergent or urgent care.

I will now pause for the committee's consideration.

The Chair: — Thank you. Thanks for the follow-up, and thanks to the ministry for the report on this front on their actions. I'll welcome brief remarks, and then we'll open it up.

Mr. Hendricks: — So the first recommendation, on page 256, has been implemented as noted by the auditor, as has the second recommendation, on page 257. The third outstanding recommendation, on page 258, around "provide consultant care for less-urgent or non-urgent patients outside of . . . [the] emergency departments" is partially implemented. Comprehensive system-flow initiatives are being developed in Saskatoon to address ongoing acute care capacity challenges, with targeted initiatives in acute care, continuing care, primary health care, preoperative care, and surgery.

The COVID-19 pandemic responses remain the key priority for the SHA, therefore targeted work to specifically progress these recommendations has not occurred. Orthopedic consults are being tracked manually and sent to the area lead of surgery, and by March 31st, 2023 the SHA will establish electronic tracking of patients presenting to the emergency department that could be seen elsewhere. I would also mention our urgent care centres, which are currently being developed as an alternative. So with that I'll turn it back.

The Chair: — Thanks for the report and all the work. And I'll open it up to questions. Ms. Ritchie.

Ms. Ritchie: — Well thank you for that update, Deputy Minister Hendricks. Maybe I'll start at the tail end there. You mentioned the urgent care facilities. Maybe you could just provide us with a little bit of a description of that model and its current status of implementation.

Ms. Garratt: — So the urgent care centres are being developed to meet the needs of individuals that wouldn't need the full-on response from the emergency department. They're for episodic care, and they are focused on the things that patients can come in for and be treated for and leave in a short time period. They also are looking at mental health patients because there's a number of mental health patients coming in through the ER that may not need kind of the full-on treatment of, you know, ER physicians and others, but need support from mental health workers and psychiatrists.

So the focus in the urgent care centres is twofold. It's the individuals that don't need to come into the ER — like, they aren't going to be admitted to the facility, but could get treatment and leave. I don't know, Mark, if there's . . . That's what we're looking at providing. There's work under way in terms of finalizing the plans for building the centres and then, once they're in place, operationalizing them.

Mr. Wyatt: — I would just add that Regina is probably moving on a faster track than the one in Saskatoon just based on land selection and the identification of where the urgent care centre will be located in Regina. And that's not yet been determined in Saskatoon.

Ms. Ritchie: — Have you identified the number and locations? Apologies if I don't know these details myself already if they've already been publicly reported.

Ms. Garratt: — One urgent care centre in Regina, and that location has been determined. One urgent care centre in Saskatoon, and we're still working on the location.

[16:45]

Ms. Ritchie: — Okay. So two in total that are planned and in development?

Ms. Garratt: — Correct.

Ms. Ritchie: — Okay. So how does this relate to service in rural areas outside of the two major cities?

Mr. Wyatt: — I guess I would say for residents of rural Saskatchewan who would consider Regina to be, you know, within their Regina or Saskatoon catchment area and would consider those centres to be the locations that they would travel for emergency or urgent care, or in some cases care that would not be available through a family physician either because of the hours of service for a family physician or a local health clinic in their community, or just it may well be a service that's not available.

The urgent care centres would provide, you know, an alternative to an emergency room whereby rather than presenting to an emergency room with what would be considered to be a lower urgency visit to an emergency room, without getting into the whole CTAS [Canadian triage and acuity scale] assessment system, but you do have different levels of urgency by which emergency patients are assessed on presentation. This is really targeting some of those low urgencies, the CTAS 4's and 5's, probably more significantly so that, you know, patients who would be potentially seeing an emergency room as their best option for a low urgency, as Sharon mentioned, episodic type of an event, that they would have the alternative of the urgent care centre as a place that would both, you know, provide a more appropriate level of service.

You know, many of these individuals don't require an emergency room and an emergency physician to do their assessment and treatment. And this would provide both a more appropriate setting for them, but also, you know, from a system perspective, removing some of the demand on the emergency departments so those who do have more serious, more urgent types of conditions will hopefully be seen more swiftly in the emergency department.

