STANDING COMMITTEE ON PUBLIC ACCOUNTS

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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[The committee met at 08:29.]

Chair Wotherspoon: — Well good morning, folks. We'll convene the Standing Committee on Public Accounts. My name is Trent Wotherspoon. I serve as the Chair of the Public Accounts.

[08:30]

I'd like to welcome and introduce the committee members that are here: Deputy Chair Wilson, MLA [Member of the Legislative Assembly] Beaudry, MLA Chan, MLA Crassweller, MLA Gordon, and MLA Pratchler.

We have the following document to table: PAC 53-30, Ministry of Education: Report of public losses, June 1st, 2025 to August 31st, 2025.

I'd like to welcome and introduce the officials from the Provincial Comptroller's office: Provincial Comptroller Brent Hebert and Assistant Provincial Comptroller Jane Borland.

I'd like to welcome and introduce our Provincial Auditor, Tara Clemett, and her officials that are with us in attendance here today with the Provincial Auditor's office as well.

Health

Chair Wotherspoon: — Our first agenda items here today will focus on the Ministry of Health. Quite a few different chapters that we'll focus on from various reports here this morning, and they're all sort of independent presentations from the auditor, or chapters by the auditor. Then we'll come back to the Ministry of Health for response on each of those, and then open it up for questions.

At this time I'd like to welcome all the officials with the Ministry of Health that have joined us here this morning, all those that are involved in the important work that you take on every day as well that's connected to our considerations here today.

I'd like to thank you for the status update that's been provided as well, and I'll table it at this time. I'll table document PAC 54-30, Ministry of Health: Status update, dated October 15th, 2025.

And I'd ask Assistant Deputy Minister O'Neill, who is seated at the centre of the table there, to give a brief introduction of all the officials that are with him here today. And then we'll turn it over to the auditor to make a presentation on the first chapter and then come back your way for comment.

Norman O'Neill: — All right. Thank you and good morning to everybody. So we'll start by just thanking the Provincial Auditor of Saskatchewan, Tara Clemett, and her team for joining us today. We recognize the crucial role that the Provincial Auditor plays in providing oversight for the Ministry of Health and our partner health agencies. We appreciate the opportunity to review these previous auditor reports and provide important progress updates.

So we are joined today by staff from the Ministry of Health, the Saskatchewan Health Authority, 3sHealth [Health Shared Services Saskatchewan], and eHealth to address any follow-up questions or discussions.

Ministry of Health representatives include David Matear, assistant deputy minister; James Turner, assistant deputy minister; Chad Ryan, assistant deputy minister; and to my left, Dave Morhart, executive director of acute and emergency services branch; to my right, John Ash, who's a vice-president of Saskatoon integrated health with the SHA [Saskatchewan Health Authority]. Other senior leader team and ministry officials will be introduced at the microphone as we progress. In addition to John, the SHA is represented by Felecia Watson who's the executive director of patient and client experience.

3sHealth representatives joining us today will be as follows: Mark Anderson, chief executive officer; Alana Shearer-Kleefeld, vice-president of employee benefit plans; Luke Malach, executive director of internal audit and enterprise risk management; and Boye Adetogun, director of claims services.

In the afternoon we'll be joined by eHealth representatives Davin Church, chief executive officer; and Aaron Mula, vice-president of digital services and chief information officer. Additionally Crystal Zorn, vice-president of security and privacy, will join us.

So again thank you to everyone for being here this morning, and we're prepared to discuss progress on any outstanding recommendations. The Ministry of Health and our partner agencies are committed to full implementation of all remaining recommendations. Our ministry and health partners share the same goal as the Provincial Auditor and her team, which is to continually improve and provide high-quality health care services for all Saskatchewan residents.

We look forward to today's review and believe they will help inform future work on these important recommendations. Thank you.

Chair Wotherspoon: — Okay, thank you very much, ADM [assistant deputy minister] O'Neill and all the officials that have joined us again here today, and those that are connecting to the work we're considering here today as well.

I'll kick it over now to our Provincial Auditor and her team to make a presentation on their chapter 14 from the 2023 report volume 2.

Tara Clemett: — Thank you and good morning. Thank you, Mr. Chair, Deputy Chair, committee members, and officials. With me today is Mr. Jason Wandy, and he is the deputy provincial auditor that is responsible for the Ministry of Health. Behind me and to the far left is Ms. Kim Lowe. She is a senior principal but works on a number of health audits that are going to be under consideration today. And then beside her is Ms. Michelle Lindenbach, and she is our liaison with this committee.

Jason's going to present the chapters for the ministry in the order that they do appear on the agenda, and this will result in seven separate presentations. He will pause for the committee's discussion and deliberation after each presentation. The first presentation about coordinating the provision of timely neurosurgery services includes eight new audit recommendations

for this committee's consideration. And then the remaining six presentations all include status updates on the outstanding recommendations that this committee previously did agree to.

I do want to thank the assistant deputy minister and all the staff at the Ministry of Health as well as the SHA for the co-operation that was extended to us during the course of our work. With that, I will turn it over to Jason.

Jason Wandy: — Thank you, Tara. Chapter 14 of our 2023 report volume 2 reports the results of our audit of the Ministry of Health's processes, for the 16-month period ended May 31st of 2023, to coordinate the provision of timely neurosurgery services in Saskatchewan. We concluded the ministry had effective processes other than the areas reflected in our eight new recommendations for the committee's consideration.

Neurosurgery services provided by the Saskatchewan Health Authority includes consultations and surgery related to the brain, spine, and nervous system that may be needed to treat conditions such as a pinched nerve in the back or neck, damage to the brain or spine from an injury, or a brain tumour.

At April 30th, 2023 about 240 Saskatchewan patients were waiting more than a year for a neurosurgeon to provide surgery. From April 1st, 2022 to April 30th, 2023 the ministry and the Authority paid over $18 million to neurosurgery physicians for services provided to patients.

Coordinating the provision of neurosurgery services is one of many aspects of the ministry's role in maintaining a system to provide comprehensive health services. The ministry's acute and emergency services branch is its primary unit responsible for coordinating neurosurgery services. This branch determines estimated funding required each year for delivering these services.

While the ministry's medical services branch works with physicians to develop initiatives toward improving access to specialists, such as neurosurgeons, the medical services branch also works with the Saskatchewan Health Authority on physician resource planning activities as well as negotiates the physician compensation agreement with the Saskatchewan Medical Association.

In our first recommendation, on page 117, we recommend the Ministry of Health and the Saskatchewan Health Authority communicate clear expectations and monitor the number of neurosurgery services provided by each physician to determine whether neurosurgery needs are met.

At June 2023 there were seven neurosurgery physicians in Regina and 13 in Saskatoon. Neurosurgery physicians can work either on a contracted or a fee-for-service basis. Under contractual arrangements, the Authority pays regular monthly amounts to licensed physicians. Under the fee-for-service arrangement, the ministry pays licensed physicians for each specific insured service provided to a Saskatchewan resident based on preset rates negotiated with the Saskatchewan Medical Association.

The fee-for-service model rewards productivity but also promotes a competitive environment where fee-for-service neurosurgeons may want as many surgical patients as possible. This creates challenges for the ministry to manage actual surgical volumes and patient wait-lists.

We found fee-for-service physicians had triple the number of patients waiting for surgery compared to contracted physicians, and nearly twice as many operating room cancellations. This suggests some neurosurgeons may have too many patients while other neurosurgeons may have capacity to treat more patients.

Our review of the contract templates for both contracted and fee-for-service neurosurgeons found they did not set out clear performance expectations. Contracts provide an opportunity to reinforce and clarify expectations for neurosurgeons to promote consistent understanding and resulting practices, such as expectations for managing patient volume and wait-lists.

Clear performance expectations could support efforts to balance patient loads and treat neurosurgery patients more timely.

In our second recommendation, on page 121, we recommend the Ministry of Health forecast the number of neurosurgery physicians and other staff required to provide neurosurgery services annually and over the long term.

Having an appropriate supply of neurosurgery physicians and support staff is important to ensure wait times are reduced and managed appropriately. The ministry uses IT [information technology] systems to forecast up to 10 years of demand for neurosurgery services by considering historical surgery volumes, medical trends such as an increase in stroke risks, and population changes such as the size or aging of the population.

For 2023-2024 we found the ministry provided its forecasts to the Authority to support the Authority's annual planning processes. However the ministry did not know whether the Authority used the forecasts. Other than funding for new contracted physicians, we found for 2023-24 the Authority budgeted based on expected demand for health services and did not consider how many physicians are required to meet the province's needs. As a result the ministry does not know whether the Authority has enough or too many neurosurgery physicians and support staff to meet the anticipated neurosurgery volumes.

Since the ministry does not forecast, or request from the Authority, the number of physicians and support staff needed to deliver neurosurgery services in the province, it cannot complete a sufficient gap analysis to assess whether the Authority has an appropriate number of physicians and support staff delivering neurosurgery services. This also impacts the ability to sufficiently conduct workforce planning over the long term.

In our third recommendation, on page 123, we recommend the Ministry of Health analyze patient referral systems used for neurosurgery services and determine an efficient system to use for referrals across the province.

Saskatchewan physicians use two different systems to refer patients for neurosurgery services. The Saskatoon neurosurgery division uses a pooled referral system while the Regina neurosurgery division uses a direct referral system. Under the pooled referral system, patients have the option of seeing the first available neurosurgeon in the pool or waiting to see a specific

neurosurgeon. If one neurosurgeon in the pool is at full capacity, patients float to others who are not, which eventually results in a more or less equally distributed workload.

At March 31st of 2023 Saskatoon had 268 patients waiting for spine surgery compared to 765 in Regina. Additionally our analysis of data found patients in Saskatoon waited about 43 days on average for their neurosurgery consultation, compared to almost 152 days in Regina. The ministry noted some patients wait longer than others due to the surgeon to whom they are referred. For example that surgeon may have a longer wait-list.

We found the ministry had not analyzed the reasons for the delays to determine any related action it may take to help patients access more timely consultations. Without analysis to determine the effectiveness of using pooled versus direct referrals, patients may be waiting longer than necessary to see a neurosurgery physician. Patients who wait longer to see a physician may risk declining health that affects their quality of life, or have difficulty working that causes financial hardship.

In our fourth recommendation, on page 124, we recommend the Ministry of Health collect and analyze complete wait time data for patients directly referred to a neurosurgery physician.

As I just noted, physicians use two different systems to refer patients for neurosurgery services: pooled or direct referral systems. While the ministry receives data for the pooled referral services, we found that the ministry does not collect complete data for the direct referral system. This is due to how fee-for-service physicians code referrals in the ministry's billing system. We found the Regina data appeared significantly understated, as there were only 65 direct referrals in 16 months, between January of 2022 and April of 2023, compared to 1,861 neurosurgery referrals made in 12 months, between April 2022 and March 2023, in Saskatoon as tracked through the pooling system.

Not collecting complete referral data limits the ministry's ability to analyze and assess wait times as well as the effectiveness of the direct referral system. It also means the ministry does not have a good understanding of total neurosurgery wait times, the total time from when a family physician makes a referral to a neurosurgery physician to the point when a patient receives surgery.

In our fifth recommendation, on page 125, we recommend the Ministry of Health work with the Saskatchewan Health Authority to increase the use of spine pathway referrals to reduce potentially unnecessary neurosurgery consultations and surgeries.

[08:45]

The Saskatchewan spine pathway is a standardized assessment and treatment process for patients with low back pain. Physicians and other health care providers can refer patients to a spine pathway clinic managed by the Authority located in either Saskatoon or Regina.

At the clinic, health care providers work with patients to help assess whether surgery is necessary or an alternate treatment option, such as physiotherapy, may resolve their condition without surgery. During the audit, neurosurgeons advised us that the spine pathway allows patients to access other supports, like physiotherapy, and many spine patients' conditions will resolve in time with these supports without surgery.

In 2022-23 Saskatoon referred about 20 per cent of its 1,583 initial assessments completed through the spine pathway for surgical consultation, and Regina referred only about 4 per cent of 733 initial assessments. These rates may suggest that more referrals to the spine pathway could significantly reduce the wait-list for spine consultations and surgeries as well as limit the number of patients getting surgery because of alternate treatments.

Between 2017 and 2023 Saskatchewan's spine surgery rates averaged higher than the Canadian average, ranking in the top three highest rates. Referring more patients to a spine pathway clinic can help the ministry and Authority better manage timely access to neurosurgery services for those who need spine surgery.

In our sixth recommendation, on page 126, we recommend the Ministry of Health work with the Saskatchewan Health Authority to document surgery prioritization criteria to support timely and fair access to neurosurgery services.

Neurosurgery physicians assign patients to a prioritization category when completing booking forms to place patients on the surgical wait-list. The Authority's scheduling units generally schedule surgeries on a first in, first out basis according to the assigned priority on the booking forms. We found neither the ministry nor the Authority had documented factors or criteria to guide the neurosurgery prioritization decisions to support consistency in fairness of access to services by patients.

Our testing of 19 patient files found the Authority completed surgery within the prioritization time frames 26 per cent of the time. From February 2022 to April 2023 our analysis found similar results in that the Authority completed 36 per cent of surgeries within the prioritization time frames. This means up to three-quarters of neurosurgery patients may be experiencing longer periods of pain, suffering, and reduced quality of life as they wait longer than expected for surgery.

In 2022-23 the ministry found Regina neurosurgery physicians prioritized more spine procedures as emergent or urgent at 83 per cent, compared to Saskatoon at 68 per cent. Inconsistent prioritization processes can lead to variation in how different surgeons categorize their patients, resulting in inappropriate surgery delays for some patients. It also increases the risk surgeons can manipulate the system to get their patients in sooner, while also increasing the volume of surgeries they can complete and be paid for. Good prioritization drives scheduling expectations and capacity planning to help prevent delays for patients awaiting surgery.

In our seventh recommendation, on page 129, we recommend the Ministry of Health work with the Saskatchewan Health Authority to assess enhancements for improving efficiency of scheduling patients for neurosurgery. The Authority's operating room scheduling teams schedule patients for surgery in the Authority's IT surgical scheduling system based on allocation of operating room time to surgeons, as well as patient prioritization and equipment availability.

During 2022-23 Regina and Saskatoon operating room scheduling teams allocated operating room time to surgeons in four- to six-week blocks of time to manage resource uncertainty and reduce the risk of rescheduled surgeries. We found the ministry had not assessed whether the time frames used to schedule neurosurgery are effective.

The ministry has a number of opportunities to look at the Authority's scheduling processes — including operating room flex days, after-hours surgeries, cancellations, and late starts — to determine whether changes can improve neurosurgery wait times. Without assessments to determine the most efficient scheduling processes, patients may wait longer for surgery than necessary. Better analysis and consideration of scheduling alternatives and enhancements such as flex days may result in better use of operating room blocks, save the health sector money, and provide patients with necessary surgery.

In our eighth recommendation, on page 131, we recommend the Ministry of Health formally establish annual action plans to address gaps in neurosurgery services. We found the ministry prepares a number of standard statistical reports from its surgical registry and provides these reports weekly or monthly to management at the ministry and the Authority. The ministry prepared over 10 different weekly reports and about 40 different monthly reports for management's review.

These reports include information such as counts of surgeries performed, patients waiting, bookings, and cancellations by month; as well as surgeries performed, outlining cases exceeding, meeting, or not meeting target time frames. However we found the ministry completed very little analysis related to the statistics reported to make review of the reports efficient and effective.

Additionally, in May 2023, the ministry provided the Authority with a report analyzing neurosurgery services, which it compiled in response to patient concerns. While the report contained good information, we found it lacked analysis, such as the causes of results, and action plans or recommendations to address the identified gaps.

Senior management and partners need robust analysis reported about progress toward targets so they can set and revise action plans to achieve long-term goals and to reduce patient wait-lists.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Okay, well thank you very much for the presentation and the important focus of the chapter as well. I'll turn it over to ADM O'Neill for brief remarks. We have the status update. We appreciate the actions being detailed there. Brief remarks, and then we'll open it up for questions.

Norman O'Neill: — All right. Thank you. Just regarding the first recommendation for the Ministry of Health and the SHA to communicate clear expectations and monitor the number of neurosurgery services, comprehensive work to establish expectations with service providers has been carried out. The framework for ongoing monitoring is in development.

In response to the auditor's recommendations, the ministry and the SHA established a neurosurgery steering committee. Moving forward, the neurosurgery steering committee will establish ongoing processes for monitoring expectations and provision of neurosurgery services, with ongoing communication and reporting to neurosurgeons.

Concerning the second recommendation, for the Ministry of Health to forecast the number of neurosurgery physicians and other staff, the department of surgery is developing a multi-year surgical resource plan to determine the number of surgeons required to meet patient demands, including neurosurgeons.

Regarding the third recommendation, for the Ministry of Health to analyze patient referral systems used for neurosurgery services, the ministry and the SHA have worked with the department of surgery division of neurosurgery to implement pooled referrals. Most of the neurosurgeons located in Regina have agreed to participate in a provincial neurosurgery pool supported by eHealth's referral management services program.

Referral management services has worked with the SHA and neurosurgeons throughout 2024-25 to develop documentation and algorithms for a provincial service to collect data to onboard new providers. Efforts are also under way to create a separate pooled referral stream specifically for low back pain referrals. The timeline for a launch of a provincial spine surgery pooling service is Q3 [third quarter] of 2025.

In relation to the recommendation no. 4, for the Ministry of Health to collect and analyze complete wait time data for the patients directly referred to a neurosurgery physician, the ministry has taken measures to improve the quality of wait 1, which is the referral-to-consult time, by using the data in the surgical registry and in billing systems. The ministry has been making changes to the surgical registry to require more robust information about referral and consult times. We anticipate this information will be available to the ministry and surgical leaders by the end of the fiscal year.

With regard to recommendation 4, for the Ministry of Health to work with the SHA to increase the use of spine pathway referrals, consultations were held with stakeholders, the ministry, and the SHA to plan to make the spine pathway part of a pooled referral service specifically for patients suffering from low back pain. The spine pooled referral service will begin accepting referrals by March 2026. Once this pooled referral service is implemented, referrals for low back pain are received by RMS [referral management services] central intake, and they will be automatically directed to the spine pathway clinic where the patient will be assessed to determine whether a surgical consult is appropriate. Based on the assessment, the referral will be forwarded to a surgeon or directed to conservative management.

Regarding recommendation 6, for the Ministry of Health to work with the SHA to document surgery prioritization criteria, a diagnosis-based surgical prioritization was implemented on April 1st, 2024 and has replaced surgeon priority in the surgical booking system. Starting April 1st, 2024 a surgeon indicates the patient's diagnosis on a surgical booking form, but the surgeon does not enter a clinical wait time priority for the surgery. The surgical system provides the standard priority associated with the diagnosis. Surgeons must provide a rationale if they wish to override the standard clinical priority.

Surrounding recommendation no. 7, for the Ministry of Health to work with the SHA to assess enhancements for improving efficiency of scheduling patients for neurosurgery, improvements in surgical efficiency are a priority of the system. As noted previously, diagnosis-based surgical prioritization will help address and improve efficiencies.

The ministry and SHA will track efficiency measures, like the postponement reasons, and address them. For example a large percentage of postponements are related to medical complications or consent withdrawal. Preoperative patient optimization initiatives make better-screened patients so that they are ready, willing, and able to undergo surgery, and allow for more efficient elective slate scheduling and reduce postponements.

Concerning the final recommendation, for the Ministry of Health to formally establish annual action plans to address gaps in neurosurgery services, the provincial neurosurgery steering committee was formed in 2024 to provide multi-stakeholder monitoring and planning of neurosurgery services related to the Provincial Auditor's report. The provincial neurosurgery steering committee intends to create a standard dashboard to review and monitor results as well as identify any gaps in neurosurgery services.

In 2025-26 the committee will start a process of establishing formal action plans with the reporting to the provincial surgical executive committee.

And those are my remarks. Thank you.

Chair Wotherspoon: — Okay. Thank you very much, and thanks to all those that are involved in, have been involved in the work that's reflected in those comments in the status update.

I'll look to committee members now that may have questions. Don't jump all at once. MLA Pratchler.

Joan Pratchler: — Thank you, Chair. And thank you for being here today. By your most recent count, how many patients have been waiting more than a year for a neurosurgeon to provide surgery?

Norman O'Neill: — In answer to the question, our most recent information is as of March 31st, 2025, and we have 99 people that have been waiting more than one year for surgical treatment from a neurosurgeon.

Joan Pratchler: — Could you differentiate that between Regina and Saskatoon as well?

Norman O'Neill: — Probably.

[09:00]

In front of us we don't have that data, but we can get it before lunch. We'd just follow up with the officials that are back in the office.

Joan Pratchler: — Thank you. I know that quarterly reviews are planned, but what is the current frequency of those counts? Is it yearly? It says March 31st that you just mentioned. Are you now currently doing them quarterly to assess how many are on the waiting list, or what would be the frequency?

Norman O'Neill: — I'll have Dave introduce himself and answer the question.

Dave Morhart: — Hi. Dave Morhart, executive director, acute and emergency services branch with the Ministry of Health. In terms of the frequency of reviewing the wait time data, there would be kind of ongoing informal review that happens all the time through, you know, the provincial head of surgery working with the department leads. However, formally that is done through the quarterly meetings as part of the neurosurgery executive committee.

Joan Pratchler: — So they're currently on quarterly?

Dave Morhart: — Yes, they're quarterly. Yeah.

Joan Pratchler: — Okay, thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Good morning. Just wanted to see if I can sort out a couple of these different items that were, I guess, identified by the Auditor General in her report. One is with respect to fee-for-service and contract, and one is with respect to pooled and direct referral methods. So I understand correctly, you are now moving towards a pooled method and moving away from the direct referral. Do I understand that correctly? So was there analysis done on that to determine that that was the best way to go forward as per her recommendations?

Dave Morhart: — In terms of kind of the pooled referrals versus direct referrals, so there was analysis done. So we looked at, you know, what other jurisdictions are doing, and it's certainly a best practice.

We kind of had the advantage, at the time of the audit, that we had pooled referrals in Saskatoon but not in Regina, so we could see the differences in those processes, in those wait times. So even just looking at that data and seeing, you know, the time that it took to see a physician for a consult, the difference between a pooled process and a direct referral, the differences were quite vast. So we could see that.

And then the other thing too with a pooled referral process, we do have that ability for all patients to be seen through a pathway, where they can get that assessment before surgery is ever booked, to see if they're actually an ideal candidate for a surgery. So they get to see like a physiotherapist and other health care providers that do that assessment to see if they actually are appropriate for surgery. So that's the other advantage of being able to do that through a pooled referral system.

Hugh Gordon: — I guess there's a couple things happening at the same time. We have contracted neurosurgeons, we have fee-for-service neurosurgeons, and we know according to the auditor's report that the fee-for-service surgeons were handling way more patients than the contracted ones but also had higher wait times, right? And they all appear — sorry, not all — but a good majority of those fee-for-service neurosurgeons resided in Regina. We know Regina was getting backlogged.

So I'm just curious, now that you've moved to a pooled referral system province-wide, if you're seeing those fee-for-service neurosurgeries being done and completed at a higher rate in Regina. Is that allowed, that those fee-for-service neurosurgeons do more surgeries, or are we still seeing the same kind of backlog in Regina for the fee-for-service neurosurgery?

John Ash: — Greetings. I'll take this next question. My name is John Ash. I'm the vice-president for integrated Saskatoon health with the Saskatchewan Health Authority and have provincial accountability for the overall surgical program within the SHA.

So to answer your question specifically, of the neurosurgeons there are only three that are still fee-for-service. The provincial department head is actively engaged in working with them to support the transition to contract.

Running parallel to that, we started some work regarding kind of the pooled referral process, and certainly we've worked with our neurosurgeons to get them to sign a letter of understanding around how they would participate in pooled referrals. So far all but four have signed that memorandum of understanding to participate in pooled referral. And once again the provincial department head is actively working to transition the remaining over to sign the pooled referral, and good progress is being made.

Just to highlight, prior to the audit there was roughly 100 patients waiting greater than 24 months for spine surgery. Currently that number is zero.

Hugh Gordon: — Sorry, just to quickly add onto that, the number of neurosurgeons in the province has not been reduced. We have just now transitioned more of the fee-for-service to contract. Do I understand that right? Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — So how has the wait time for neurosurgery consultations been impacted since this implementation of pooled referrals?

[09:15]

Dave Morhart: — So I just want to clarify before answering the question. So we're just actually in the process of onboarding Regina to the pooled referral process, so we haven't actually completed that work. So we don't have the data yet to see what the impact would be, because previously we just had the wait time data for like the direct referral process that would have been cited in the auditor's report. So we don't actually have the data yet to see what that pooled referral process in Regina, how that will have an impact on the wait times.

Joan Pratchler: — So when did it start in Regina, this new process? You're waiting for the data. When did it start?

Dave Morhart: — Yeah, so I can provide some additional clarity. So we have been working with the physicians, with the surgeons to move to the pooled referral, but it actually isn't in place yet. So we're looking at Q4 of this fiscal to have that in place, yes.

Joan Pratchler: — Okay, thank you. I'm just looking at the recommendation no. 5 on page 2 of the document that was submitted, and I see the last part of that recommendation: "unnecessary neurosurgery consultations and surgeries." And then I draw your attention to page 131 of the report. It says, "Saskatchewan generally performs more spine surgeries per 100,000 population than most other provinces." And Saskatchewan has a spine surgery rate of 130.1 per 100,000 and Manitoba has 54 and Alberta has 80.4.

> Saskatoon refers patients to the spine pathway more than twice as often as Regina, and only 10-25% of patients referred through the spine pathway required a subsequent surgical consult.

This drew my attention that, is there a possibility that unnecessary neurosurgeries are happening here in our province?

John Ash: — First off, thank you for your question. So part of looking at the audit recommendations and overall wait-lists, one of the identifying factors was that we had a variation in the utilization of, or the implementation of the pathway between Regina and Saskatoon. We certainly recognize there is variation and, to your point, noting that the rates of spine surgery are higher in Saskatchewan than in other jurisdictions.

The root cause analysis identified that one of the contributing factors is we need to standardize the use of that pathway. So that has been a primary focus for the SHA and working with our surgeons. I know we're focusing on that letter of understanding to get pooled referrals and work through that process because we want to be able to bring patients in, have them properly assessed by a multidisciplinary team to determine whether there is a non-surgical path for them to receive the appropriate care.

And we're roughly around kind of 15 per cent of people going through that pathway now are determined to need surgery. So we want to continue to focus on that work.

Joan Pratchler: — I just want to circle back to the pooled referral process and the outcomes with that. Have any of these pooled referral patients been sent to other cities in the province for their surgeries?

Dave Morhart: — So thank you for the question. So again the pooling right now is only happening in Saskatoon. So in the current process for those patients that are pooled in Saskatoon, they are only referred to a Saskatoon surgeon. So they aren't referred out to another location. However with the future state, with the provincial pooled referral system that we are working to implement by Q4, patients will have the option to indicate if they are willing to travel to see the surgeon that has the shortest wait-list essentially. And so in that case, if they do choose to travel, they may be referred to a surgeon in another location.

Joan Pratchler: — Does the ministry have any plan to contract neurosurgery services from the private sector?

Dave Morhart: — Can I just ask for clarification? Did you say for "neurosurgery service"?

Joan Pratchler: — It's for neurosurgery . . .

Dave Morhart: — Okay, specific to neurosurgery.

Joan Pratchler: — Contract neurosurgery services to the private sector, such as out of province, or other type of private sector care.

Dave Morhart: — Thank you.

John Ash: — Thank you for your question. So we have no plans to send patients out of province for back surgery. We do have a third-party provider that provides surgical services long-standing for about 13 years within the province. We've just renewed that contract with them. And there is a very small subset of spine surgeries that could be treated at that surgical centre. But just to be really clear, most spine surgeries are quite complex, which would not be appropriate. It would be just a very small subset.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Just want to try to tackle a couple of different things here. One of the points that the Auditor General highlighted in her report was there seems to be a lack of analysis to determine whether or not the ministry had enough, or you had enough staff and resources in order to hit your targets. So I just was wondering if the ministry is not doing a sufficient forecast for the number of neurosurgeons, and maybe we could expand that to support staff, all staff required to perform the yearly target for surgeries.

I was wondering if you could comment on that, if you've done a sufficient forecast on resources in that regard now and you've got a good idea of what that is, and if you could also share with me what that target is and if you expect to hit it with current resources.

John Ash: — In follow-up to your question, the Ministry of Health identifies volumes. We then work with the Ministry of Health and internally within the SHA, identify what is the specific resourcing required — that's staff and equipment — to be able to meet those volume targets. So our department head of surgery and department head of anesthesiology are all in the final stages of developing an HHR [health human resources] plan specific. It's being laid out in order to meet those volume targets.

Sorry. Since the audit, we actually have added an additional neurosurgeon.

Hugh Gordon: — So as a follow-up to that, just curious as to . . . Okay, I don't know if the targets, your targets, were clearly reflected in the report.

[09:30]

So I'm just wondering what those are and with your current staffing resources are you confident you're going to be able to reach that target? That was the, I guess, the gist of my question.

Dave Morhart: — Thanks for the question. So in terms of the targets specifically for neurosurgeries, so with our modelling what we forecasted as our annual neurosurgery volumes should reach 1,060 procedures in Regina and 1,150 in Saskatoon. And in terms of if we have the physician resources to meet the target, we feel that we would have the sufficient amount of surgeons to meet that target.

Joan Pratchler: — I was wondering if we could talk a little bit about operating room scheduling. As noted in the report, if I understand correctly, Saskatoon has flextime; sort of urgent cases come up, you just schedule down that. I noticed Regina has a higher proportion of surgeries performed on the weekends and a considerable amount performed after hours. That costs, higher costs for that.

So having this pooled referral, as that, you know, moves forward, will the consideration of scheduling surgeries, where it appears to be quite successful in Saskatoon with flextime, and Regina, the disparities between the two, will those be addressed then as well?

John Ash: — In response to your question, so specifically with regards to flextime in Regina, we have not implemented that as of yet. Our intention is to focus on the pooled referrals and transitioning the surgeons to contract, at which time then we would look at the flextime process.

Joan Pratchler: — And just a follow-up to that. So this recommendation came out in 2023 report, which meant the situation obviously was occurring prior to that. And when I look at recommendation no. 7, it said that preoperative patient screening implementation, the after-hours review, will be happening April 1st of 2026. So that's like three years, four years till it comes to fruition. What are you sensing are the key barriers impacting that length of time in addressing this?

John Ash: — With relation to your question, there is quite a bit of work going on, or there has been historically around, you know, preoperative assessments and screening and so forth in each city.

Our primary work is looking at engaging physicians to standardize that process. And everything's interrelated, so it's really around pooled referrals to achieve that. It's moving them to contract, the LOU [letter of understanding], also working on standardizing preoperative assessment and screening which then feeds into some of the pathway work. So all of that is kind of coming together, which would allow us to address this recommendation — hence the timeline.

Joan Pratchler: — And then would that follow sort of a pilot kind of process as well to see if it's working, and then fully implement? Or how does that process eventually come to working really well?

John Ash: — We know in many . . . Like I had indicated earlier, some of this work is going on already in each site, so it's really around standardizing it. With our surgical executive team — and specifically with the neurosurgery team and the committee that they have — that will be part of their review process to identify are all of our processes ensuring the best possible patient care and what continuous improvement work would need to continue. And the primary focus of that neurosurgery team is really around continuous improvement around many of the processes that are in place.

Joan Pratchler: — So do you anticipate it could be done before 2027?

John Ash: — I wouldn't be able to comment on that. But if we're

able to make things happen quicker, it certainly will. We're going to implement based on our readiness. And if that happens sooner, then that certainly will occur.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I just want to circle back to the spinal pathways recommendation there. You did mention you're hiring more physiotherapists. Can you give me a number about how many you have hired? And then, you know, how many of them are out of province, new graduates, or internal hires, if you have any of that information. And if you don't, perhaps you can provide it at a later date.

Dave Morhart: — So in terms of hiring the physiotherapists, so we are just starting that work to expand the spine pathway. And so for '25-26 it was identified we needed four additional physiotherapists to work within those pathways. So funding was provided in the '25-26 budget for those four additional physiotherapists.

To date, two of those have been hired. And I can't comment on if they were internal hires, or if they were new or came from out of province. I don't have that data.

Hugh Gordon: — And you've determined four additional is going to assist in meeting your goal?

Dave Morhart: — Yeah, so in response to your question, we have determined that at this time those four additional would be sufficient for this year. However we do know that as we expand the pathway we'll need to continually evaluate that, and we may need to add additional resources in the future.

Chair Wotherspoon: — Any further questions, committee members? Not seeing any. These were eight brand new recommendations here today, so substantive considerations. Thanks so much to Health for your focus on them, and good questions from committee members.

I'd welcome a motion to concur and note progress with respect to recommendations 1, 2, 3, 4, 5, 6, and 8. Do I have a mover? MLA Beaudry moves. All agreed? That's carried.

And I'd welcome a motion that we concur with recommendation no. 7. Moved by MLA Beaudry. All agreed? That's carried.

All right, we'll move right along to the 2023 report volume 2, chapter 21.

Jason Wandy: — Thank you, Mr. Chair. The Ministry of Health, under an agreement with the Saskatchewan Abilities Council, a service provider, loans special needs equipment such as wheelchairs, walkers, or lifts to persons with disabilities at no cost. It refers to this arrangement as the special needs equipment program. The total cost to operate the program in 2022-23 was $7.6 million.

Chapter 21 of our 2023 report volume 2 describes our third follow-up audit of management's actions on the two outstanding recommendations we made in 2016 about the ministry's processes to provide special needs equipment to persons with disabilities. By June 2023 the ministry implemented one recommendation through its service provider completing maintenance as required on loaned equipment or appropriately following up with clients to schedule repairs. One recommendation remained outstanding.

On page 194 we continue to recommend the Ministry of Health work with its service provider to identify special needs equipment on loan that is no longer utilized and to recover this equipment within a reasonable time frame. We found the ministry reviews information in the IT system that tracks loaned equipment and periodically provides the service provider a list of deceased clients or clients who had equipment on loan but who left the province.

[09:45]

However the ministry has not set out its expectations of the service provider in using this information, and we found the service provider does not use the information to focus its efforts to recover unused equipment. Our analysis of the ministry's lists identified some unused equipment on loan the service provider may want to focus on recovering. For example we identified seven power wheelchairs, which can cost up to $20,000 to replace, loaned to clients within the last five years who are now deceased or no longer living in Saskatchewan.

At March 31st, 2023, the service provider had 63 clients waiting for power wheelchairs with 15 clients waiting for more than four months. Efforts by the service provider to recover unused equipment from deceased clients or clients who left the province may reduce the amount of clients waiting and their wait time. Establishing criteria to identify unused equipment worth recovering would help the ministry and its service provider focus their efforts on recovering usable and much-needed equipment for persons with disabilities.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Thanks so much for the follow-up on this work. Of course this has already been considered by this committee. There's been questions and whatnot. Thanks for the status update showing the implementation on this front and the work on that front. I'd open it up now . . . or if there's a brief remark from the ADM.

Norman O'Neill: — I'll just note maybe on the first recommendation, regarding the recommendation to work with service providers to identify special needs equipment on loan that is no longer utilized and to recover this equipment within a reasonable time frame, the ministry and its service provider implemented a process to recover special needs equipment of significant value which is no longer being utilized. And I'll stop there.

Chair Wotherspoon: — Thank you for that. Any questions, folks? MLA Gordon.

Hugh Gordon: — I'll try to keep it tight here. I'll try to pack a couple things in here. Hopefully you can knock them off in due course.

Could you just tell us how many pieces of special needs equipment are on loan or currently in the possession of individuals who are either deceased or out of province? And could you share with us your plans to recover any outstanding items that are in possession of people no longer in need of that equipment?

Chad Ryan: — Just to clarify, that was special needs equipment?

Hugh Gordon: — Yes, I believe so.

Chad Ryan: — Okay. ADM Chad Ryan. So currently right now we have total on-loan equipment . . . Sorry, I just thought I had it in front of me. We have 3,526 pieces of equipment on loan. What we look at is that we also look at a variable rate with returns over the course of a year. It's hard to determine specific returns. We can't average returns just due to some years we may have 1,000 pieces of equipment returned; some other years we may have only 200. It really depends on that utilization.

Part of the return policy that we do is that we have an agreement with SaskAbilities that issues equipment. What SaskAbilities does is that, any equipment over $1,000, what they do is (1) they put a sticker on it; (2) is they actually send out a letter. And so as of January 2025, we sent letters to all people who have equipment on loan to them reminding them to return it. So those are typically people who are deceased and equipment over 1,000 that we're targeting.

We do see higher rates of returns, and so in certain years we may see a return at again about 118 per cent of equipment versus other years about 60 per cent.

Hugh Gordon: — And if you could share your plans, like what are your exact plans to recover? Say you've sent the letter and you've got no response for whatever reason. What other steps do you take in order to recover that equipment?

Chad Ryan: — Yeah, we'll take a moment here. Okay. Yeah, so a bit of a process here. So what we do is that we do communicate with the individual who had the equipment loaned to them. Now if we're not able to contact with them, we do contact the immediate family, and that progresses onto the estate for that individual as well. Notification is sent monthly to those individuals.

As well, what we also do is that specifically we have a large amount of equipment loaned out to long-term care facilities, for example. So we work with those facilities specifically to contact them — as well as the same kind of procedure, on a monthly basis and through letters — to have that equipment returned from the facility itself.

Joan Pratchler: — So I just want to understand the new process that you have in place. I'm looking at page 195 of the report where it says the ministry is working with eHealth to improve an IT system to enable better tracking, you know, of equipment. It says here that management indicated that the current system lacks functionality enabling the service provider to remove obsolete or outdated equipment.

My question is, did eHealth create their own program? Did that IT department create their own tracking program of software? And I don't know; I just wonder.

Chad Ryan: — So the system itself is not a specialized system under eHealth. It's actually just a SaskAbilities program that they operate internally themselves. The program itself is being prioritized for an upgrade under eHealth in the coming years, and so that work is going to be prioritized to work on, coming later.

Joan Pratchler: — And do you think that there will be some consideration to talking to the end-user to make sure that the functionality is working for them?

Chad Ryan: — Yeah, so there would be working with multiple stakeholders, specifically SaskAbilities themselves, as well as the Ministry of Health to ensure we kind of see those based on the auditor's recommendations so they're aligned, yes.

Joan Pratchler: — Okay, thank you.

Chair Wotherspoon: — Not seeing any further questions — and just noting to all those folks that are watching this at home, we have considered this chapter before and this is simply follow-up — I'd welcome a motion to conclude consideration of chapter 21. Moved by MLA Crassweller. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We'll move right along to chapter 12 of the 2024 report volume 1. I'll turn it over to the auditor.

Jason Wandy: — Thank you. The Ministry of Health directly compensates fee-for-service physicians at agreed-upon rates for specific services provided to residents with valid health coverage. The ministry pays over $560 million to almost 1,900 physicians under a fee-for-service arrangement each year. Physicians may submit bills for incorrect amounts because of misunderstandings, mistakes, or on occasion, deliberate actions. The ministry cannot practically confirm the validity of all billings before paying physicians. As such, the ministry must have effective processes to detect inappropriate payments to physicians.

Chapter 12 of our 2024 report volume 1 describes our third follow-up audit of management's actions on the two outstanding recommendations we originally made in 2017 about the ministry's processes to detect inappropriate fee-for-service payments to physicians. By March 2024, the ministry implemented one of the recommendations by implementing a new physician-claims IT system to improve processing for physician billing.

The system will help reduce the amount of labour-intensive manual assessments previously done by ministry staff. It will notify physicians immediately if their billing submissions are rejected or accepted, thereby reducing overpayments. The ministry will continue to add edit checks to the new claims IT system as it identifies new risks in relation to inappropriate physician billings.

Having a risk-based strategy supported by an adaptable IT system will allow the ministry to detect inappropriate physician billings before payment, reducing the amount of effort needed to

assess and collect inappropriate payments back from overpaid physicians.

The ministry partially implemented the remaining recommendation on page 167, where we recommended the Ministry of Health assess options to conduct more investigations into physician billing practices that it suspects of having inappropriately billed the government.

We found the physician-claims IT system implemented in 2024 improved data collection, enabling better data analysis to further identify inappropriate billings. With the new, more advanced system having improved business rules and edit checks, ministry management expect physician-claims analysts to spend less time adjudicating claims and more time performing investigations.

At March 2024 we found the ministry had not yet revised its investigation capacity or design. As a result, with the new claims IT system still in its infancy, the ministry had not yet performed additional investigations because significant amounts of data were not yet available for analysis. Therefore the ministry's process to investigate physician claims remained unchanged from our 2022 follow-up audit.

In 2023-24 seven physicians were ordered to pay roughly $1.3 million compared to 12 physicians ordered to repay about $2.6 million in 2022-23. Enhancing the ways the ministry conducts investigations into physician billing practices may identify and recover more inappropriate billings as well as reinforce with physicians the importance of appropriate fee-for-service billing practices or identify areas where the ministry needs to offer further education and support.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Well thanks so much for the follow-up. Thank you to the ministry for detailing the actions that've been taken to implement these important recommendations. I'd invite ADM O'Neill to offer a brief remark, and then we'll look if there's any questions.

Norman O'Neill: — As the first recommendation is implemented I'll just touch on the second, which is for the ministry to assess options to conduct more investigations into physician billing practices. The ministry explored options to conduct more investigations. The new physician-claims IT system implemented in 2024 improved data collection, enabling better data analysis to identify inappropriate billings. The ministry's also staffed two permanent full-time audit positions to increase audit and investigation capacity.

And those conclude my remarks.

Chair Wotherspoon: — Thank you for that. Committee members, any questions? MLA Gordon.

Hugh Gordon: — Thank you. I was wondering if you could expand or tell us . . . utilizing a new IT system for physician billings. I was wondering if you could just tell us how many physician billings have been requested under this new system? And are you actually seeing a reduction in inappropriate billings because of that new system being engaged? Are you seeing that impact on inappropriate billings?

[10:00]

James Turner: — Good morning. ADM James Turner. So just on the total volumes through the system. So physicians do have six months to submit billings, so sometimes there's a lag in the timing of their submission of billings. So the '23-24 total paid amounts through the system were $566 million and that was an increase of 0.7 per cent from '22-23. Now we would anticipate probably a similar growth rate going forward, just as a standard utilization increase. So that's probably what we can expect in terms of the volumes.

In terms of the tools in the system, so like just as an example, physicians can now input times and add documentation into the submission with their billings. So actually it will self-serve, so that we don't have to spend time adjudicating things or looking at them at the back end. It goes in. The system will actually check for it, make sure it's valid. So those are the kind of tools that will reduce some of the inappropriate submissions. I don't have a hard number to tell you about what that total looks like. I think as the system stabilizes, we'll know what that difference looks like relative to what it was before.