And you know, the low urgency patients who come into emergency departments are triaged as such, and sometimes they'll spend many hours sitting in the waiting room, sitting beside people who are in distress; sitting beside people who may have, you know, something that could be contagious. And so trying to also remove that part of the, you know, the health care experience for people who are really just trying to get a broken ankle set or casted or something like that.

Ms. Ritchie: — Yeah. Yeah, I guess as I think about, you know, those kinds of services that traditionally or historically people would approach emergency rooms about, I wonder what, you know, how you're going to sort of educate so people understand and how they can even make that determination so they know to go to the urgent care versus an emergency room.

Ms. Garratt: — There will be a lot of communication about what they're intended for. There also will be built into the plans a capability to respond to whatever emergency comes in the door because people may not get it right. And we've done a lot of evidence review from other places that have urgent care centres about what the challenges are and what we need to be prepared for when we open. And we know that it will be, there will be learning in the initial phases and people will . . . to land it right. But we'll need to be able to be prepared to respond, and then we have ambulance and other support as needed if we need to transfer individuals.

Just in terms of the rural areas, there is emergency care available in rural hospitals around the province, and the urgent care centres aren't meant to replace that. Those services we'll continue to manage and support, and the SHA is working hard to stabilize those services.

Ms. Ritchie: — Can you tell me about the staff complement to staff the facilities? Will those be new FTEs or will they be redirected from other parts of the authority?

Ms. Garratt: — It's my understanding there'll be new FTEs, new staff, new positions.

Ms. Ritchie: — Can you tell us how many? Has that been identified?

Ms. Garratt: — That's not been identified yet. It's too soon in the process for me to be able to respond to that.

Ms. Ritchie: — So going to back to the, I assume this is the facilities themselves that you're working with SaskBuilds to develop. So what stage of development are we in right now for Regina and Saskatoon?

Ms. Garratt: — So for the Regina site I think we're at the point of finalizing the plan, but maybe you can get a better . . . Yeah. We work with the ministry, SaskBuilds, and the SHA to finalize all of these. So yeah.

Ms. Morrissette: — Thanks, Sharon. Yeah, so as mentioned, we are working on two locations, one in Regina and one in Saskatoon. We're a little further ahead in the Regina location, and so we have contracted with the building constructor, and so work is under way to get that project fully designed and started. In the Saskatoon case, we are still working through site selection and working through a number of different factors around finding the site that will work best for this particular project in that location.

Ms. Ritchie: — Now I think you mentioned the contractor has been selected. Can you tell us which firm has received that?

Ms. Morrissette: — I would like to but I cannot recall if we've made that fully public yet. So I'll maybe just reserve that, and for certain we can share that with the group when it's been made public. Apologies. I just can't recall, and I don't have the note in front of me.

Ms. Ritchie: — What sort of contract model are you using?

Ms. Morrissette: — I think it will be a design construction model. Yes.

Ms. Ritchie: — Will there be any sort of a partnership, P3 [public-private partnership] model?

Ms. Morrissette: — Thank you. No. So the SHA will own and maintain the building once it is constructed.

Ms. Ritchie: — Thank you very much. No further questions.

The Chair: — Thanks for the questions. Thanks for the work on these fronts. Any further questions from committee members with respect to chapter 23? Not seeing any, I'd welcome a motion to conclude considerations. Mr. Skoropad moves. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's carried.

Just to the Ministry of Health and the Saskatchewan Health Authority and all those out on the front lines and all those professionals and all those that are connected to the work that we've been talking about, thank you so very much for your service, for your work. And you've come through and continue to endure the consequences and challenges of a pandemic, and we thank you for that service and for that leadership, every last worker on the front lines through to leadership.

At this point in time I would welcome a motion to adjourn.

Ms. C. Young: — I move.

The Chair: — Moved by Deputy Chair Young. All agreed?

Some Hon. Members: — Agreed.

The Chair: — That's usually the most popular motion of the day. That's carried. This committee stands adjourned until 8:15 tomorrow morning.

[The committee adjourned at 16:53.]