Hugh Gordon: — Exactly, and that kind of gets to the heart of my question which is like, you know, talking about actual dollars in terms of inappropriate billings. You would know what that looked like over the last few years, you know, leading up to these changes. So it would be very interesting to note if you can report in the future what those savings actually look like in dollar terms. And we could say yes, this IT system is assisting in reducing that by this amount. Does that make sense? I know you probably . . . Maybe not in like real-time terms, but just sort of like historically, we've been able to save or reduce inappropriate billings by a certain amount. Because if it's done appropriately, like at the source, every time it catches it you wouldn't know what you're saving, right? Am I understanding it correctly?

If it's up to the physician to put the appropriate documentation in, fill out all the data, and then, you know, if it's catching it at source then you may not be able to quantify that. But I'm just talking about maybe in historical terms you could say, with the introduction of this new system you could give us a dollar figure in a year's time — I don't know when — to say, we've reduced it by X amount.

James Turner: — I can probably just answer that one. So I think there is a plan to do a pre- and post-assessment on what that looks like. We're just not stabilized through that system. And then we might actually see that it's actually like a lot lower now, given those checks. So the evaluation might show the inappropriate billings are actually far lower given those checks relative to what we were seeing before, but that will have to be evaluated through a pre/post review.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Thank you. Are any investigations automatically triggered by one rejected claim? By multiple rejected claims by the same physician? And how many claims were found to have been rejected in error?

James Turner: — All right, so thanks for the question. The answer is yes, we do have the capacity in the system to actually

look at combinations of billing or actually look at targeted practices. And so we are able to do that. One example would be sort of time-based codes. So we can actually have the system look at where time-based is overlapping to actually look where there is concurrent billings for the same time. So the time-based codes have enabled us to actually see and sort some of those out easier.

In terms of the rejection-in-error number, I don't have a total number of what would be rejected in error. And so this is also a benefit of the new system, is it actually rejects before it even gets through. So on the old system it would get through and then get rejected. And so we actually now are able to prevent the submission of billings that aren't meeting the proper criteria. So there's an upfront screen that just, they don't even get to submit it.

Joan Pratchler: — So would there be any claims submitted in error then? I guess with time-based that would be different.

James Turner: — Yeah, there would still be codes submitted in error. So the payment schedule is a really complex document — it's over 400 pages — and so this is where the education component would come in, in that sometimes it's not that physicians are intending to bill inappropriately. It's that the rules are very complex.

And so there might be a combination where they bill a couple things inappropriately that the system didn't detect because the initial screen is fairly simple. And so there might be some complexity at the back end where we're like, no, that doesn't quite look right. And so I think that can still happen in the new system. It's just reduced the frequency of the most common combinations of things that aren't able to be billed.

Joan Pratchler: — So just to refresh my memory, when did that new system start taking effect?

James Turner: — So it was February of 2024.

Joan Pratchler: — And then are there continual reviews or checking in on that system to see if there's any modifications or updates? Has the pilot gone far enough that there has been some review?

James Turner: — I think the stabilization period for the first year, it was a bit rockier than we anticipated in that first year. And so I think there will be sort of constant reviews and improvements done as a PDCA [plan, do, check, act] to check and adjust things. I just think that first period of stabilization was far more intense than we actually anticipated, and so I think some of those things that we had planned for the first year are now just starting to get actioned.

Joan Pratchler: — Thank you very much.

Chair Wotherspoon: — Not seeing any further questions on this follow-up chapter. Thanks again to those that have been involved in the implementation of these recommendations. I'd welcome a motion to conclude consideration of chapter 12. Moved by MLA Chan. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried.

We'll move right along. I'll turn it back over to the Provincial Auditor to focus on chapter 13 of the 2024 report volume 1.

Jason Wandy: — Thank you. The Ministry of Health is responsible for monitoring the prescribing and dispensing of opioid medications. The ministry monitors prescribed opioids by funding the prescription review program operated by the College of Physicians and Surgeons of Saskatchewan. While opioid medications can bring significant improvement to patients' quality of life by relieving pain, opioids pose a risk for misuse or diversion leading to addictions, overdoses, and deaths. Saskatchewan had 343 deaths related to opioid toxicity in 2023, an increase of about 91 per cent since 2019.

Chapter 13 of our 2024 report volume 1 describes our second follow-up audit of management's actions on the four outstanding recommendations we originally made in 2019 about the ministry's processes to monitor the prescribing and dispensing of opioids to reduce misuse and addiction. We continue to find two recommendations not fully addressed.

By March 2024 the ministry assessed the benefits and challenges of recording hospital-dispensed opioids in the provincial drug IT system and determined the challenges outweigh the benefits. Therefore it does not expect to record hospital-dispensed opioids in the provincial drug IT system. Rather opioids prescribed at patient discharge from a hospital will be recorded in the provincial drug IT system and monitored through the program.

In addition the ministry provided the program with provincial access to urine drug-screening results to help program staff conduct effective analysis in identifying potential opioid misuse. Urine drug-screening results can help program staff confirm whether patients used opioid medications as prescribed or identify potential opioid misuse.

The ministry partially implemented our recommendation on page 172 where we recommended the Ministry of Health determine whether the prescription review program is helping reduce the misuse of prescribed opioids in Saskatchewan.

In 2023 the ministry engaged an external consultant to evaluate the program's effectiveness and impact on reducing the misuse of prescribed opioids in Saskatchewan. The consultant assessed the program in four areas — design and delivery, effectiveness, efficiency, and sustainability — and reported that while the program demonstrated positive results in changing prescribing practices for some opioids, the opioid crisis persists in Saskatchewan.

The ministry planned to meet with its partners, for example the College of Physicians and Surgeons of Saskatchewan and the Saskatchewan College of Pharmacy Professionals, in late May 2024 to establish an advisory committee and a working group to implement agreed-upon recommendations from the consultant's report, including developing clear program objectives, determining opioid information to share with partners, and establishing service agreements with each of its partners

It expected to complete this work in 2024-25. Having clear program objectives with regular information sharing and

reporting between key program partners would strengthen the program and give the ministry a sense of the number and nature of potential opioid misuse cases in the province.

The ministry did not implement our recommendation on page 173 where we recommended the Ministry of Health establish a risk-based approach to identify concerns in opioid dispensing in Saskatchewan pharmacies.

The external assessment of the prescription review program in June 2023 identified a need for better collaboration between the program's partners, specifically having the program share regular monitoring results with the Saskatchewan College of Pharmacy Professionals to monitor opioid dispensing in pharmacies. The ministry expected to have a more detailed approach to better monitor pharmacy dispensing after all program partners met in May 2024.

At present program staff continue to refer any potential cases of inappropriate pharmacist dispensing practices to the Saskatchewan College of Pharmacy Professionals. In 2022-23 program staff referred 15 pharmacists with potentially inappropriate dispensing practices to the college.

At December 2022 Saskatchewan had just over 1,200 pharmacists and 140 pharmacy technicians in 418 community pharmacies. Because the program does not specifically collect and analyze data about dispensing practices in Saskatchewan's pharmacies, the ministry does not know whether any specific provincial pharmacies contribute to Saskatchewan's opioid crisis.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the follow-up. Very important chapter originally presented to us a number of years back and this committee considered, I believe, in 2022. I'll turn it over to the ADM for brief remarks. Then we'll open it up for questions.

[10:15]

Norman O'Neill: — As recommendations 1 and 4 are considered implemented, I'll just touch on numbers 2 and 3. So regarding the second recommendation — to determine whether the prescription review program is helping reduce the misuse of prescribed opioids — the Ministry of Health had an external program evaluation completed on the prescription review program in June 2023. Key areas identified for improvement include developing clear annual program objectives, determining what opioid-related information should be shared with partners, and establishing formal service agreements with each partner.

In May 2024 the ministry met with all partners to establish an advisory committee and a working group to implement the agreed-upon recommendations. The advisory group has been tasked with advancing the development of program objectives, clarifying information-sharing protocols, and formalizing service agreements. In continued collaboration with partners, the ministry remains committed to moving this work forward, with full implementation expected by summer 2026.

Regarding the third recommendation — to establish a risk-based approach to identify concerns in opioid dispensing in Saskatchewan pharmacies — the Ministry of Health has not yet developed a risk-based approach. The external assessment of the prescription review program completed in June 2023 highlighted the need for improved collaboration among program partners by sharing regular monitoring results with the Saskatchewan College of Pharmacy Professionals to support oversight of opioid-dispensing practices in pharmacies. In continued collaboration with partners, the ministry remains committed to moving this work forward, with full implementation by summer 2026.

That concludes my comments.

Chair Wotherspoon: — Thanks for the comments. Thanks for the work that's been undertaken and the work that's committed to on this front. Looking to committee members that may have questions. MLA Pratchler.

Joan Pratchler: — Thank you. What is the rough estimate of the cost to change other IT systems such as eHR Viewer to make them compatible with the proposed changes to hospital dispensing records? And is there a cost estimate for the modification to track patients' in-patient versus out-patient medications?

Chad Ryan: — All right, so I'll just provide an update for the question. So specifically when it was looked at, when the analysis was completed on the IT system, the cost resource outweighed the patient safety component based on the analysis.

And so what they found is that having the two operating data systems proved better for patient regarding prescriptions being provided within the hospital, being controlled setting, as well as looking at the community in a different setting whereby focusing on the referring GP [general practitioner] or moving then to the community pharmacist for oversight.

Joan Pratchler: — Do you track how many people die of opioid overdose in this province who are prescribed opioids?

Chad Ryan: — Okay, just to start out on this, and so when reporting these numbers, these numbers are tracked and publicly reported through the coroner's office. So in 2024 we have 346 deaths suspected related to drug toxicity. And the explanation behind that is that we don't have it confirmed between illicit and licit drugs, so a better answer to come through possibly the coroner's office on that.

Joan Pratchler: — And then just to follow up, was there any cost-benefit analysis or did the cost-benefit analysis estimate by what margin those deaths could have been reduced then?

Chad Ryan: — Okay, just going back to the issue at hand, so again we are not able to differentiate between illicit and non-illicit drugs and deaths. And so the issue then would be is that we cannot apply an analysis to that to determine the cost estimates on those.

Joan Pratchler: — So if I wrote down properly, we'd have to go through the coroner to find those details?

Chad Ryan: — What I know is those numbers are posted

publicly. And whether or not, I don't know specific how they post it on that. But it would be a follow-up on that side.

Joan Pratchler: — Okay. And what would be the reason that the Ministry of Health wouldn't or this department wouldn't do that, given the connection that we have with the pharmacists dispensing, hospitals dispensing doctors' prescriptions for opioids? Wouldn't that fit under the IT umbrella of this?

Chad Ryan: — Again, I think it just goes back to the simple component is that it's suspected deaths. So we are tracking confirmed and suspected drug toxicity deaths. We do have those numbers. Those are then posted by the coroner's office which actually does that investigation into that. So we do receive those numbers back, as well as the public, back on that. But beyond that we don't have the actual illicit versus non-illicit drug use for that individual who's affected.

Joan Pratchler: — Right. And so someone has the precursor information that person X was prescribed opioids for a certain amount of time, could have had a drug toxicity for a variety of . . . How many different drugs are out there? But somebody does have the precursor or the access to the precursors that opioids were prescribed to person X on their exiting the hospital or as part of their treatment plan.

[10:30]

Chad Ryan: — So again I'm going to have to go back. So the issue is that if an individual does pass away as a result of an opioid, it is suspected, so we will know if that individual on our side was prescribed that opioid. However what I do not know is I do not know whether that opioid that was prescribed was actually the cause. Therefore it's still suspected.

What I do know though is that in the event where we're seeing irregularities within prescribing or dispensing, we do have the prescription review program which then monitors both physicians as well as pharmacies in prescribing as well as dispensing. As noted that any information that would have been shared between, say, the coroner's office and prescription review program or any data that would have been monitored, that would have been highlighted by the prescription review program and then sent off to the College of Pharmacy essentially then, to professional College of Pharmacy, to then look at that a little bit more to analyze it and then contact that said pharmacy where that possible error or issues were arising for prescribing those opioids.

Joan Pratchler: — Right. Well that helps clarify. Because we know research shows that if someone has been on opioids for, you know, a wisdom tooth pulled out, and that just carries on and carries on and now we have a bigger problem. But I'm glad to hear that it's tracked in some manner. Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I was curious, touching on your prescription review program, if your jurisdictional scans of other PRPs [prescription review program] gauge how much those PRPs reduced the misuse of prescribed opioids and their jurisdictions, and if so, did that help formulate your goal for Saskatchewan?

Chad Ryan: — So I can report that the prescription review program does have an advisory committee, and this advisory committee is conducting a j-scan [jurisdictional scan] right now. This j-scan will result in benchmarks which the committee then will implement by the summer of 2026.

Hugh Gordon: — Thank you.

Joan Pratchler: — I just want to talk a little bit more about the recommendation regarding that risk-based approach to identify concerns. And you've mentioned there's been some progress towards that, on establishing that and identifying, you know, some concerns. Is the goal then to actually implement a risk-based approach then by June of 2026?

Chad Ryan: — So I can report that on that recommendation, it's in progress. And so what I mean by that is, to date, that the prescription review program is tracking the dispensing as well as prescriptions of pharmacies. A more targeted approach on the risk assessment is in its works. Again, we're going to look at full implementation by summer 2026.

But specifically some of the moves that we've made in the interim is that we've implemented requirements for all pharmacists and physicians to look at prescriptions, look at the pharmaceutical information program, so the PIP system, to ensure that they're looking at that. The other thing too is that we've required pharmacies to have delayed safes installed within pharmacies which then protect those opiates from robbery and such.

As well as that we also do quite a bit of education through the prescription review program, so specifically looking at forgery components in communication and small steps. The prescription review program is an education component to it and allowing the regulatory body then to follow up with any further investigations. So I could say that it's in progress and on way with implementation summer of 2026.

Joan Pratchler: — What have been some of the successes in improving collaboration with the partners like the College of Pharmacy Professionals?

Chad Ryan: — Okay. Just a couple to note is that again, going back, is that the implementation . . . Some success is the implementation of the time-delayed safe. We've also had field officers that go out and inspect within pharmacies themselves. We also have greater collaboration with the federal government who also does inspections on an annual basis.

As well as the main component is that education to the prescribing and dispensing. To note, we are looking at, in this next eight to nine months, is an implemented competency assurance program, working on a broader audit framework which includes a review of pharmacy prescribing and dispensing practices. So creating some guidelines and terms around that, and specifically focusing on narcotic audits, including narcotic destruction as part of their regular field office visits. So again, that education as well as more practical.

Joan Pratchler: — Thank you. Just ballpark, how many potential cases of inappropriate pharmacists' dispensing were referred to the College of Pharmacy Professionals last year? Do you know offhand?

Chantelle Patrick: — Hi. Chantelle Patrick, executive director of drug plan and extended benefits branch. So the Saskatchewan College of Pharmacy Professionals, they track this on a calendar year, and so not fiscal year. And so in 2024 there was 21 reported.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I understand that the ministry still hasn't got a service agreement with the College of Pharmacy. Do I understand that correctly? Yes. So I just was wondering when we can expect to see that in place. I notice your update said there were informal discussions going on. And I just was curious what you expect to gain from that service agreement? What would that entail? How does this assist in reducing the misuse of prescribed opioids?

[10:45]

Chad Ryan: — So what we know to date, the partners are getting what they want to speak to, so agreements are coming. Specifically what we're looking at within the agreements themselves is to get a bit of a cadence regarding the types of reporting that we'd want to look at, the frequency of actually meeting to discussions, update to any of the information that's available to public or any of the partners there, and offer clarity across the board to each where they stand.

So we are looking forward to these agreements. There's a lot of conversations happening to date regarding that, to that, for again that implementation for the summer of 2026.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Thank you. And just to follow up a little more, have you tracked how many incidents of inappropriate prescribing were caught as a result of the prescription review program staff accessing drug-screening results? Those may or may not have been referred to the College of Pharmacy.

Norman O'Neill: — So we don't have the data in front of us but we can provide a written response after. Last time we had 30 days as our window, so if 30 days works we can follow up.

Chair Wotherspoon: — Yeah, you bet. Thirty days is great and you can supply that back through the Clerk to the committee. Thank you very much.

Joan Pratchler: — Just one last question: what safeguards are in place to ensure that the prescription review program staff appropriately access results?

Chad Ryan: — And so just a point of clarity . . . Just to clarify, access results in what type?

Joan Pratchler: — I'm not even sure what kinds and how they go about doing it. But surely there must be safeguards in place that people can't willy-nilly go and get things.

Just like ER viewer. As a nurse, you have to have the credentials. You have to have these things. And they do regular checks to see who's accessed the information and who hasn't. It would be flagged. I don't know if that's how this works as well. I'm not sure. I just want to know what might be in place for that to keep everyone safe.

Chad Ryan: — So with regards to your questions and the safeguards in place is that, yes, there are appropriate safeguards in place. And so specifically what that would mean is that staff would go through a similar process as it would be a nurse or any other health care professional. So access is based on a privilege and analysis of that individual and allowed that right. So that information then is held and not obtained or accessed externally.

Joan Pratchler: — That's all my questions.

Chair Wotherspoon: — Any further questions on this chapter? Certainly it's, you know, a very important chapter and substantive questions and responses, so thanks for all the work on this front. I'm not seeing any. I'd welcome a motion to conclude consideration of chapter 13. Moved by MLA Beaudry. All agreed? That's carried.

We'll turn things over, back to the Provincial Auditor to focus on chapter 19 of the 2024 report, volume 2.

Jason Wandy: — Thank you, Mr. Chair. The Ministry of Health is responsible for ensuring people with chronic diseases such as diabetes receive appropriate care. It works in partnership with various agencies, for example the Saskatchewan Health Authority or eHealth Saskatchewan, to deliver diabetes-related programs and monitor the incidence and prevalence of the disease in the province. At March 2023 there were about 101,000 Saskatchewan residents with diabetes.

This chapter describes our fourth follow-up audit of management's actions on the three outstanding recommendations we first made in 2012 about the ministry's strategies for preventing diabetes-related health complications. By September 2024 the ministry implemented the three remaining recommendations.

The ministry collected and analyzed care information related to diabetes and diabetes-related complications. For example, it continues to increase physician use of its chronic disease management quality improvement program IT system. This system collects data from participating physicians about key health care services and programs provided to people with diabetes.

There were 900 physicians and nurse practitioners using the system in May 2024 compared to 791 using the system in July 2020. Using this data the ministry began producing monthly chronic disease reports as well as clinic reports for Saskatchewan Health Authority-operated clinics. These reports help inform priorities for service improvement. The ministry also collects and tracks data on diabetes-related complications and uses this information to assist with program planning.

The ministry also provides the Authority with chronic disease information organized by geographic area, prevalence, and age-standardized prevalence. The Authority began using this information to generate an online dashboard in 2024. According to the Authority's dashboard, the overall diabetes prevalence rate increased from 8.2 per cent in 2017-18 to 8.5 per cent in 2020-21, with the northeast, including communities such as La Ronge, Creighton, and Big River having the highest prevalence rate at

10.1 per cent and Saskatoon having the lowest at 7 per cent.

In 2024 the ministry and the Authority started a mobile point-of-care testing pilot project in northeast Saskatchewan for diabetic clients. Having data on the prevalence of diabetes across the province can help the Authority and the ministry determine areas with greatest need for resources. Preventative measures and better disease management can reduce the prevalence of diabetes-related complications and the impact of the disease on quality of life and lead to lower health care costs.

I'll now pause for the committee's consideration.

Trent Wotherspoon: — Thanks for the follow-up on this front. I'll turn it over to the ADM for a brief remark, and then we'll check in and see if we have questions.

Norman O'Neill: — As all outstanding recommendations are considered implemented, I'll just forgo any remarks.

Trent Wotherspoon: — Thank you very much. Thanks for the work on this front as well to all the officials that made it happen. I'll open it up if there's any questions. MLA Gordon.

Hugh Gordon: — Thank you. I just was wondering if you've seen a reduction in hospitalization for diabetes-related health complications since the usage of your IT system CDM-QIP [chronic disease management quality improvement program] increased.

Norman O'Neill: — So we think we can capture that data. We don't have it with us. We'll take a look into our systems with what we do have and if we can we can return in 30 days.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — How may individuals have participated in the mobile point-of-care testing pilot project?

[11:00]

Norman O'Neill: — So this is another one that I think we'll have to follow up with. We just don't have the data in front of us at this time.

Chair Wotherspoon: — Thanks. So on that front you've made an undertaking to get that information back to us within 30 days. Is that reasonable?

Norman O'Neill: — Yeah.

Chair Wotherspoon: — Yeah, thanks so much. Pratchler.

Joan Pratchler: — In just circling back to the question that my colleague asked about reduction or the data on the reduction of hospitalization for diabetes and related health complications, it seems to me that that would be a wonderful indicator to show the success of the program. Is that? And when you provide that, if that is not an indicator, what would it take to make that an indicator? That would be something to be celebrated, I would think.

Melissa Kimens: — Thank you. Melissa Kimens, executive director of the primary care branch, administrative health. Thank you for the question. We don't have that data as we had mentioned earlier. However it would be something to celebrate if it did show the trend that we expect that it will. However we will have to look for the rate as opposed to a whole number just given population change, growth that we've experienced in the province. So overall the number is likely going up in terms of whole people, and yet the rate we would like to see that there has been an impact from the use of the CDM-QIP. Thank you.

Joan Pratchler: — Great. I have one last question regarding that point-of-care testing pilot project. Does the ministry have any way of gauging which individuals using these services would have had to travel for care versus not seeking care?

Melissa Kimens: — Thank you. We don't track the travel saved for individuals. So I'm sorry we're not able to answer that question.

Joan Pratchler: — Is there any consideration for tracking that? Because sometimes that's a barrier to access.

Melissa Kimens: — We could look to see if there's a mechanism to gather that when patients are receiving the point-of-care testing. So that is something that I can certainly take back and look how it could be operationalized, but at this point in time it's not.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — Any further questions, committee members? Not seeing any with respect to chapter 19, so I'd welcome a motion to conclude consideration. Moved by MLA Crassweller. All agreed? That's carried.

We'll move along to chapter 20 of the 2024 report volume 2, and I'll turn it back to the auditor.

Jason Wandy: — Thank you. In health care a critical incident is a serious adverse health event that did or could have resulted in serious harm or death of a patient. Critical incident reporting is a recognized tool in improving patient safety in the health care sector.

The Ministry of Health is responsible for overseeing critical incident reporting, evaluating whether those steps health care organizations identify are likely to prevent reoccurrence of similar future incidents and preparing patient safety alerts that address system-wide concerns. In 2023-24 health care organizations such as the Saskatchewan Health Authority and the Saskatchewan Cancer Agency reported 215 critical incidents to the ministry compared to 145 reported critical incidents in 2022-23.

This chapter describes our first follow-up audit of management's actions on the 10 recommendations we made in 2021 about the ministry's process for using critical incident reporting to improve patient safety. By June 2024 the ministry made some improvements to its critical incident reporting processes, but further work remains.

It implemented three recommendations. The ministry expanded the list of adverse health events it requires health care

organizations to report as critical incidents to fully align with good practice, it confirmed critical incident reporting forms are complete, and compared specific critical incidents to other health data sources such as from the Canadian Institute for Health Information.

The ministry partially implemented the two recommendations on page 198 where we recommended the Ministry of Health ask health care organizations to include root causes of the incident when reporting critical incidents, and where we recommended the Ministry of Health or responsible health care organization apply consistent criteria to assess whether planned corrective actions effectively address causes of critical incidents.

When completing a critical incident report, the ministry requires health care organizations to document recommended actions for improvement to address contributing factors or causes identified. In May 2023 we found the ministry appropriately added documentation guidance to the Saskatchewan critical incident reporting guideline, which provides additional information about each field required in a critical incident report, including a description for contributing factor and recommended action.

The ministry's critical incident review committee reviews all reported incidents for compliance with the guideline, including an assessment of contributing factors identified and whether recommended actions sufficiently addressed those factors and prevent or mitigate future harm. Good practice recommended by the Canadian Patient Safety Institute includes using the hierarchy of effectiveness to aid in determining whether corrective action will be strong enough to modify behaviour and improve patient safety.

Our assessment of 20 critical incident reports found 17 reports with weak planned corrective actions based on the hierarchy of effectiveness, for example, expecting actions like updating protocols or training staff instead of adding an IT system alert that forces action.

We also found in 10 reports health care organizations did not explain why the incident happened. Without this information, the health care organization may not identify all contributing factors and develop appropriate actions to address them.

The ministry did not implement our recommendation on page 201 where we recommended the Ministry of Health follow up when receipt of critical incident reports are beyond established reporting deadlines. *The Critical Incident Regulations, 2023* set out time frames for our health care organization to notify and report the results of critical incident investigations to the ministry.

Our analysis of reported critical incidents between April 2022 and May 2024 found most incidents reported to the ministry came from the Saskatchewan Health Authority. It reported 334 critical incidents to the ministry, and the Saskatchewan Cancer Agency reported six critical incidents.

Our analysis of critical incidents found the ministry continues to frequently receive critical incident reports from health care organizations later than the time frames required by law. In 2023-24 we found the ministry received 62 per cent of initial notifications later than the three-day requirement compared to 44 per cent in 2019-20. We also found the ministry received 90 per cent of the critical incident reports later than the 60-day requirement compared to 73 per cent in 2019-20. The ministry indicated it does not follow up with the Authority to determine why it takes longer than the required deadline of three business days to notify it of a critical incident.

In addition, we found the ministry does not follow up on final critical incident reports not received within 60 days of the notification of the incident. The ministry indicated it expects to focus on the timeliness of reporting once it sees improvements in the quality of reports and implementation of recommended actions.

The ministry partially implemented our recommendation on page 204 where we recommended the Ministry of Health monitor the status of implementation of corrective actions set out in critical incident reports. In September 2022 the ministry began receiving quarterly critical incident listings from the Authority that included the number of corrective actions or recommendations, the due date, the status — such as incomplete or complete — for each incident.

In its 2022-23 annual critical incident report, the ministry reported 340 outstanding recommendations as of June 2023, with 94 per cent noted as not implemented and past the planned implementation date provided by the Authority. Based on our analysis of the Authority's critical incident listing at March 2024, we found 58 recommendations still outstanding from the Authority's 2022-23 critical incidents, averaging 209 days late in terms of planned implementation.

We also found the ministry does not regularly confirm whether the information provided by the Authority is complete and accurate. We identified six critical incidents that the Authority previously reported to the ministry but were not included in the March 2024 listing.

On page 205 the ministry partially implemented our recommendation where we recommended the Ministry of Health and/or responsible health care organization utilize criteria to determine when to issue patient safety alerts, and it did not implement our recommendation where we recommended the Ministry of Health work with the Saskatchewan Health Authority to monitor the effectiveness of patient safety alerts.

In October 2023 the ministry drafted criteria for when to issue patient safety alerts, which the provincial patient safety executive committee approved in December 2023. Following a critical incident review, the ministry determines whether a patient safety alert may be required based on specific criteria, for example, consideration of the potential for the issue, including risk of death, to exist at other reporting health care organizations.

When a critical incident meets the criteria, the ministry then conducts further analysis and issues a patient safety alert. We found the criteria and rationale for issuing patient safety alerts aligned with good practice. The ministry had not issued any patient safety alerts since September 2019, but it indicated it planned to potentially issue two safety alerts by December 2024.

The ministry also had yet to develop guidance for assessing the effectiveness of patient safety alerts; it planned to do so in

2024-25. Using standard criteria to determine when a patient safety alert is warranted reduces the risk that an alert is made for a minor or localized issue.

The ministry partially implemented our recommendation on page 207, where we recommended the Ministry of Health analyze critical incidents for systemic issues. In 2022 the ministry began preparing annual reports on critical incidents using information from its critical incident IT system and the Authority's quarterly critical incident listings to summarize and analyze incident information by areas such as by health care organization, department, or patient outcome.

In each area the ministry provides trend information for a five-year period. While the number of critical incidents decreased significantly in 2022-23, the ministry noted the decrease was not necessarily an indication the health care system was safer; rather, organizations may not be reporting all critical incidents.

The ministry's annual reports on critical incidents highlighted certain systemic issues identified through its trend analysis. For example, in both its 2021-22 and 2022-23 reports, the ministry noted the two most common never events were critical incidents related to an unintended foreign object left in a patient following a procedure and stage 3 or 4 pressure ulcers acquired after admission to a health care facility.

In January 2023 the ministry created the framework for implementing critical incident system-wide improvements that include steps such as identifying an area for improvement, collecting data, developing strategies, implementing strategies, and monitoring their effectiveness.

[11:15]

The ministry, along with the Authority, planned to trial the framework on the unintended foreign objects left in a patient following a procedure. Management expected to begin this work in 2024-25.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Thank you very much for the presentation and I think for the follow-up on this front as well. This chapter was originally brought to us in 2021. This committee's supported, concurred in these recommendations. We've had some of the actions detailed as well by Health.

I'd invite some brief remarks from the ADM if there's any, and then we'll open it up for questions.

Norman O'Neill: — I'll touch on the items that are not considered implemented.

So starting with recommendation no. 2, concerning the recommendation for the Ministry of Health to ask health care organizations to include root causes of the incident when reporting critical incidents, the ministry now requires reporting organizations to amend their critical incident reports if the critical incident review committee identifies that the contributing factors provided do not truly explain why a critical event incident occurred. If the reporting organization is unable to provide the requested information, then they are asked to state this in the critical incident report. The ministry is continuing to work with the SHA to implement further improvements over the fall of 2025.

Regarding the third recommendation, which is to apply consistent criteria to assess whether planned corrective actions effectively address causes of critical incidents, reporting organizations will be required to amend their critical incident reports with improved corrective actions, unless the critical incident review committee is satisfied that better options were explored and found to be unattainable. These reasons will be documented in an amended critical incident report. Implementation of an updated critical incident report template is expected to be completed in January of 2026.

The next item is recommendation no. 5, which is for the Ministry of Health to follow up when receipt of critical incident reports are beyond established reporting deadlines. The ministry and SHA held a two-day improvement event for all reporting organizations in September of 2025, and included other stakeholders such as patient and family advisors.

The purpose of this event was to better understand critical incident reporting processes and barriers or challenges experienced by each organization, which will lead to the identification of internal process improvements towards meeting reporting deadlines. A work plan for improving on the timeliness of critical incident reporting was developed at the event, and progress on deliverables throughout the fiscal year will be monitored.

The ministry will also disseminate a monthly report that is shared with the reporting organizations, listing all critical incident reports that are overdue. A phased implementation began in September of 2025 with a focus on closing the oldest critical incidents first. The implementation of a follow-up process for overdue critical incident reports will be completed by Q4 of '25-26.

Regarding recommendation no. 6, which is to monitor the status of implementation of corrective actions set out in critical incident reports, the ministry and SHA are planning a second improvement event with a date yet to be determined for all reporting organizations to attend in the late fall, where the focus will be on improving processes to implement corrective actions.

Regarding recommendation no. 7, which is for the ministry and all responsible health care organizations to utilize criteria to determine when to issue patient safety alerts, it is deemed implemented by us as of April 2025. The criteria include consideration of the potential for the issue to exist in other reporting organizations. It can be corrected by systemic actions taken to prevent or reduce errors by front-line care providers.

For recommendation no. 8, which is for the ministry to work with the SHA to monitor the effectiveness of patient safety alerts, the ministry will collaborate with reporting organizations as they work through the new process for monitoring the effectiveness of patient safety alerts. The duration of this process will vary depending on the reporting organization based on how the patient safety alerts apply to their programs. The start of patient safety alerts monitoring by the ministry and applicable reporting organizations will begin in Q3 of this year.

For recommendation no. 9, which is for the ministry to analyze critical incidents for systemic issues, we do consider this recommendation as being implemented as of April 2025.

In 2023 the ministry developed a framework for implementing critical incident system-wide improvements. This includes an analysis of past critical incidents in comparison with other health data sources. Since 2024 the ministry has applied the framework and completed an analysis of three subsets of critical incidents. Results from the analysis were shared with the patient safety executive committee and the relevant operational leaders from reporting organizations to support strategic planning and improvement initiatives. Ongoing, the ministry will continue to utilize the framework to analyze critical incidents for systemic issues on an annual basis.

And that concludes my comments.

Chair Wotherspoon: — Thanks for the presentation. Thanks for much of the work that's been undertaken as well. I'd look to committee members that may have questions. MLA Pratchler.

Joan Pratchler: — Thank you. My, a lot of work has happened. When I look at the definition of what a critical incident is — it's on page 195 — it's a serious adverse health event that did or could have resulted in serious harm or death of a patient. And I'm just curious, would poorly communicated ER [emergency room] closures be considered a critical incident?

Dave Morhart: — Hi. Dave Morhart, executive director of acute and emergency services branch with the Ministry of Health. Thank you for the question.

So specific to your question, like a disruption itself wouldn't necessarily be considered a critical incident. But if it did lead to a delay in diagnosis or treatment that did lead to serious harm to the patient, then that would certainly qualify as a critical incident based on the definition.

Joan Pratchler: — Yeah. And so I'm referring to if there's an ER closure in location X and the notice on the door says, go to location Y. And location Y is also closed, that that may be considered a critical incident that they were asked to go to a place where now . . . there is no more.

Dave Morhart: — Yeah. So I think that, like the clarification would be that it would, you know, depend on the event. And like if that occurrence resulted in a delay or diagnosis that led to harm to the patient, then that's where it would be considered a critical incident.

Joan Pratchler: — So that would be tracked. That kind of event could be tracked and would be tracked and addressed?

Dave Morhart: — Yes, we would anticipate that if an event like that were to occur, that that would be reported to the ministry. Yeah.

Joan Pratchler: — Okay, thank you. How many deaths from nosocomial infections were there last year?

Dave Morhart: — So we were able to look at our data, and in '24-25, which would be the most recent, there was one reported.

Joan Pratchler: — Good. Just want to refer to page 195 in the report where it says as of June 30th, 2023, 94 per cent of corrective actions noted were not yet implemented by the Authority. I'm just wondering, how does that compare with how many aren't implemented this year?

Dave Morhart: — So specific to that data, so a couple of things . . . And I know you didn't note that in the auditor's report it said 340 outstanding corrective actions as of June 30th, 2023, and 94 per cent not yet implemented.

So the updated data based on '24-25, so the number of outstanding corrective actions is 198 in total, and the number that are outstanding would be 85 per cent.

[11:30]

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — When a critical incident is caused by staff error, I was wondering if you could tell us what the process is for mediation of that situation.

Dave Morhart: — So I just want to provide a bit of clarification. So when we talk about critical incident management, it's really looking at kind of a system-level view of errors. It actually doesn't get down to, like, the individual staff level. But I do know that reporting organizations, mainly the Saskatchewan Health Authority, they do have a separate process that would deal with specific errors made by staff, and it's something that they would call an accountability review. So they would have a process in place for dealing with those individual errors.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Have any systemic issues been identified as a result of tracking critical incident notification information or improvements, so that it goes from 94; now we're down to 80 — whatever I wrote down here — 80-something? Are there systemic issues that are behind any of this? Those numbers seem awfully high.

Dave Morhart: — So just I hope I understood the question correctly. I think you were looking if there was any systemic issues that is preventing faster progress or further progress on implementing corrective actions, right? Okay, so yeah. I don't know if I would necessarily call these systemic issues, but I can provide you, like, with some of the reasons.

So you know, when we first started doing this work a few years ago after the initial auditor's report, there was a lot of focus on improving critical incident reporting and management. And so a lot of that work, particularly with the SHA, was around addressing like a backlog of critical incidents that they had — and I guess, which is a good thing obviously. But what comes with addressing a backlog is now you have a significant number of new corrective actions that are being added. So even though we're seeing that number come down from, you know, it was 300-and-some down to 198 with still several overdue, I think we have seen that progress considering that there are a number of new corrective actions that have been identified with addressing

that backlog.

Some other reasons that might be contributing is when you are dealing with a backlog, sometimes you're dealing now with information that is several years old. And so you have new people involved, new staff that were maybe a part of that initially that are no longer with the system anymore, so it becomes challenging to close off some of those corrective actions when there's been that kind of lag in time. So we're working with the Health Authority on how we can address those.

And then some of them identify things that require maybe IT system improvements and things like that. So they can't actually be implemented until those things happen, which can take some time as well.

And just the last thing I would note is there was reference to a two-day improvement event that happened in September. That event really focused on kind of the initial reporting — so addressing some of those delays in timelines in reporting, and the content of the report itself, and ensuring there was quality in terms of corrective actions — and the contributing factors were identified. We do have another event planned for later this year, where we're going to address kind of that next step, which would be once we receive the report at the ministry, how can we improve that process for implementing and monitoring corrective actions, so that we'll hopefully identify some of those additional issues that you had mentioned.

Joan Pratchler: — So have you noticed maybe over the past that the increases or decreases in critical incidents are either that people are reporting more — they're getting better at reporting so it looks, you know, there's more, because we want improvement and patient safety — or there's just simply a decrease in events? What might be driving some of those numbers as people become more educated about this process?

Dave Morhart: — So I think, you know, first I would note that in '24-25, which is our most recent data, there were 139 critical incidents reported. So I think in '22-23 was what the auditor's report had noted was 146. We did go up to 212 in '23-24 and then saw the drop to 139.

So I don't know if I can, you know, with great certainty know what the decline could be a result of. I mean it could be that there are fewer occurring, but it could also be that there is under-reporting. You know, when we look at some other sources of data, it could indicate that there is under-reporting.

So one of the things that we're doing within the ministry right now is we're actually updating our critical incident reporting guideline to provide some additional clarity for reporting organizations about what should be or shouldn't be a critical incident. And so I think that clarity will help at least in the identification of the critical incidents which we could then in turn see that number increasing.

Tara Clemett: — Can I just make a comment? I just want to say that when we did the audit, we did make a recommendation around the need for the ministry to analyze the data that was coming by the health care organizations that report the critical incidents. In many instances that is the Saskatchewan Health Authority that is encountering the critical incidents.

So when we did this follow-up, we were satisfied the ministry's doing a better job of correlating, okay, what are these critical incidents that are coming to us from the SHA and comparing that to other data. So the SHA is required to report to CIHI [Canadian Institute for Health Information] as such. And so they started to correlate and to sort of make sure the SHA, what they're reporting to this Canadian organization is also is what's getting reported to them. So we were more satisfied they are making sure there's completeness there.

I will just add too, as an office we do anticipate undertaking work at the Saskatchewan Health Authority around critical incident reporting. And I think that'll give us a line of sight whether there is critical incidents occurring at the Saskatchewan Health Authority that are not making their way to the ministry as such. So it'll give us just a different area of focus that'll go, okay, this is their role as almost more the regulator. There is then obviously the doer who has to report as such and fix. So we'll be undertaking that work soon.

Chair Wotherspoon: — Thank you, Auditor. MLA Gordon.

Hugh Gordon: — Just to kind of touch on what you mentioned about what constitutes a patient safety alert. I'm just wondering if you could elaborate about what warrants such an alert — and I wonder if it's tied in to something that you just mentioned — and why no incident has met that threshold apparently since September of 2019.

[11:45]

Dave Morhart: — In response to your question in terms of the criteria of a patient safety alert, I guess I would note too that individual organizations would have processes for patient safety alerts. So like the Saskatchewan Health Authority would have their own process for a patient safety alert, and they would have issued several in that time. The ministry itself developed the criteria for identifying patient safety alerts I think around the time of the follow-up audit or just before that. So it's been around for a few years I guess. But prior to that, there were no like established criteria for doing that. So I think that maybe the issue is you didn't have the criteria, hence the auditor's recommendation so that these time frames wouldn't go by where one isn't identified.

So in terms of the criteria itself, it is quite detailed. So in '24-25 the ministry adapted the patient safety alert criteria used by NHS [National Health Service] England to determine when to issue a patient safety alert and then began formally applying it at that time. So currently when the critical incident review committee reviews a critical incident and closes that critical incident, they do apply the patient safety alert criteria and its applicability to determine if it would meet the criteria for a patient safety alert.

So the ministry has a new work standard that they've developed for issuing and monitoring patient safety alerts through the critical incident review committee. I do have, it's kind of like a decision tree box that NHS England uses that does have some of that criteria. So it asks if it's within our scope. Is there a risk of death or disability? Can the issue be rapidly addressed at the source? Is the issue new or under-recognized? Are there constructive organization level actions that would reduce the risk of death of disability?

So I think the one thing to note is just when the ministry issues a patient safety alert — versus, say, an organization — that's typically too when we've identified that the issuing of a patient safety alert would benefit all organizations across the health system, so not just one. Like if it's an SHA issue then we would expect them to issue a patient safety alert. If it's just something very specific to the SHA, but if it's something that could potentially cross all health care organizations, then that's where the ministry would kind of step into that role of issuing a patient safety alert.

Chair Wotherspoon: — Any further questions, members? Not seeing any I'd welcome a motion to conclude consideration of chapter 20. Moved by Deputy Chair Wilson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We'll move along to chapter 4, and I'll turn it back to the auditor.

Jason Wandy: — Thank you. Chapter 4 of our 2024 report volume 2 reports the results of the 2023-24 annual audits of 35 health care affiliates. For each of the health care affiliates, all have effective rules and procedures to safeguard public resources. The 2023-24 financial statements for each of the health care affiliates are reliable. All health care affiliates except for All Nations' Healing Hospital Inc. complied with legislative authorities governing their activities. All Nations' did not comply with legislative requirements and obtain approval from the Ministry of Health for two 2022-23 capital projects exceeding $100,000 until 2023-24.

As All Nations' did not undertake any further capital projects valued at greater than $100,000 during '23-24, we were unable to confirm it would have obtained Minister of Health approval as required by legislative requirements. Not seeking the minister's approval for capital projects increases the risk money may be spent on items not considered a priority for the health care system.

I will also just note that the audit results for the 2024-25 found All Nations' still did not undertake any further capital projects valued at greater than $100,000 during '24-25. As such, our upcoming 2025 volume 2 report in December 2025 will deem this recommendation addressed.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the follow-up here. Thanks to the ministry for the implementation; of course this has been questioned and considered and concurred in by this committee. Any quick remarks, ADM, before we see if there's a question?

Norman O'Neill: — As it's considered implemented, I'll just note that we'll continue to send out the reminders that we do every year and leave it at that.

Chair Wotherspoon: — Great, thank you. Any questions, members? Not seeing any, I'd welcome a motion from a committee member. Moved by MLA Chan. Well I guess I should state the motion first: to conclude consideration of chapter 4. MLA Chan moves. All agreed? Okay. That's carried.

Saskatchewan Impaired Driver Treatment Centre

Chair Wotherspoon: — We're going to move right along and turn our attention to the Saskatchewan Impaired Driver Treatment Centre and chapter 21.

Jason Wandy: — The Saskatchewan Impaired Driver Treatment Centre located in Prince Albert provides a residential treatment alternative to incarceration for adults convicted of a second or subsequent impaired driving offence.

The centre received just over $1 million from the Ministry of Health in 2021-22 to provide care to the 319 clients that were admitted. Chapter 21 of our 2022 report volume 2 describes our second follow-up of management's actions on the one remaining recommendation we first made in 2018 relating to the centre's processes to deliver the impaired driver treatment program to reduce recidivism.

By July 2022 the centre implemented the last remaining recommendation. The centre developed the remaining program success measures and targets for its three program objectives and reported results to its board quarterly. If a target was not met, the centre described action plans to improve the results. Overall the centre was meeting its targets for each of the objectives at April 2022.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Okay. Thanks again for the focus of this work. For folks following at home, this has been considered here before. This is a follow-up and implementation has been reported. So thanks to all those that have been involved in making that happen. Any remarks, ADM?

Norman O'Neill: — As it's considered implemented, I'll just forgo any remarks.

Chair Wotherspoon: — Any questions from committee members? Not seeing any, I welcome a motion to conclude consideration of chapter 21 before us. Moved by MLA Crassweller. All agreed? All right, that's carried.

3sHealth

Chair Wotherspoon: — We're going to move right along, shift gears just a little bit for a follow-up chapter with respect to 3sHealth. And I'll turn it over to the Provincial Auditor.

Jason Wandy: — Thank you. Health Shared Services Saskatchewan, also known as 3sHealth, administers four disability benefit plans for certain health care employees, for example health care staff working in hospitals and long-term care facilities. In 2022-23, 3sHealth served 46,000 active plan members. The disability plans protect plan members against loss of income due to injury or illness. In 2022, 3sHealth issued over $52 million in disability income payments to plan members.

Chapter 8 of our 2024 report volume 1 describes our first follow-up audit of management's actions on the four recommendations we originally made in 2022 about 3sHealth's processes to manage disability claims for certain health care employees. By January 2024, 3sHealth implemented two recommendations and

partially implemented the remaining two recommendations.

3sHealth partially implemented the recommendation on page 147, where we recommended 3sHealth send completed disability benefit claim applications to adjudicators on time. 3sHealth did not always process incoming disability benefit applications on time, which delays adjudicators' decisions.

3sHealth's goal is to have claim decisions completed within 8 days 90 per cent of the time. In our testing of 30 applications we found 3sHealth met the 8-day target 73 per cent of the time. Management indicated that staff turnover, leaves, and an increasing volume of applications were major factors contributing to not meeting targets.

We found 3sHealth did take action to improve its processing of disability claims timely after our follow-up audit period by filling four vacancies and adding two more staff to the benefits service team. Delays in processing incoming applications affect timeliness of claims, decision making, and payment of benefits to plan members.

3sHealth partially implemented the recommendation on page 146, where we recommended 3sHealth follow its established timelines to complete appeal reviews on disability claims and document reasons for significant delays. We found 3sHealth began tracking the timeliness of appeals and documenting the rationale for delays in a spreadsheet. It expected staff to complete all appeals within 30 business days.

3sHealth's records indicated that staff completed 85 per cent of appeals on time. The two main reasons for any delays were high volume or waiting for additional information. However we also found 3sHealth's tracking spreadsheet contained inaccurate calculations and incomplete information, resulting in inaccuracies in its timeliness calculations. These inaccuracies reduced 3sHealth's results for completing all appeals within 30 days from 85 per cent to 55 per cent for the February 2023 to January 2024 period. Missing appeals and inaccurate calculation of timelines present a risk of inaccurate reporting to management and the public. It also risks not identifying additional resources to address delays in completing reviews.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the presentation, the focus of the work. Of course this is a follow-up presentation here today. And thanks as well to the team at 3S [Health Shared Services Saskatchewan] for some of the actions and updates that have been sent our way. I'll invite ADM O'Neill to provide a brief remark if he has one.

Norman O'Neill: — I'll just touch on the first two recommendations. So in regards to the sending disability benefit claim applications to adjudicators recommendation, 3sHealth strives to meet service standards, including sending completed disability benefit claim applications to adjudicators on time. Year to date for 2025, 3sHealth has achieved or surpassed the 90 per cent target in six out of seven months. One month reported 88 per cent. Benefit services has dedicated resources to the processing of new disability applications.

And on the second recommendation, regarding the recommendation to establish timelines to complete appeal reviews, 3sHealth strives to meet its service standard of completing disability claim appeals within 30 business days and is now processing the majority of claims within this standard. At the start of 2023, 3sHealth had a backlog of appeals. They dedicated additional resources to clearing this backlog. With more resources contributing to the appeal reviews and improved tracking and visibility, 3sHealth is now better able to meet our demand.

3sHealth is leveraging service now to better track and manage appeals due to triaging errors at the point of original receipt, which impacted our metrics. We have worked with our administrative staff to improve their knowledge to minimize these errors in the future. The service now tracks all appeals in progress, and 3sHealth uses the service now to run reporting on a daily, weekly, and monthly basis. And this allows the manager and specialists to monitor how work is progressing to ensure that it's completed on time.

That's my remarks.

Chair Wotherspoon: — All right, thanks so much. Open it up to committee members if there is any questions. MLA Pratchler.

Joan Pratchler: — Congratulations on all the work that must have happened in that period of time. Just a quick question or an observation that there appeared to be a lot of staff turnover that might have been part of, you know, the challenges. Are all vacancies currently filled now? And how many FTEs [full-time equivalent] are currently working in adjudication?

[12:00]

Mark Anderson: — Okay. All right. Thank you very much for the question. My name's Mark Anderson. I'm the CEO [chief executive officer] at 3sHealth. Pleased to provide an answer there.

So there's two parts to the process and so there's staff involved at both stages. The first is setting up the application when it first comes in, and we have a team of what we call benefit services officers that do that. We have 18 of those individuals. And we have one administrative position that is currently vacant. But all the BSO [benefit services officer] positions are filled. And then we have 13 adjudicators that actually handle the adjudication of the claim and determine if it's eligible, and those are all full at the moment.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Just was wondering if you could list some of the reasons for significant delays and then the measures used to address them.

Mark Anderson: — Okay. Thank you for the question. So one of the key drivers of delay is volumes of applications that come in and fluctuations. It's not always a steady number; it can vary depending on different periods. And then of course the workforce that's available. And so if we do get a number of things come in, as an example, during the summer, that can cause some issues as

well. Or as was reported previously we have some turnover, then it can cause some challenges in terms of caseloads.

So in terms of things we do about that, we have a daily meeting to load level and take a look at caseloads by adjudicator and also to monitor and track those service metrics that I mentioned. So we can move work between . . . The benefit services officers at the front end do other work other than just setting up initial applications, so we can pivot some of their other focus to ensure we're caught up on that front. That's another tactic we use to try to maintain the service standard.

Hugh Gordon: — Just to add onto that, is a lack of information also contributing somewhat to delays? Is there poor communication for example?

Mark Anderson: — It can contribute, you know, if we don't have a complete application, as an example, or if there's missing medical. Those types of things can contribute to delays on that side of it. But often we try to follow up with an initial expectation call so people understand what that's going to look like and what kind of information we need.

Hugh Gordon: — And just one last question here: I was just wondering if you've seen a reduction in the number of complaints from plan members regarding disability benefit claims, and if you have seen an improvement in the timeliness of resolution for those claims.

Mark Anderson: — So just I have an answer to one and then just a question on the second one just to make sure I understood the question. But in terms of number of complaints that we've received, so in 2022 we had 11; in 2023 we had 13; 2024, 10; and so far in 2025, seven.

And the second question, I'm sorry, was around timeliness of the adjudication process?

Hugh Gordon: — Yeah, essentially.

Mark Anderson: — Of the adjudication, okay. Thank you. Okay regarding the disability initial application in quarter 1 of 2025 we met the service standard of 8 days 93 per cent of the time; quarter 2, 94 per cent; and quarter 3, 94 per cent.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — No further questions, folks? Okay. Thanks, CEO Anderson, to you and your team for the work on this front. I'd welcome a motion to conclude consideration of chapter 8 here. Moved by MLA Beaudry. All agreed? Okay, that's carried.

We'll have a recess and reconvene at 1 p.m. with a focus on eHealth.

[The committee recessed from 12:07 until 13:00.]

Chair Wotherspoon: — Okay, we'll reconvene the Standing Committee on Public Accounts. I'm going to turn it over just briefly here to ADM O'Neill. He's let us know he has an answer to a question that was asked this morning with respect to chapter 14.

Norman O'Neill: — So you had asked about our wait-list. And we had 99 individuals on the neurosurgery wait-list, and it was the split between Regina and Saskatoon that you'd asked about. So as of March 31st, 2025, the 99 is broken down between 22 in Saskatoon and 77 in Regina. We also checked more recent, so July 31st, 2025 we have 81 individuals on the wait-list and 35 of those are in Saskatoon, 46 in Regina.

eHealth Saskatchewan

Chair Wotherspoon: — Thank you. Thanks very much for providing the information here today. We'll turn our attention here now to three chapters. We're going to consider each of them one at a time here with respect to eHealth. First chapter has six new recommendations. I'd welcome CEO Church and his team here as well to the committee, and I'll turn it over to the Provincial Auditor to make presentation on chapter 13.

Tara Clemett: — Thank you, Mr. Chair, Deputy Chair, committee members, and officials. With me today is Mr. Jason Wandy and he's the deputy provincial auditor that is responsible for the audit at eHealth Saskatchewan. Behind me as well we have Mr. Jordan — on my far left — Mr. Jordan McNaughton, and he is a senior manager in our audit that was involved in the audits at eHealth Saskatchewan. And beside him is Ms. Michelle Lindenbach and she's our liaison with this committee.

Today Jason will present the chapters on the agenda in the order that they appear and it will result in three separate presentations. He will pause for deliberation and consideration by the committee after each presentation. The first presentation about maintaining key health care IT servers does include six new audit recommendations for the committee's consideration, and the other two chapters and presentations are status updates on outstanding recommendations previously agreed to by this committee.

I do want to thank the CEO of eHealth Saskatchewan and his staff for the co-operation that was extended to us during the course of our work. With that, I'll turn it over to Jason.

Jason Wandy: — Thanks, Tara. Chapter 13 of our 2023 report volume 2 reports the results of our audit of eHealth Saskatchewan's processes for the period ended July 31st, 2023, to maintain IT servers that host key health care systems and data to protect against known vulnerabilities. We concluded that eHealth had effective processes other than the areas reflected in our six new recommendations for the committee's consideration.

eHealth manages the health sector IT network, including more than 5,000 servers and over 1,000 applications, hosting a significant amount of confidential data. These IT systems are essential to the delivery of health services by the Saskatchewan Health Authority, Saskatchewan Cancer Agency, and 3sHealth. Outdated IT infrastructure and software provide an opportunity for online attackers to breach IT networks and compromise data. Cyberattacks can take an IT system or entire organization offline, leading to patient care interruptions, privacy breaches, and expensive recovery costs.

In our first recommendation on page 100 we recommend eHealth Saskatchewan regularly detect and quickly remove unauthorized IT servers, if any, on the network. eHealth manually tracked

physical servers it manages using spreadsheets and asset tags, and it kept information about virtual servers using an electronic server management system. We found the information tracked in the server management system did not include details about the applications or databases hosted by the server or how critical these systems and their data are for delivering health services.

During our server testing we found eHealth's network diagrams were not up to date. For example, referred to incorrect or replaced servers, making it difficult to determine specific servers related to each key health care IT system and their related criticality. Without this information, eHealth cannot efficiently consider IT system criticality to help prioritize when it applies updates to each server.

We also found eHealth did not have a way, such as an automatic discovery system, to alert its staff when new servers connect to the network. These discovery systems help to quickly identify and remove any unauthorized or rogue servers that can introduce vulnerabilities. A rogue server can not only be a target for attackers but also can create performance issues such as slowing down a network. Exploited vulnerabilities through an unauthorized server can lead to unauthorized access or changes to sensitive health systems and data.

In our second recommendation, on page 101, we recommend eHealth Saskatchewan track the IT systems and their criticality hosted on key health care IT servers to support maintenance decisions. By March 2024, eHealth planned to implement an asset management system to track information about servers, including hosted IT systems, and to automatically identify any unauthorized servers connected to the network. Without sufficient tracking of IT systems hosted on key health care IT servers and their related criticality, eHealth may not appropriately prioritize updates to efficiently maintain all servers to protect them from known vulnerabilities. eHealth can use this information to prioritize updates for critical IT systems.

And our third recommendation, on page 103, we recommend eHealth Saskatchewan implement security measures to address the risks introduced by having unsupported servers hosting key health care systems and data. Our testing of 341 key health care IT servers found 20 servers who were running unsupported operating systems where vendors no longer supply updates for new vulnerabilities identified. Operating system vendors identify new vulnerabilities daily, so the longer servers are unsupported, the greater the risk an attacker may identify and exploit an unpatched vulnerability.

Agencies should carefully evaluate risks of delaying IT system and related server upgrades — for example, additional costs to address a successful cyberattack, significant server downtime, risks to the agency's reputation, or compromised patient data. We found eHealth did not have a plan to address risks of unsupported servers timely.

In one case, it planned a project in 2021 to upgrade unsupported servers and described related risks to its partners in the project plan. However eHealth and its partner delayed the project with no clear timeline set for completion, and did not add mitigating controls in the interim, for example, additional intrusion monitoring or isolating unsupported servers on the network. Without effective and timely plans to protect unsupported servers from new vulnerabilities, there's increased risk of unauthorized access, or changes to, or downtime of key health care systems and data.

In our fourth recommendation, on page 104, we recommend eHealth Saskatchewan periodically review whether appropriate individuals have privileged access to key health care IT servers. Privileged accounts pose a greater security risk, as these users can bypass security controls built into an IT system by accessing the system directly through the servers instead of logging in to a user account in the IT system.

Our testing of 87 users with access to make changes to IT servers found one user who left eHealth in November 2022, but whose access eHealth had yet to remove at July 2023. We found eHealth used controls to prevent this user from logging in to the privileged account after leaving eHealth. Additionally, we found nine users where eHealth was uncertain of the continued appropriateness of their level of access granted.

Without a process to periodically — for example, quarterly — review privileged server access, there's increased risk of unauthorized individuals inappropriately accessing and making changes to sensitive health care systems and data.

In our fifth recommendation, on page 105, we recommend eHealth Saskatchewan regularly analyze security information logged for key health care IT servers to support timely server updates for identified security vulnerabilities. eHealth used server vulnerability scans to identify missing security updates.

We found 16 of the 341 servers we tested were not included in the vulnerability scans. This means eHealth did not have all possible information to help protect the servers against potential security vulnerabilities. Management advised us its vulnerability scans missed these 16 servers due to implementation issues when transitioning from a monthly scanning process to a continuous scanning process during 2023.

eHealth also did not analyze security information such as trends from scans over time, network incidents, or problems reported through security tickets to identify potential risks for maintenance processes.

At July 2023, eHealth was transitioning operation of its vulnerability management processes to an external service provider. It expected this service provider would help to verify whether it scans all servers as well as help it analyze security information to identify potential risks related to maintenance processes.

In our last recommendation, on page 106, we recommend eHealth Saskatchewan regularly report to its senior management and partners about significant risks and mitigation plans related to maintenance of key health care IT servers. At July 2023, eHealth had not sufficiently defined reporting requirements about IT server maintenance risks to share with its senior management or partners.

eHealth signed a master service agreement in 2022 with its key partner, the Saskatchewan Health Authority, but the agreement did not set out reporting requirements or agreed-upon service targets, for example, IT server update and availability levels.

We found that while eHealth prepared a preliminary report for the Authority in June 2023 as part of its work to define reporting requirements, the report did not include targets or results specific to IT server maintenance. Establishment of key service targets can also help eHealth to define reporting requirements to its senior management. Such reporting may help eHealth identify potential risks early and avoid missing certain service expectations.

Without sufficient formal reporting, senior management and eHealth's partners may not sufficiently understand existing risks that could prevent timely provision of health care services or that could compromise the security of patient data. Health care providers need timely access to accurate and complete patient information to support quality health care.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the chapter and the presentation. It's got some new recommendations before us here today. I'll turn it over to ADM O'Neill for some brief remarks and then we'll get into some questions.

Norman O'Neill: — Okay, regarding the recommendation for the removal of unauthorized IT services, eHealth centrally manages the provision of resources and access to its core data centres to prevent unauthorized implementation on its IT infrastructure. Strong physical controls exist for the core data centres. Through ongoing inventory reviews, eHealth will identify and retire non-compliant servers to strengthen infrastructure security and consistency during 2026-27. Automation will be leveraged in 2027-28 to continuously detect, validate, and manage server assets, preventing unauthorized deployments and maintaining compliance.

Concerning the second recommendation to track IT systems and their criticality, eHealth has developed a comprehensive asset list for servers, which identifies the server attributes, the applications housed, and related criticality. eHealth continues to work with partners to understand the criticality of services provided. This information will help support future maintenance planning.

Regarding the third recommendation, to implement security measures to address risks introduced by having unsupported servers, eHealth works with technology vendors and partners to identify changes in support status, which will guide work plans for upgrades or requirements to provide compensating controls.

eHealth implemented a third-party-managed security operations centre to improve the management and responsive server updates based on vulnerabilities. Development of a vulnerability management policy is under way which will formalize steps such as identifying risks, remediating issues, and reporting on security matters. The timeline for implementation of the vulnerability management policy is March 2026. Network reference architecture is being developed to provide direction for network segmentation and further security controls for unsupported servers.

With respect to the fourth recommendation to periodically review whether appropriate individuals have privileged access, eHealth conducts annual reviews of privileged access and ensures the removal of unnecessary permissions. eHealth's account management and access control policy is being updated and is expected to be completed in March 2026.

[13:15]

An identity road map has been established which includes further improvements such as the implementation of a tool that will enhance privileged access management. The first round of projects is expected to begin in '26-27. eHealth is exploring the ability to limit privileged actions to certain machines.

Regarding the fifth recommendation to analyze logged security information for key health care IT servers, eHealth utilizes a variety of tools to log and analyze security-related risks and events across its IT environment. eHealth has engaged a third-party-managed security operation centre to improve the management of and response to vulnerabilities.

And finally with regards to recommendation no. 6 which was to regularly report to senior management and partners about significant risks and mitigation plans, eHealth continues to update and develop information technology service agreements with its partners to govern and manage the provision of IT services. Under these agreements eHealth is implementing partner-specific IT risk reporting. Informal discussions are held with partners on an ad hoc basis. A new joint security, privacy, and risk subcommittee supports the SHA's information technology service agreements.

Utilizing eHealth's developing asset inventory as mentioned, a core set of KPIs [key performance indicator] is being identified to report on risk and mitigation plans for IT systems. The initial focus for KPI and reporting development is aligned with the criticality of systems identified through disaster recovery program enhancements.

Those are my comments.

Chair Wotherspoon: — Thanks so much for the comments. Thanks to those that are involved in the work on this front. I'm going to open it up now to committee members for questions. MLA Pratchler.

Joan Pratchler: — Thank you. Hello. I was wondering, has eHealth had any known cyberattacks in the past three years?

Davin Church: — Davin Church, CEO of eHealth Saskatchewan. So just due to the nature of our organization, we manage various cyber events on a regular basis, on a daily basis. We have not had any cyber events in the past three years that have resulted in any type of compromise of health system or any information that we house.

Joan Pratchler: — Do you have a dynamic workload management system?

Davin Church: — Are you able to define what you're referring to by dynamic workload management system?

Joan Pratchler: — That you've got all these servers. If one server needs help, it moves and discusses with other servers and moves the workload around so that it's not particular to specific servers, that they're all connected.

Davin Church: — So we do use virtualization technology to allow that load balancing to occur across our environment.

Joan Pratchler: — So how many unauthorized IT servers have been removed from the network in the last year? And did eHealth identify any of these servers were on the network for the purposes of cyberattack or theft of patient data?

Davin Church: — We have had zero identified and zero removed.

Joan Pratchler: — Zero identified and sorry?

Davin Church: — Zero removed.

Joan Pratchler: — Zero removed. On page 101 of the report it says that eHealth expects staff to test and apply all emergency updates, you know, within 48 hours. Could you help me understand what your policy is of time expectations for normal updates?

Davin Church: — We have a monthly patch management schedule that we also work in conjunction with the vendors on when they will be releasing various updates and patches for their systems. And then we also work with our partners to ensure that when those are applied they have minimal disruption to operations. And so we also plan that schedule out with our partners across all systems.

Joan Pratchler: — Is that monthly? Weekly? Yearly?

Davin Church: — We have a monthly patch cycle.

Joan Pratchler: — Okay. How far are you along in defining criticalities?

Davin Church: — We have worked with our partners across the system to identify all mission-critical applications. And we're now working through which remaining applications are considered vital is that next layer, and we'll continue to work down from a priority perspective through that process.

Joan Pratchler: — Okay. Was there any attempt to start with the servers that are known to be the most critical?

Davin Church: — Yes, that was the approach, was to start with the most critical servers.

Joan Pratchler: — And can you tell me more? Like how many of those there would be?

Davin Church: — So because of the virtualization, a physical server doesn't have . . . Critical apps can be across a number of those and so really with that workload management, we focused around what are the critical applications and then identifying which servers that they are on as opposed to starting with the servers themselves and moving to the applications after.

Joan Pratchler: — Okay.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I was wondering if you could help out a non-technophile here. Just wondering if you could just explain to me how when a new server connects to the network, how does it go undetected? How does that even happen?

[13:30]

Davin Church: — So to clarify, like the servers that were unauthorized, they were not servers that were connected to the environment, you know, in recent times. They were servers that were sitting in facilities from legacy business operations. And so as those were identified, we were then bringing them into our approved environment. So protective services as an example is one, where because of the nature of their business, they had servers in facility within their own offices as opposed to within the provincial environment. And so as we identify those unauthorized servers, that's when we bring them into the approved data centre environment on our servers.

Hugh Gordon: — Does that mean they still had access through those servers to the rest of the system?

Davin Church: — They were running their legacy applications for their business operations on those legacy servers. Now, and as we identified them, we moved those into our provincial environment for them to continue to operate.

Chair Wotherspoon: — Pratchler.

Joan Pratchler: — I'm looking at page 103. This is talking about provincial access to IT service. It says here that one of the users left in November 2022, and it wasn't removed until July 2023. That's about nine months, nine users. They were of uncertain appropriateness.

When I look at the recommendation here, it says that a policy will be developed in 2025-26, will be implemented '28-29. The pattern I'm seeing is there's a long delay of time between the time an incident or a situation or a concern is, you know, brought forth to a certainty when it will be ameliorated. And in that time, you know, a variety of things could happen that may not be all that good. Can you help me understand why such a delay of time in a computer world like that?

Davin Church: — So your question around delays of timeliness in removing the privileged access, essentially, you know, that is a breakdown in process between individuals completing the proper forms in a timely way when they're offboarding an employee. So since then we have implemented a new process around guidance and follow-up of employee offboarding. And then our revised policy will also address the timeliness of reviewing those privileged access accounts on a more frequent basis.

Joan Pratchler: — And what would that more frequent basis be?

Davin Church: — Quarterly would kind of be the general standard, on a quarterly basis.

Joan Pratchler: — Okay. Have there been any privacy incidents due to users with wrongful privileged access to the servers in the last year?

Davin Church: — There have not.

Joan Pratchler: — Thank you. On page 104 it reads that during 2023, eHealth was transitioning from a monthly scanning to a continuous scanning process. Management advised that its vulnerability scans missed these servers, 16 servers, due to implementation issues. What is your exception process for those situations?

Davin Church: — During that time we were in the process of deploying that scanning to servers and we continue to do that. And so we will be completed and have that vulnerability, real full-time scanning on by the end of the fiscal year.

Joan Pratchler: — And so those 16 servers, are they still an issue or is that a . . .

Davin Church: — No, we would have been in implementation at that point in time.

Joan Pratchler: — Oh, okay. I understand that you have some service providers. Do you get regular reports from your service providers on your security scan results?

Davin Church: — We do get regular reporting, both internally as well as from our partners, that we leverage around our security scanning and security support. And we're currently developing KPIs within that as well and continuing to improve and evaluate those on an ongoing basis.

Joan Pratchler: — So regular means weekly? Daily? Monthly?

Davin Church: — Monthly. Now if there's any critical vulnerabilities, those are in real time.

Joan Pratchler: — Okay. When did those server scans by that external service provider begin?

Davin Church: — I don't have the exact timing in front of me, but we can get it before we're done today for you.

Joan Pratchler: — Sure. Okay, thank you.

Chair Wotherspoon: — Go ahead, MLA Gordon.

Hugh Gordon: — Reference here to the external service provider. Can you please share with the committee who that external service provider or providers are?

Davin Church: — We have a managed service provider. Security Resource Group, out of Saskatchewan, is our managed service support for that. And then there's varying numerous tools used that are leveraged for that monitoring.

Hugh Gordon: — Sorry, what was the name of the provider again?

Davin Church: — Security Resource Group, SRG.

Hugh Gordon: — And they're based out of Saskatchewan?

Davin Church: — Yeah.

Hugh Gordon: — That's good. Could you just share with us briefly perhaps how that service provider has assisted in improving your ability to analyze security information on its key health care IT servers?

Davin Church: — So some of the supports and services that they provide are 24-7 monitoring of our environment. They review all logs from across the entire environment to identify any potential issues, vulnerabilities, those kinds of things. They also provide us automated detection response. So if there is anything detected they also respond and support our teams in any response if anything is detected. And then they have also been a partner in expanding the end-point protection work that we've been doing in relation to previous other audit recommendations.

[13:45]

And also kind of have been key in supporting us in deploying the vulnerability management tools and supporting response strategies around those vulnerabilities.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — I'd like to look at page 105. It says that management advised us at eHealth that they used an informal, internally set target that at least 80 per cent of servers have all current patches applied. Now this was as of, well 2023. So that would mean 20 per cent, or up to 20 per cent, don't have current patches applied. It just requires one to have a problem, and hackers have all kinds of automated tools these days.

Can you give us some peace of mind that 100 per cent of the patches are applied 100 per cent of the time?

Davin Church: — So any servers that aren't maintained from a patching perspective are running legacy applications used by our health care partners and their business operations, meaning that the systems that they currently use cannot operate on newer technologies.

So our first approach in those scenarios is to segregate those servers from the rest of the network so that they can't actually have any impediment on the rest of the health system network. Where that's not possible, we deploy other mitigating controls from a technical perspective and work with our partners to identify and create a risk-informed plan around how to address that going forward so that we can have a plan going forward but not negatively disrupt their business operations in those scenarios.

Joan Pratchler: — Okay, thanks. I'm looking at page 106, the discussion around reporting to senior management and eHealth partners regarding, you know, security. And it looks to me that the recommendation or the time frame for implementation for addressing security risk be 2026-2027. Can you tell me what your top five KPIs are for security?

Davin Church: — So I have the answer to your previous question as well as this one. So I'll start with the most recent question, and we can go back to the previous question on vulnerability reporting and when that started.

So a couple things. So our top five KPIs that's reported internally

are vulnerability management, so number of vulnerabilities identified versus remediated; number of malicious incidents or attempts on our environment; the success of our training and awareness campaigns and our phishing campaign, where we do simulated phishing tests across the organization; number of threat risk assessments completed in order to identify potential risks of new systems and ones that are being asked for; and then as well, progress scans to our ISO [International Organization for Standardization] maturity index model there.

We also have a security officers committee with the SHA — which includes their internal audit as well as our enterprise risk management teams and security teams — who are currently defining which KPIs we'll be reporting to their board. And then we also report the number of vulnerabilities to the 3sHealth board for the systems that they're running and technology that they're operating on.

For your previous question, we began reporting, giving those monthly reports on vulnerabilities in March 2024 from our partner. And the vulnerability management project when we started to . . . The project to actually begin deploying the vulnerability detection software was in 2023.

Joan Pratchler: — Okay, thank you. There was a challenge it appears in this report of transferring that information from your server maintenance risk reports to senior management. So what is being done to ensure that senior management is reading the IT server maintenance risks? And are these being shared with ministry officials or they are with just eHealth senior staff?

Davin Church: — We provide that reporting in those KPIs on a monthly basis to our executive team — so we read that monthly — as well as our senior leadership team. And then we also provide that through the security officers committee to our partner organization, which have senior level management on those groups, who then take that back through their own organizations, and in some cases they report that also through their boards.

Joan Pratchler: — So do I hear you say that information is provided to ministry officials as well then?

Davin Church: — Yes.

Joan Pratchler: — Okay. Good. Thank you. That's all I have for this chapter.

Chair Wotherspoon: — Any further questions from committee members? Okay, so these are all six new recommendations, and so I'll welcome a motion that we concur and note progress with recommendations 1, 2, 3, 4, 5, and 6. Do I have a mover? MLA Beaudry. All agreed? Okay, that's carried.

Moving right along, I'm going to turn it over to the auditor to focus on chapter 17 from the 2024 report volume 2.

Jason Wandy: — Thank you, Mr. Chair. eHealth Saskatchewan is responsible for managing critical IT services used to administer and deliver health care services in Saskatchewan, which includes configuration and security of portable computing devices accessing the eHealth IT network. Portable computing devices — for example, laptops and smartphones — create security risks because they may become infected with viruses or malware and are easy to lose. At August 2024 almost 32,000 portable computing devices could access the eHealth IT network.

Chapter 17 of our 2024 report volume 2 describes our second follow-up audit of management's actions on the six outstanding recommendations we initially made in 2019 about eHealth's processes to secure health information on portable computing devices used in delivery of Saskatchewan health services from unauthorized access. By August 2024 eHealth made some progress towards securing portable computing devices, but more work is needed.

eHealth partially implemented the recommendation on page 177 where we recommended eHealth Saskatchewan implement a written, risk-informed plan to protect laptops with access to the eHealth IT network from security threats and vulnerabilities. eHealth implemented its standard laptop configuration including encryption with almost all its laptops using a supported operating system as of August 2024. However eHealth continued to permit unrestricted use of USB [universal serial bus] ports in laptops. It planned to implement a pilot program to mitigate these risks by March 2025.

eHealth also needs to restrict the users' ability to access a laptop's BIOS [basic input output system] settings, permitting users to control device settings at the hardware level. eHealth decided in August 2024 to restrict access to BIOS settings and was working on a plan to implement this as a standard configuration setting.

Blocking USB ports can prevent devices from downloading data or uploading malicious software or tools. Access to BIOS settings allows users to change hardware configurations increasing the risk of security vulnerabilities if they make unauthorized changes.

eHealth partially implemented the recommendation on page 177 where we recommended eHealth Saskatchewan standardize the configuration settings for mobile devices with access to the eHealth IT network to mitigate associated security threats and vulnerabilities. And it implemented the recommendation on page 178 where we recommended eHealth Saskatchewan analyze the cost-benefits of using a central mobile device management system to secure and monitor mobile devices with access to the eHealth IT network.

eHealth selected a central mobile device management system to help secure and monitor mobile devices. While we found eHealth appropriately configured the central device management system in accordance with good practice, it had only transitioned 14 per cent of its mobile devices to the central system, resulting in the configuration settings for many mobile devices continuing to not align with good practice in several areas, for example, password requirements, blocking jailbroken or rooted devices, or containerization.

eHealth indicated it planned to transition all mobile devices to its central mobile device manager by March 2026. Inconsistent configuration settings on mobile devices results in increased security risks.

eHealth partially implemented the recommendation on page 179

where we recommended eHealth Saskatchewan take appropriate action to minimize the risk of security breaches when a portable computing device is reported lost or stolen. eHealth uses information from its ticketing system to manually update a spreadsheet about lost or stolen devices.

[14:00]

Between January 2023 and August 2024, we found eHealth recorded 12 incidents that resulted in 18 lost or stolen devices. Using information obtained from the Saskatchewan Health Authority, we found six additional lost or stolen devices managed by eHealth not included in its tracking spreadsheet. While we tested two of these devices and found eHealth appropriately disabled the devices and removed them from the network, eHealth may not know the full extent of lost or stolen portable computing devices at health sector agencies to which it provides services.

Additionally we found eHealth does not have authorization to disable all of the Authority's mobile devices, that is, for almost 2,400 mobile devices in Saskatoon. eHealth indicated it is working with the Authority to obtain authorization to disable these devices when necessary to do so. It expected to obtain such authorization by March 2026.

Not having complete information about lost or stolen devices or a centralized incident management process increases the risk of lost or stolen portable computing devices not being appropriately removed from the network and those devices being compromised, putting personal health information at risk.

eHealth partially implemented the recommendation on page 180 where we recommended eHealth Saskatchewan implement a risk-based plan for controlling network access to mitigate the impact of security breaches. eHealth indicated it was developing a plan for establishing network access controls for all health sector agencies. Establishing IT network access controls to restrict user access to only what they need at any given time makes it much harder for attackers to escalate privileges and take aim at vital assets in the event a portable device is compromised.

Without network access controls, eHealth does not sufficiently control access to the eHealth IT network, and it does not restrict where users and devices can go or what they can do on the eHealth IT network. Without adequate security on network access ports, the eHealth IT network may be vulnerable to attack through these open ports. Controlling IT network access helps to mitigate the risk of security breaches and the extent of breaches.

eHealth partially implemented the recommendation on page 181 where we recommended eHealth Saskatchewan utilize key network security logs and scans to effectively monitor the eHealth IT network and detect malicious activity. eHealth continues to monitor pieces of the eHealth IT network, including end-point protection and real-time scanning from key points in the eHealth network, but it does not scan all areas of the IT network and analyze results to detect malicious activity.

While eHealth Saskatchewan began using a service provider in May 2023 to help monitor and manage the security of its IT network, at August 2024 it had yet to transfer responsibility for monitoring all aspects of the network to the service providers as planned. Without effective IT monitoring, eHealth may not detect malicious activity and mitigate risks of a successful attack on its corporate network within sufficient time to prevent a security breach.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Thanks so much for the follow-up work on this front. And I'll turn it over to see if there's brief comments from ADM O'Neill. Otherwise we'll open it up.

Norman O'Neill: — I do have brief comments. Just surrounding the written plan to protect laptops with access to eHealth IT networks from security threats and vulnerabilities recommendation, eHealth has implemented protection on the system's settings which has been rolled out as part of our standard laptop configuration.

eHealth has completed a risk assessment on the use of USB ports as part of its overall information security management system. The pilot to restrict the use of USB storage devices is progressing within eHealth. Use will only be permitted on an exception basis where there is a business need. Expanding the restriction of USB storage devices to other agencies will be explored.

Regarding the second recommendation to standardize configuration settings for mobile devices, eHealth continues to transition devices to the standard mobile device manager. As of mid-August 2025, 45 per cent of devices have been transitioned. The remaining devices will be transitioned in 2025-26 using a phased approach to minimize potential impacts.

Regarding the fourth recommendation, to take appropriate action to minimize the risk of security breaches for lost or stolen devices, eHealth has obtained authorization to disable all partner mobile devices when required. This is expected to be completed in this fiscal year. A knowledge document has been developed to formalize the provincial process. Monthly reporting out of the ticketing system has been developed to support the tracking of lost or stolen devices.

Regarding the fifth recommendation, which is to implement a risk-based plan to control network access, eHealth continues to mature the information security management system, which determines security controls using a risk-assessment approach. eHealth developed a multi-year network and connectivity road map that outlines the target end state for establishing centralized, facility-based network controls for all health sector agencies and network access ports. Planning for resource commitment and capital funding has begun. The first round of projects is expected for 2026-27.

And finally, to implement the recommendation related to utilizing key network security logs and scans, eHealth engaged a vendor to provide a service to manage end-point detection and response, which monitors logs for suspicious activity. eHealth is exploring options for extending network security monitoring to remaining systems and services. Thank you.

Chair Wotherspoon: — Thank you. I'll open up now to committee members for questions. MLA Pratchler.

Joan Pratchler: — Have there been any security incidents due

to USB storage devices being used in this past year?

Davin Church: — Davin Church, CEO, eHealth Saskatchewan. No, there has not.

Joan Pratchler: — I see on page 178 when we're talking about devices and processes to secure them, it says that eHealth enforces a policy of password protection, that kind of thing, in one of its three mobile device management systems. For 14 per cent of the mobile devices that they manage now, or that they manage, I think I heard that that number is better than 18 per cent. It's 45 per cent. That still would leave 55 that aren't, and the deadline that I heard here is not for another year or so-ish. Did I understand that?

Norman O'Neill: — It's the end of this fiscal year.

Joan Pratchler: — Oh, this fiscal year, okay. And you feel that that's safe enough? Quick enough?

Davin Church: — That 45 per cent was as of August. We only have 1,600 users left, so we're over 90 per cent complete.

Joan Pratchler: — Oh, okay. Thank you. Do you use the mobile device manager locks in managing any of these mobile devices at all?

Davin Church: — Are you referring to what the policies are technically to how long your password has to be, and those . . . Is that what you're referring to around using mobile device management for locks?

Joan Pratchler: — Perhaps I should ask this first. Have there been any security incidents due to a mobile device that did not have a mobile device manager installed? And so one of those may be a mobile device lock or manager?

Davin Church: — No, there have not been any incidents as a result of a mobile device.

Joan Pratchler: — Okay, thank you. How many devices were lost or stolen last year? And has there been any effort to track whether the devices were lost or stolen due to improper procedure on the device user's part?

Davin Church: — Between September 2024 and August 2025 there were 19 devices that we manage, lost or stolen. Our role in the event of a lost or stolen device once we are notified is we initiate a remote wipe of that device so that if it is turned on it will . . . and all information will be wiped. And then we also go through the process of disabling in the interim until we have the opportunity for the user to reset their credentials and passwords and so forth.

Joan Pratchler: — Okay.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Just to add on to that really quick. How are you tracking lost or stolen devices?

Davin Church: — Since the audit occurred we've implemented a new ticketing system. And so all of that lost and stolen device is tracked and reported on through there, as well as all steps are provided that are necessary to any teams that have roles and responsibilities involved in that process.

Hugh Gordon: — So just to clarify, that's not a spreadsheet you're using anymore? That's something else?

Davin Church: — Yeah.

Hugh Gordon: — Part of the IT system now?

Davin Church: — Yes, we've implemented a new tool across our service desks for that.

Hugh Gordon: — Thank you.

Joan Pratchler: — And I'm just looking at that last recommendation on page 181. It appeared what precipitated that recommendation was that second paragraph and I highlight it: ". . . but it does not scan all areas of the IT network and analyze results to detect malicious activity." And I see that planned actions for implementation are continued improvements to the managed service program. Could you give me an example of, you know, two or three improvements?

[14:15]

Davin Church: — So some of those improvements that we're working through are edge monitoring, threat hunting, advanced threat analytics, increased sophistication of our end-point monitoring, as well as additional monitoring of any of those legacy technologies that we are unable to properly segregate from the rest of the network.

Joan Pratchler: — And is that through your service provider that is mentioned here?

Davin Church: — It's a combination of our internal teams as well as our service provider.

Joan Pratchler: — And it says here that on the recommendations that the timeline for implementation for continued improvements is TBD [to be determined]? Can you quantify that?

Davin Church: — We have a five-year security road map which we are continuing to follow. Really the biggest thing is that as that threat environment changes, we then do shift if there is any maybe later opportunities that we'd planned that we need to pull ahead in the schedule. So really what we'd be basing it on now is working through our year-to-year road map.

Joan Pratchler: — So it's quite fluid then?

Davin Church: — It can be, depending. Yeah.

Joan Pratchler: — That's all my questions.

Chair Wotherspoon: — Any further questions on the chapter, committee members? Not seeing any, thanks for the work and for the commitment to implement these recommendations, the work that will be required. I'd welcome a motion to conclude consideration of chapter 17. Moved by MLA Crassweller. All

agreed? That's carried.

I'll kick it back over to the Provincial Auditor to focus on chapter 1, our final chapter with eHealth here today.

Jason Wandy: — Thank you. Chapter 1 of our 2024 report volume 2 reports the results of our annual integrated audit of eHealth Saskatchewan for the year ended March 31st, 2024. We found eHealth's financial statements were reliable and it complied with the authorities governing its activities related to financial reporting and safeguarding public resources. Additionally eHealth had effective rules and procedures to safeguard public resources except for the areas highlighted in our two recommendations.

eHealth partially implemented the recommendation on page 15, where we recommended eHealth Saskatchewan sign an adequate service-level agreement with the Saskatchewan Health Authority. At March 2024 eHealth did not yet have an adequate IT service-level agreement in place with the Authority as they had not finalized key aspects — for example, security and disaster recovery requirements — of the agreement signed in May 2022. eHealth management indicated they expected to finalize the remaining key aspects of the master services agreement with the Authority during 2024-25.

Adequate service-level agreements clearly outline key IT service expectations. Without a clear understanding of expectations and whether they are fulfilled, the Authority's systems may be vulnerable to security breaches or be unavailable.

eHealth partially implemented the recommendation on page 16, where we recommended eHealth Saskatchewan have an approved and tested disaster recovery plan for systems and data. At March 2024 eHealth was responsible for 52 critical IT systems. These are critical for the delivery of health care in Saskatchewan. We found eHealth completed 36 partial tests — for example, recover a component of a system from a backup — and 10 tabletop tests of IT system disaster recovery playbooks. However eHealth had not completed any full disaster recovery testing.

Disaster recovery testing verifies plans can be implemented successfully and critical IT systems can be restored after a disruption. Without tested disaster recovery plans, eHealth, the Saskatchewan Health Authority, Saskatchewan Cancer Agency, and the Ministry of Health may not be able to restore their critical IT systems and data — such as the personal health registration system or provincial lab systems — in a timely manner in the event of a disaster.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Thanks so much for the follow-up and the presentation. I'll turn it over to ADM O'Neill for brief remarks, and then we'll open it up to questions.

Norman O'Neill: — All right. I'll just touch on recommendation 2, surrounding the approved and tested disaster recovery plan recommendation. eHealth established a disaster recovery program. The five-year disaster recovery road map continues to be implemented. All critical eHealth-managed services have a disaster recovery playbook and have been tested using various testing methods, for example, walk-through exercises, tabletop exercises, and partial tests.

A testing plan is being developed to ensure systems are sufficiently tested over time. A central repository has been developed to lay the groundwork for a comprehensive and accessible hub for recovery plans. eHealth is developing performance metrics that will provide valuable insights into the effectiveness of the disaster recovery efforts and support effective decision making. Thank you.

Chair Wotherspoon: — All right, thank you for the work on this front. I'll open it up to committee members for questions. MLA Gordon.

Hugh Gordon: — I'd like to ask you, if the system goes down, what is your mean time for recovery?

Davin Church: — Currently we're working through the business impact assessments with the partners to identify, based on the level of criticality, what those return-to-operation times are and acceptable downtimes are, in order for us to then identify the gaps between our current capabilities and identify how we would then resolve the need and the resumption times to the capabilities.

Hugh Gordon: — To follow up on that, you know, understanding how long it would take for your system to recover if it went down, I think, would be really important. I imagine a number of very, very essential services that everyone is depending on at various levels, in the ministry and SHA and elsewhere, for all kinds of health care providers.

Are you able to provide me any insights as to how much data you can accept the loss of if there was a system that went down? Do you have a grasp of how much data you can acceptably lose, or is that dependent?

Davin Church: — The business impact assessment will determine what that recovery point objective is, and that is unique to each business area within our partner organization. So that's really up to them to determine as opposed to eHealth. eHealth proper, our business impact assessment will be done by the end of this fiscal year, so we'll have that for our internal systems completed.

Important to note when we talk about loss of data as well, we do have geographical redundancy in our backups. And so we do have that between two data centres of backups of the data that we house as well in that. And then we're also continuing to work through and improve our disaster recovery testing of those critical systems to determine how and ensuring that we can recover those and how quickly we can recover those critical systems and the prerequisite systems that also need to be recovered in the event of a disaster.

Hugh Gordon: — So to kind of tie into that a little bit, have you been able to identify which systems are critical for continuing operations on a day-to-day basis, that in the event they weren't recoverable, you've got an adequate plan in order to I guess mitigate that?

Davin Church: — We are confident that in the event that a

specific system could not be recovered — of those critical systems that were originally identified through that audit of those mission-critical systems — that we could recover those with data up to the most recent backup. It's important to note though, business continuity is obviously, you know, would be within those specific service areas around maintaining the continuity of the actual services being provided in the event of an outage.

Hugh Gordon: — But to be clear, you haven't done a full assessment on the mean time for recovery of those systems either yet. That's still in the works.

Davin Church: — That's correct. What we're currently identifying is a way to actually go to a full rebuild because we don't have the opportunity to take lab systems down and attempt to rebuild them from a production perspective. So our process has been working through some of those partial trials, and then as major upgrades are required, working through that full plan as those major upgrades are occurring in order to achieve that.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — So IT people tell me that if you haven't tested a disaster recovery plan, you don't have a disaster recovery plan. Have you tested your disaster recovery plan?

[14:30]

Davin Church: — We believe we have tested that DR [disaster recovery] plan for those critical systems. Our approach is not to take those systems down end to end, as a traditional disaster recovery testing would indicate, because of the impact to patients and citizens of removing those systems. So through our incremental testing and tracking those incremental tests to get to a full test of those plans, we do believe we have.

Joan Pratchler: — Okay. I see here on the last recommendation, it was in the 2007 report and then 2008. And here we are in 2025. And in the recommendation it says here it's a five-year road map with milestones along the way. Twenty years — in computer time, that's a pretty long time.

How does one . . . And us in the Public Accounts are to represent the voices of the citizen. How does one justify almost 20 years length of time to secure citizens' and health care operations data? And what steps are being taken to speed that up and to ensure that it's going to be always current and not take that amount of time to ensure such critical information in health care in this province will be at the level it needs to have for the excellent . . . for our citizens.

Davin Church: — I can't speak to historically how approaches or attempts were made to resolve this recommendation over the last 18-or-odd years. What I can say is we have taken the approach of the five-year road map, as well as an independent audit every 18 months against an ISO standard around our disaster recovery model and our maturity against getting there, and which we also report that to our board. And the independent auditor has an opportunity to speak to our board and present that. And from our perspective, we're confident that at the next follow-up audit by the Provincial Auditor that we'll have this implemented.

Joan Pratchler: — Good. Thank you.

Chair Wotherspoon: — Any further questions, committee members? Not seeing any, I'd like to thank CEO Church and the entire team over at eHealth for their work on these fronts and for their involvement in our considerations here today. And I think that concludes our consideration with respect to eHealth, but also Health here today. So I'd certainly invite ADM O'Neill to provide any parting remarks and to thank him and his team all across Health for their time here today and all their work on these fronts as well. Got any parting remarks before we kick you out of here?

Norman O'Neill: — I'll keep them brief because you're going to kick me out. But I would just thank the Provincial Auditor and her team for the good relationship that we have. We'll thank the committee for listening to our subject matter today. And I'll thank the officials that joined us and provided their knowledge.

Chair Wotherspoon: — Thank you. Thanks again. And thanks to committee members. We'll have a very brief recess while we . . . Well I guess we should have a motion to conclude consideration on — thank you very much MLA Crassweller — to conclude consideration on chapter 1. He's identified it, so he's the mover. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay, that's carried. Thanks so much everyone.

[The committee recessed for a period of time.]

Social Services

Chair Wotherspoon: — Okay, folks, we'll reconvene the Standing Committee on Public Accounts here. And we're going to turn our attention to the Ministry of Social Services, and then we'll conclude with some review with respect to the Sask Housing Corporation.

I want to welcome all the officials that have joined us here today and all those that are connected to the work that we're considering here today. And I want to welcome Deputy Minister Bourgoin to provide just a brief introduction of all the officials that have joined her and us here today. You can refrain from getting into the chapters at this point. We'll get over to the auditor for her presentation, then come back your way. So I'll turn it your way, Deputy Minister Bourgoin.

Richelle Bourgoin: — Thank you very much.

Chair Wotherspoon: — Oh, whoa. Uh-oh.

Richelle Bourgoin: — Oh, dear. Well the carpet's a little cleaner than when we started, so thank you.

I'm very happy to be here today and I'm really pleased to introduce my colleagues that are with me: Brittany Csada, our assistant deputy minister of housing and president and CEO of the Saskatchewan Housing Corporation; Tobie Eberhardt, the

assistant deputy minister of child and family programs; Grant Hilsenteger, the assistant deputy minister of finance and corporate services; to my left, Joel Kilbride, the assistant deputy minister of disability programs; and Julene Restall, the assistance deputy minister of income assistance.

As you can see, we're also joined by other ministry colleagues who will introduce themselves if they are called upon to answer questions. And we're really happy to be here and look forward to the conversation. Thank you.

Chair Wotherspoon: — Thank you very much. I'm going to turn it over to the Provincial Auditor. The two chapters before us here today, we'll deal with them independent of one another, and we'll focus first, of course, on chapter 31.

Tara Clemett: — So, thank you, Mr. Chair, Deputy Chair, committee members, and officials. With me today is Mr. Jason Wandy, and he is the deputy provincial auditor that is responsible for the portfolio of work that does include the Ministry of Social Services as well as Sask Housing. And behind him is Ms. Michelle Lindenbach, and she is our liaison with this committee.

Jason will present the chapters for the ministry in the order that they do appear on the agenda. This will result in two separate presentations. He will pause for the committee's deliberation and consideration after each presentation.

The first presentation does include just a status update on previous recommendations that the committee has agreed to. The second presentation includes four new audit recommendations for the committee's consideration.

I do want to thank the deputy minister and her staff for the co-operation that was extended to us during our work. With that, I'll turn it over to Jason.

Jason Wandy: — Thanks, Tara. The Ministry of Social Services funds and licenses group homes and approved private service homes to provide accommodation, meals, and care to about 1,700 adults with intellectual disabilities, referred to as clients. In April 2024 the ministry licensed about 280 group homes and 180 approved private service homes in Saskatchewan.

Chapter 31 of our 2024 report volume 2 reports the results of our first follow-up audit of management's actions on the nine recommendations we first made in 2021 about the ministry's processes to monitor whether ministry-funded group homes and approved private service homes provide quality care to adults with intellectual disabilities. By April 2024 the ministry implemented one recommendation and continued to work on six recommendations, and did not implement two recommendations.

For the two recommendations on page 269, we found the ministry partially implemented our recommendation that the Ministry of Social Services use a central system to track key information about group and approved private service homes, and it implemented our recommendation that the Ministry of Social Services monitor resolution of deficiencies stated in conditional licences for group and approved private service homes within a reasonable time frame.

We found the ministry developed a centralized tracking system for monitoring group homes' licensing information — for example, licence expiry dates — but had yet to update its system to also include licensing details for approved private service homes. It planned to do so during 2024-25.

We found the ministry appropriately monitored home operators' resolution of deficiencies set out in conditional licences. At March 2024, 18 per cent of group homes and 20 per cent of approved private service homes had conditional licences, compared to 45 per cent and 70 per cent in 2021, respectively.

Our testing of 15 homes with conditional licences found the ministry maintained regular contact with home operators who had conditional licences. Having a centralized system to track steps completed in the home licensing process can help with monitoring licence expiration, completion of inspections, along with receipt and review of required documentation.

[14:45]

For the two recommendations on page 271, we found the ministry partially implemented the recommendation that the Ministry of Social Services update home inspection checklists to cover key risk areas at group and approved private service homes, and did not implement the recommendation that the Ministry of Social Services annually inspect each group home to assess if it meets the minimum program standards requirements.

We found the ministry updated its home inspection checklist for staff to examine key risk areas at group homes — for example, handling of medications — but had yet to update its home inspection checklist for approved private service homes. It expected to do so by October of 2024.

We found the ministry continued to not require its staff to visit each group home at least annually to assess whether each home meets minimum program standards. The ministry indicated it continues to look for opportunities to increase the number of group homes it reviews annually through establishment of a quality assurance unit. In 2023-24 the ministry inspected 104 out of 282 group homes.

Having comprehensive checklists to assess key home safety areas potentially impacting clients' health and safety is necessary to determine deficiencies and correct them before serious incidents occur. Without regularly inspecting each group home to assess program standards, the ministry may not know whether clients receive appropriate and quality care.

We found the ministry did not implement the recommendation on page 272, where we recommended the Ministry of Social Services verify completion of periodic criminal record checks for people caring for adults with intellectual disabilities. *The Residential Services Regulations* require group home operators to establish policies requiring criminal record and vulnerable sector checks for management, staff, and volunteers working with clients. The regulations also require approved private service home operators to provide the ministry with the results of criminal record and vulnerable sector checks for operators and other adults in the homes.

The ministry requires group home operators to establish policies requiring criminal record and vulnerable sector checks and

requires approved private service homes to present a criminal record check and a vulnerable sector check for all adults living in the home upon initial licensing.

However the ministry indicated it is working to determine how often to require criminal record checks and vulnerable sector checks for people providing services to people with intellectual disabilities in group and approved private service homes. It expected to establish a process to verify completion of periodic criminal record checks during 2024-25. Lack of verification of periodic criminal record checks for people providing services to vulnerable populations, such as adults with intellectual disabilities, increases the risk of financial, physical, or sexual abuse.

We found the ministry partially implemented both recommendations on page 273, where we recommended the Ministry of Social Services periodically assess the quality and fulfillment of person-centred plans for adults with intellectual disabilities, and where we recommended the Ministry of Social Services have regular contact about the person-centred plans with adults with intellectual disabilities.

We found the ministry drafted standards for providing person-centred case management to adults with intellectual disabilities based on their assessed needs, desires, and goals. It planned to pilot these draft standards during 2024-25. Until implementation of the new standards, we found the ministry continued to expect group and approved private service home staff to develop person-centred plans with their clients and review them at least every two years. Additionally we found the ministry continued to expect its case managers to have at least once-a-year contact with clients living at group homes and once every quarter with clients living in approved private service homes.

Our testing of 30 client records found three client records did not include any person-centred plans; four client records had existing plans over two years old, with the oldest plan developed in 2015; 14 client records did not have evidence of ministry staff reviewing clients' person-centred plans or outcomes; and 11 client records indicated ministry staff did not have regular contact with the clients — that is, no contact within the last year.

Without periodically reviewing the person-centred plans and meeting with clients, the ministry does not know whether clients receive quality care to live fulfilling lives. Furthermore the ministry may not know whether any issues or concerns exist if ministry staff do not periodically visit or contact clients.

We found the ministry partially implemented the recommendation on page 274, where we recommended the Ministry of Social Services analyze serious incidents for systemic issues. Since our 2021 audit, we found the ministry developed a serious incident dashboard, providing some analysis of serious incidents reported by group and approved private service homes.

In addition, we found the ministry implemented a new form for reporting serious incidents in April 2024. The new form requires ministry staff to document the physical address of where the incident occurred. Such information can help the ministry to better identify homes with more frequent or persistent concerns when analyzing serious incidents.

While the ministry currently has limited data to inform analysis by physical address, staff indicated they will comparably analyze incident data in 2024-25 of the various homes providing services to clients. Limited or ad hoc analysis risks the ministry not identifying homes with persistent issues, increasing the risk of missing homes providing unsuitable services for adults with intellectual disabilities that should not be licensed.

We found the ministry partially implemented the recommendation on page 276, where we recommended the Ministry of Social Services monitor for timely implementation of recommendations set out in serious incident investigation reports at group and approved private service homes. We found the ministry did not consistently follow up with home operators on their implementation of recommendations from serious incident reports.

We tested eight serious incidents from 2023-24 that warranted an investigation and found six of the final reports included recommendations. However not all recommendations included expected timelines for implementation. Ministry staff did not properly follow up with three home operators regarding timely implementation of recommendations.

The ministry not following up on and monitoring the status of serious incident recommendation implementation may lead to similar incidents reoccurring. Identifying delays in implementing corrective actions will provide the ministry with important information about whether it needs to further support the home to prevent specific types of incidents from occurring.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Thanks very much for the presentation and the important follow-up here. I'll turn it over to Deputy Minister Bourgoin for brief remarks. Of course, this is a follow-up chapter and we've concurred already at this table as a committee with these recommendations and had an opportunity to have some questions. But, Deputy Minister, go ahead, and we'll see what we have for questions.

Richelle Bourgoin: — Thank you very much. And thank you for the presentation. Related to the recommendation that the ministry use a central system to track key information about group homes and approved private service homes, the ministry considers this recommendation implemented. We have updated our centralized licensing database to better track key information related to licensed group homes and approved service homes.

There are two recommendations under 3.2, and I will speak to them separately. Related to the recommendation that the ministry update home inspection checklists to cover key risk areas at group homes and approved private service homes, the ministry also considers this recommendation implemented. We've updated our inspection checklists to address best practices for water temperature, medication handling, and waste disposal, for example. The program standards checklist that is used for group home licensing was updated in January of 2024, and the annual review checklist used for approved private service home licensing was updated in October 2024.

Related to the recommendation that the ministry annually inspect each group home to assess if it meets the minimum program

standard requirements, the ministry considers this recommendation partially implemented. In January 2024 we fully implemented the program standards report, and that report includes the requirement to complete a minimum of one program standards review every year for each service provider licensed under *The Residential Services Act*.

But since the previous audit, the ministry's new disability programs quality assurance unit was established, and that team is beginning program standards review in our north service area group homes this month, in October. We will expand this to group homes in the rural centre service area by March of 2026. The quality assurance team will conduct an analysis of the completed program standards reports to determine the effectiveness of this approach.

Related to the recommendation that the ministry verify completion of periodic criminal record checks for people caring for adults with intellectual disabilities living in group homes and approved private service homes, the ministry considers this recommendation implemented and on track for full implementation by the end of this fiscal year.

The ministry began a phased approach to fully implement an annual criminal record declaration for all service providers by the end of this fiscal year. Group home operators were informed of this new requirement in May. We're on track to have that completely delivered by April, when new service agreements will include the requirement for annual criminal record declarations. The requirement's also being added to agreements with approved private service home operators over the course of this fiscal, and again at the time of annual licensing renewals.

The ministry considers the following two recommendations under chapter 3.4 to be partially implemented: that Social Services periodically assess the quality and fulfillment of person-centred plans for adults with intellectual disabilities living in group homes and approved private service homes, and that the ministry have regular contact about the person-centred plans with adults with intellectual disabilities living in group homes and approved private service homes.

I'll speak to each recommendation separately, but with respect to the quality of person-centred plans, or what we call PCPs, the program standards report was rolled out in January of 2024 and verifies that the PCPs are in place. The ministry also has a case management project under way, and that has developed a tool to measure the quality of those plans specifically.

With respect to having regular contact about the PCPs, I noted earlier the program standards report verifies that those person-centred plans are, in fact, in place in group homes and tracks completions as well as renewal dates of those plans. Approved private service home operators are also now required to implement a new residential support plan for all residents this fiscal as part of their annual licensing review.

To fully implement both recommendations by the end of the 2026-27 fiscal year, the ministry is expanding our outcomes-based service delivery project. This project focuses on ensuring that clients served by third-party service providers receive quality support and have positive outcomes from the programs and services that we deliver. For disability sector service providers already participating in the project, we will work with them to integrate the outcomes-based service delivery framework into individual, person-centred plans and focus on service-level indicators in overall planning and program delivery.

Related to the recommendation that Social Services analyze serious incidents related to adults with intellectual disabilities for systemic issues at each group home and approved private service home, we also consider this recommendation implemented.

The new disability program's quality assurance unit oversees and tracks serious incident reporting. To strengthen their work, new serious incident definitions have been developed. A process is in place to flag outstanding abuse investigations to ensure they are completed in alignment with policy and expected timelines. And finally, a proactive strategic plan has been developed to analyze reported serious incidents for common trends and provide recommendations to address and prevent those trends.

Related to the recommendation that the ministry monitor for timely implementation of recommendations set out in serious incident investigation reports at group and approved private service homes, the ministry considers this recommendation partially implemented.

Standardized reporting on serious incidences has been established and those reports are being scrutinized and monitored by the quality assurance unit. The ministry has conducted analysis that will be the basis for recommendations to improve service quality and incident follow-up. And by the end of the 2026-27 fiscal year, we will move forward on key actions based on those anticipated recommendations that will come from that work.

Thank you very much. I'll turn it back over to the Chair.

Chair Wotherspoon: — Thanks so much, Deputy Minister Bourgoin, and all those that have been involved in this work and the commitments that have been made as well. I'll open it up to committee members now for questions. MLA Pratchler.

Joan Pratchler: — I really have to commend this group on the amount of work that must have happened in these last . . . half of a year practically. Thank you for that.

I'm looking at recommendation 3.1, just a little more information maybe. What specific data will be tracked in that database mentioned in that recommendation?

[15:00]

Chair Wotherspoon: — Just before you provide a response there, I just wanted to table the status update as well: PAC 55-30, Ministry of Social Services: Status update, dated October 15th, 2025. Thanks to those that are involved in that work that's reflected in that status update and those that prepared it.

Joel Kilbride: — Thanks very much. Joel Kilbride, the ADM of disability programs. So in that database we have information about the addresses of the homes: those that are licensed, those that are up for renewal for licensing, those that have deficiencies that need to be addressed. All that information is located in there.

Joan Pratchler: — One-stop viewing.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — So what did the ministry find when it was reviewing its inspection checklists? What, if anything, was added to the checklist?

Joel Kilbride: — Some information and expectations were outlined in amendments that were made to *The Residential Services Act* in regulation around safe water temperature, waste disposal — what's the other piece? — and medication administration.

Joan Pratchler: — Has anything else been added to that checklist for those few items or was anything else enhanced?

Joel Kilbride: — We'll have to bring that back. I'm sorry, we don't have any additional information on that.

Joan Pratchler: — [Inaudible] . . . usually about a month. If you can just send it to us, that would be great. Just wondered.

Joel Kilbride: — Well thank you.

Chair Wotherspoon: — Thanks so much. So we'll just keep it formal through the Chair on the undertaking. You're able to provide that information within a month? Is that reasonable? And you can just do it through the . . . The Clerk will provide you kind of the process to do that. Any further questions, MLA Pratchler?

Joan Pratchler: — Can you provide an update on how the program standards reviews in the north service area are going so far?

Joel Kilbride: — So we just started that process, and only one has been completed so far.

Joan Pratchler: — How many do you think will be needed to be completed? Like what's your "-ish"?

Joel Kilbride: — We should be able to get that answer back to you shortly. If you want to move on, we can come back to it.

Hugh Gordon: — I just want to touch on the resolution of deficiencies in a number of your care homes, both private and otherwise. What were some of the barriers that you had to overcome or are overcoming in order to monitor the resolution of those deficiencies in those homes?

Jeff Redekop: — Good afternoon. Jeff Redekop, executive director with service delivery and disability programs. So the question was about what are some of the issues we have to address in some of the inspections. So we have a short list of a few things that are on our list here.

Sometimes it's the physical repairs, sometimes fairly extensive ones that can include, just going from memory, bathroom and kitchen repairs in terms of some of the homes. Sometimes we have a temporary space increase during, you know, renovations that need to be addressed as part of that remediation. And sometimes there are things related to, I can't think of an example, but things might be related to zoning if there's something we have to remediate in terms of the zoning of a home.

And I think that's generally the list. A lot of it is repairing. You know, I'm just looking through at some of our capital, just going through my memory in terms of some of the capital improvements we've had to do to adjust some of these things. And in addition to renovations, we've addressed these, like sometimes making the ground level. That can change over time in terms of the physical structure of the group homes. Those are a few examples.

Hugh Gordon: — I guess just to clarify, I was just wondering like if there was issues that were getting in the way of resolving these deficiencies in these care homes. Like is it just a matter of working with those different stakeholders, making sure that they have adequate either funding to resolve issues that are detected, they have adequate training, adequate personnel? What might be the delays in that process in ensuring that when these deficiencies are detected that there's, you know, a timely resolution of that? And I'm just curious if it's something that's across the board or if it's something unique to each facility.

Richelle Bourgoin: — I speak to the very specific needs that we have with some of our group homes and the clients specifically, because we do at times transition clients from an existing group home into another group home or have a change in residency. The needs of the individual might be very specific. And so for example, a certain size of bed that simply needs to be procured. And so we can sometimes experience some delay in making sure that we have the right fit for the client that we're serving in that time.

It may not be something that's profoundly structural, but to Jeff's point where we do have larger issues, such as shifting in some communities and houses that are not brand new as an example, or if we see that there's been some moisture and there's a problem with the basement, then we are sometimes at the mercy of the contractors that provide the support that we need to be able to bring those homes to the point that we want them to be, just like many of our neighbours on the blocks that will be experiencing similar types of problems with the houses that they are in.

Hugh Gordon: — Thank you. I want to move on to completing annual inspections. I just also was wondering, you partially implemented that recommendation. I'm just curious to know what further challenges remain in order for you to, you know, fully implement that recommendation? And if you could tell us what those barriers might be.

Joel Kilbride: — Thank you very much for the question. I just want to start by sort of being clear that we do have people that go in the homes annually. There's caseworkers that go in the homes. Each home, a physical inspection is done. There's fire inspections, health inspections that are done. And we also have other positions that visit homes. There's managers of community and client service that have relationships with CBOs [community-based organization] and clients. So we are in the home.

This is really just about the program review. And one of the reasons in the past I think that we wanted to make sure a program review was done for every CBO and not necessarily for every

group home is that there are program coordinators that oversee more than one group home, and so they would be responsible for the programming. Now we do want to move in the direction of trying this out again in the North and then move to a rural centre service area and see if there's any value in reviewing every home.

And I have a follow-up answer on the number of homes in the North. It's 55.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Just one last question, I think. Heaven forbid there's a serious incident. Could you just walk us through what is the ministry's process should that occur? And how does that look like until resolution of some nature?

Jeff Redekop: — If I recall the question — oh, sorry, Jeff Redekop. The question was about what's kind of the process if there's a serious incident. Yeah, first of all I mean, I guess the fundamental requirement there is that we have policies and processes in place to report serious incidents, which are in place.

And with our own directly operated homes and the homes that are approved private service homes operated by private individuals licensed under our residential services Act and CBO or third-party providers that are providing group homes, so that process is in play for our staff and our community contractors. And making sure that people are aware of that critical thing. So this is the foundation for ensuring that reporting does occur.

And when there's an incident, the requirement is . . . And it depends on the type of incident. For example, if it's an allegation of abuse, that would be something that would be reported immediately to within our various systems. We have processes in our service incident reporting documentation that shows kind of who reports to who, when. So that's all laid out.

And once there's a report in, you know, we — for example, our ministry folks — would engage with the third party . . . I mean of course, before that, taking steps to make sure whatever incident is stopped and people are safe, if people need to go to the hospital — which is a rare thing, but it does occur in some serious incidents. Making sure that clients are safe is the number one priority.

[15:15]

Following that, we would certainly engage with the organization, and the next step — I'm not covering every step because we have other things to get to — but following that there may be a need to do a further review of an incident and document steps that we could take to prevent such instances from occurring again. And then whatever those might be, implement those recommendations.

But one of the critical things that Joel spoke about earlier, and Deputy Minister Bourgoin, was the establishment of our new quality assurance unit which provides basically the staff to do the work and focus on reviewing how we're performing, and having a look at not only the serious incidents that occur at a one-off but on a systemic basis, whether that be per group home, per community-based organization, or per individual. So we now have, with our refined dashboard, the availability to analyze that information in a far more detailed way.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — Any further questions, committee members? Not seeing any at this time, I'd welcome a motion to conclude consideration of chapter 31 moved by Deputy Chair Wilson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We'll turn our attention to chapter 9 of the 2024 report volume 2. We have some new recommendations in this chapter, and I'll turn it over to the auditor.

Jason Wandy: — Thank you, Mr. Chair. Chapter 9 of our 2024 report volume 2 reports the results of our annual audit of the Ministry of Social Services for the year ended March 31, 2024. We found the ministry complied with authorities governing its activities and had effective rules and procedures to safeguard public resources, except for the matters described in our chapter.

The ministry implemented two recommendations in 2023-24. We found the ministry implemented our recommendation about starting to verify the accuracy of Saskatchewan income support, or SIS, program clients' income information with the federal government. The ministry implemented a process to start verifying the accuracy of SIS program clients' income information and confirmed the accuracy of income for a sample of clients based on federal government information. It intended to further expand this work in 2024-25.

Additionally, we found the intent of our recommendation about reinforcing with staff the requirements for paying shelter benefits under the SIS program to be implemented. But we found the program continued to not consistently comply with legislative and policy requirements associated with paying shelter benefits to clients under the SIS program, resulting in incorrect payments during the year. Our analysis found overall estimated errors in SIS payments were not significant for '23-24 — under 2 per cent of the ministry's total SIS payments. We will continue to examine SIS payments on an annual basis to determine significance.

We found the ministry partially implemented the recommendation on page 55, where we recommended the Ministry of Social Services record and recover overpayments related to its Saskatchewan income support program in a timely manner. An overpayment occurs when the ministry pays a SIS client before receiving all information necessary to confirm a client's eligibility for benefits or it makes an error in determining a benefit amount or when a client potentially provides inaccurate information to the ministry. At March 2024 the ministry reported accounts receivable of almost $10 million related to SIS overpayments, a 38 per cent increase from 2022-23.

The ministry's IT system used to administer SIS benefits allows staff to establish automatic payment recovery beginning the following month and record the related amount due that is accounts receivable for overpayments from future SIS benefits.

Our testing of eight SIS client files with known overpayments found ministry staff did not record the overpayments for seven files and did not set up the collection from future benefits through the automatic payment recovery process. Ministry staff set up the overpayment for one file but did not do so timely. Not recording amounts due and not initiating automatic payment recovery delays timely overpayment recovery. In addition the ministry will have limited ability to collect on overpayments if clients leave the SIS program.

Our annual audit of the ministry also included assessing the design and implementation of the ministry's processes up to July 31 of 2024 for procuring hotel rooms when income assistance or child and family program clients require hotel stays. We decided to do this work in response to concerns raised in the Legislative Assembly during 2023-24. This chapter includes four new recommendations for the committee's consideration in relation to this work.

In the recommendation on page 61, we recommend the Ministry of Social Services maintain sufficient documentation to support appropriate selection of hotels needed for its child and family program clients. In March 2024 the ministry implemented a pilot project requiring staff to obtain three quotes from hotel providers when procuring hotels rooms for clients in Saskatoon, Regina, Prince Albert, and Moose Jaw.

The ministry's program support branch developed a list of confirmed hotel providers by contacting hotels located in these cities to identify interested providers. Branch staff maintain a price-quote list, calling three hotels for each location on the listing twice each week, on Monday and Friday, to obtain nightly room rates. Branch staff share the price-quote list each Monday and Friday with other staff — for example, caseworkers or after-hours service providers — who may be booking hotel rooms for clients.

When procuring hotels for clients, the ministry expects staff to document details in the case management systems surrounding a client's need for a hotel — for example, they are homeless, the shelters were full, or domestic abuse — along with necessary approvals by a supervisor or a manager as well as the nightly rate obtained.

We assessed the ministry's implementation of its three-quote pilot between March and June 2024 for four income assistance clients. We reviewed documentation within the case management system, confirming staff appropriately used the price-quote list and obtained necessary approvals to procure the hotel rooms.

For three child and family program clients we reviewed documentation within the case management system, confirming staff within the child and family programs branch obtained necessary approvals to document the hotel rooms. However, we were unable to determine whether they appropriately used the price-quote list when selecting the hotels — for example, staff did not document their consideration for each hotel chosen — or whether they obtained the lowest-priced hotel from the current price-quote lists.

Having sufficient documentation about hotel selection enables the ministry to demonstrate its consideration of best value in its procurement of hotel rooms while treating hotel providers fairly and equitably.

In the two recommendations on page 63 we recommend the Ministry of Social Services centrally track and monitor hotels it pays and at what rates for clients of its income assistance and child and family programs. And we recommend the Ministry of Social Services complete a robust evaluation of its pilot projects to procure hotel rooms for clients of its income assistance and child and family programs.

At the end of 2023-24 the ministry initiated two pilot projects associated with procuring hotel rooms for clients, as I have already discussed. One project requires staff to obtain three quotes when procuring hotel rooms and choose the hotel appropriate for client needs with the lowest rate. The other project involves contracting a hotel provider in both Regina and Saskatoon to provide five hotel rooms, every night, at a single fixed rate for a one-year period.

Beginning in August 2025 the ministry planned to evaluate its two pilot projects for the one-year period ending July 31st, 2025. However, we found the ministry had yet to consider all data requirements or to determine baselines or targets needed for its evaluation. While we found the ministry did contemplate its data requirements for the two contracted hotels within its agreements with the hotel providers — that is, requiring hotels to provide monthly reporting about usage and any damages — the ministry cannot easily obtain data for evaluating its three-quote process as it maintains detailed client hotel data within multiple systems. For example, the ministry indicated staff spent considerable time during 2023-24 compiling data about client hotel stays to help answer questions from legislators.

To effectively evaluate its pilot projects, the ministry needs reliable data on which to base its assessment. The ministry requires such information to determine whether the project's improved its ability to procure suitable hotel rooms for clients efficiently and effectively. It needs to complete this evaluation timely and provide the results to senior management to also support future decisions and/or changes needed.

In the final recommendation, on page 64, we recommend the Ministry of Social Services work with the Ministry of Finance to consider how to publicly report payments made to vendors on behalf of income assistance and child and family program's clients. When the Ministry of Social Services pays vendors on behalf of its clients, it records these payments as operating transfers. These are transfers to or on behalf of individuals for which the government does not receive any goods or services directly in return.

According to the financial administration manual maintained by the Ministry of Finance, the government's Public Accounts volume 2 includes payee details for transfers where payees received $50,000 or more except in the following circumstances: for high-volume programs of a universal nature, or income security and other programs of a confidential and personal nature.

Historically the Ministry of Social Services has applied the exception when preparing its disclosures for volume 2 and has not disclosed payments made to vendors like hotels on behalf of its clients. We compared the ministry's payee details in volume 2

to similar reporting in two other Canadian provinces, that being Alberta and Manitoba, and found the ministry's counterparts in both provinces report the payee details for payments made to vendors like hotels and grocery stores on behalf of clients exceeding a specific threshold, for example, $10,000 or $50,000.

Public reporting about payments made to vendors on behalf of clients such as in volume 2 or within the ministry's annual report can help the ministry to increase transparency about its use of vendors and demonstrate accountability for its programs.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Well thanks for the presentation, the important chapter, and the focus of your work here today. I'll turn it over to Deputy Minister Bourgoin for comments and then we'll open it up for questions.

Richelle Bourgoin: — Thank you very much, and thank you for presentation. Related to the recommendation that the ministry record and recover overpayments in the Saskatchewan income support program in a timely manner, the ministry considers this recommendation implemented.

Since the audit the ministry developed and implemented a strategy to ensure overpayments are recorded and recovered in a timely manner. Specifically this includes a targeted review of Saskatchewan income support program cases with an overpayment to ensure a plan to recover the overpayment has been established. This work continues and cases that do not have a recovery plan in place are being addressed.

Training for employees on the process of entering and recovering overpayments in the system have been developed and implemented. And finally, new system functionality enables overpayments to be transferred and recovered across case files.

Related to the recommendation that the ministry maintain sufficient documentation to support appropriate selection of hotels needed for its child and family program clients, the ministry considers this recommendation implemented.

We've updated our processes and implemented training to ensure consistency of documentation for hotel selection for children and families in need. By the end of January of this year, we updated child and family program's business process manual to include the ministry's three-quote hotel price process and held a series of information sessions with child and family program employees on the three-quote process; and ensuring that consistent documentation of hotel selection, the rates, and the other relevant information is contained in our case management system. Going forward, the ministry will continue to use the price-quote list for hotels to identify the most affordable, as well as appropriate, accommodation to meet the immediate needs of our clients.

There are two recommendations listed under 5.4 that I will address separately. Related to the recommendation that the ministry centrally track and monitor hotels it pays, and at what rates for clients of income assistance as well as the child and family programs, the ministry considers this recommendation implemented.

Since the auditor's report, the ministry has developed a centralized process in Saskatoon, Prince Albert, Regina, and Moose Jaw where designated employees track and monitor hotel invoices. This information helps us to really provide an overview of the number of hotels in use, the rates charged. It of course supports transparency and gives us the ability to analyze those trends over time. We continue to review the current processes and the administrative requirements to track hotel usage. It remains a priority, and this will inform any potential adjustments or alternative approaches that balance operational demand with the importance of transparency in reporting.

Related to the recommendation that the ministry complete a robust evaluation of its pilot project to procure hotel rooms for clients of income assistance and child and family programs, we also consider this recommendation implemented.

In response to the recommendation, we conducted an evaluation of two pilot processes that were put in place in 2024: the contracted block-room model in Regina and Saskatoon, as well as the weekly three-quote process used in Regina, Saskatoon, Moose Jaw, and Prince Albert. Our evaluation included data collection, incorporating information from the centralized hotel invoice-tracking process, hotel invoices, vendor master lists, weekly hotel price quotes, contract information, utilization records. And we also conducted interviews with the employees that were involved to understand their experience in that process.

Our detailed evaluation report has been provided to the auditor's office. Findings confirm that hotel stays remain a necessary part of service delivery at the Ministry of Social Services. But in line with the report's recommendations, the ministry will continue to use the three-quote hotel price process, and it's extended the procurement of blocked hotel rooms. The renewed contracts include five hotel rooms in Saskatoon — unchanged from our previous contract — but eight hotel rooms in Regina, which is an increase in three rooms per night to meet demand in the city.

[15:30]

Related to the recommendation that Social Services work with the Ministry of Finance to consider how to publicly report payments made to vendors on behalf of the income assistance and child and family program clients, the ministry considers this recommendation partially implemented. We note that the Provincial Auditor found the ministry's reporting standards to be consistent with the government policy for reporting payee details.

We will continue to adhere to the government's financial reporting policies. Presentation of vendor payments will not change in the 2024 Public Accounts volume 2 being released this fall. We will continue to work with our colleagues at the Ministry of Finance to ensure that we're fully compliant with their policies on public reporting.

And I will turn it back over to the Chair.

Chair Wotherspoon: — Thanks for the update on the work that's been undertaken. I would open it up now to committee members that may have questions. MLA Gordon.

Hugh Gordon: — Do you have any data on overpayment rates or track how much overpayment occurs?

Julene Restall: — My name's Julene Restall. I'm the assistant deputy minister of income assistance programs. So a little bit more about overpayments. So overpayments occur when a ministry pays benefits to a client that they're not eligible for or there's a change in circumstances which individuals don't inform us about, and therefore it impacts their eligibility for benefits.

Within our SIS program we have a policy that outlines the amount of recoverable overpayments that we assess on a monthly basis. So that would be a recovery of $50 a month because we want to ensure that people aren't experiencing hardship because of those overpayment amounts. We reflect that overpayments are a debt to the Crown. And we do have to collect on those, but we obviously take that into consideration with working with clients.

If there's a ministry error that has driven the overpayment, we do have the ability at the supervisor and manager level to decrease the overpayment recovery rate to $25 a month. So we do have that ability within our policies.

For overall overpayment amounts, for our SIS program, it is actually anticipated that the SIS program would have an increase in overpayment amounts over a period of time. It's a rather new program. Especially since the Saskatchewan assistance program and the transitional employment allowance program have shut down, one of the things that has actually occurred through this is we actually can move our historical overpayments from SAP [Saskatchewan assistance program] and TEA [transitional employment allowance] onto our SIS programs. So when a person was on those past historical payments, we are moving that over onto our SIS overpayment amounts.

So that's why you also would see an increase in the overpayment amounts within our programs, which is a different approach from what we've had in the past. Overall for the amounts, we do not collect that regularly and actually report the overpayment amounts outstanding on an annual basis.

Richelle Bourgoin: — I can maybe just add for some additional context, an overpayment does not necessarily mean that a mistake has been made. And in many cases with our clients, that payment occurs and then subsequently there's a change in circumstance for that client, so for some of our clients, for example, transitioning to the Saskatchewan employment incentive. And so it allows us to work with that client through case management to balance out.

And when Julene was talking about the repayment that occurs, it gives us the flexibility to ensure that those clients continue to have what they need to be successful while we manage that over a period of time.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Sorry, if I could just tag on to that then. Like do I understand correctly that payments under SIS are still being given to the client and not to the landlord, for example?

Richelle Bourgoin: — Not exclusively. And so the baseline for clients that are enrolled in the Saskatchewan income supplement means that they have agency to make independent decisions, but we want to support them to be successful with the resources that are being provided. And so we have individuals that do manage their own finances and successfully, either with supports that are available in the community, through the ministry, or within their own family unit.

But alternatively if that isn't a solution that will be successful for the client, we have the ability to roll them into trustee management services. I can say the acronym is TAMMS [trusteeship and money management supports] and it's very long. I can't think of it. But it allows us to work with partners in the communities that we have that will help with money management services to ensure that things like rent are paid directly to the landlord.

Hugh Gordon: — The point, I guess, I'm trying to discern here is that, you know, for those clients that are capable, that's great. You know, you hopefully do not incur an overpayment, and everything goes well and goes to where it's supposed to be. But I'm just wondering, for those clients where they had a payment going directly to the landlord, that would have been another check and balance in ensuring an overpayment doesn't occur. Because the landlord would be receiving an amount; they would be like, well why am I receiving this? This client's no longer renting from me.

So that's why I just put that out there. I don't know if there's a more clear answer to my question.

Julene Restall: — I think talking about direct pay, I do want to preface that there is direct pay that's available on the SIS program for clients that do require it for direct pay for rent as well as utilities, so that is an option. We also have expanded obviously our trusteeship and money management supports, our TAMMS program. We now actually have over 1,300 spaces available throughout the province that can really support clients on managing not just their rent and utility bills, but their overall income assistance benefits. And that's a really great benefit for individuals that could have very complex needs.

For example, they also have the ability to support them by providing them supplementary money throughout the month instead of having one big payment. They can look at the whole amount of money that they're receiving through our SIS program and provide them weekly benefits on a weekly rate, which is a really big benefit for individuals that are requiring that additional support.

So I think that's the major one, but I do want to preface that we do have direct pay that's available on SIS. What we also have seen in the past is obviously people do move and then we have to look at how can we collect back that benefit. So there's a little bit of a balance there too.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — So just hearing your explanations, over the past while it seems to me that it would be quite a variety of amount of time to collect an overpayment. I mean that's going to really . . . Even if I asked an average, it wouldn't give me very much information.

Now how does that compare with concerns with SAID [Saskatchewan assured income for disability]? Like do we have overpayments in SAID? Would that follow the same kind of story

as what's here?

Julene Restall: — Yes. So our SAID program has an overpayment assessment policy as well. It is separate from SIS. It's dependent on the full amount that an individual is eligible for, and there are specific policies on that amount. But we have a very similar approach for both of our programs.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Since implementing recommendation 4.3, has the ministry seen a decrease in time that it takes to recover an overpayment?

Julene Restall: — At this current time we don't track the period of time that it takes to recover because it is on a case-by-case basis, dependent on what that amount of overpayment is.

Hugh Gordon: — I'm wondering if you could explain the increase in accounts receivable for overpayments from '23 to '24.

Julene Restall: — So a little bit about that. As I mentioned earlier, since the closure of the SAP and TEA programs, our caseload has actually expanded greatly. So with the higher amount of cases that are on the caseload, we would anticipate a higher probability of overpayments being made as we continue to grow and mature as the program ages.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — What are the steps that the ministry takes to ensure consistent documentation in the CFP [child and family programs] Linkin case management system surrounding hotel selection?

Tobie Eberhardt: — Good afternoon. Tobie Eberhardt, ADM for child and family programs. Since the policy came into place about the three-quote process, we've taken a number of steps in CFP to ensure that this recommendation was implemented.

We held four sessions with our employees at the end of 2024 to go through the processes of how they should document it in our Linkin case management system. And that presentation content is available to all staff on a SharePoint now.

In addition, in January 2025 we updated our business manual for Linkin to outline where they should be locating that information in Linkin. And again we developed some Q & A [question and answer] sessions that were offered to all our staff, including our management staff providing the oversight around that.

Joan Pratchler: — And do you feel that, you know, a comfort level, the staff has a comfort level in feeling successful in doing those with all that support that you've given them?

Tobie Eberhardt: — Yeah, I think that they feel that there's consistency on where to document it into Linkin. So very clear on where they should be placing it, and then that allows our supervisors to go in there and make sure that they're documenting it in the right place as well.

Joan Pratchler: — And compliance would be quite high with the documentation?

Tobie Eberhardt: — I know we were going to do a follow-up. So yeah.

Joan Pratchler: — Okay. Good. Thank you. Okay, I have another question. I know on page 58 of the report there's a list of the hotels all the way up to '23-24. Are there additional hotels that need to be added to that list?

Grant Hilsenteger: — My name's Grant Hilsenteger. I'm the ADM responsible for finance and corporate services. So on page 58, these are the hotel expenditures that we put together. There was a request for this, and so we put this together specifically to provide information back to a member of the legislature that asked for this. And what we were providing here was just the top three hotels that were being used that year in whatever city at that time. So what you're seeing here is all that we were reporting.

Joan Pratchler: — Are there additional ones that are on that list that you can provide us? Not right now.

Grant Hilsenteger: — I think we did for these years. I think we still have that, yes. I think we could provide that.

Joan Pratchler: — Okay, great. If that could . . . just add it. Add it to the list.

A Member: — Yes, we can table that.

Chair Wotherspoon: — Thanks. And just to make sure we have the . . . Thanks for the undertaking to provide that information. And is 30 days reasonable? And that can be supplied through the Clerk back to this committee. Thank you very much. And that'll provide updated information for the previous years, this past fiscal year as well. Is that correct?

Richelle Bourgoin: — That's correct.

Chair Wotherspoon: — Right, thanks. MLA Gordon.

Hugh Gordon: — Thank you very much. And just to tie on to that one, is there like some robust vetting policy procedures you go through when selecting a hotel? Have you guys, you know, I guess reinforced your vetting procedures as to which hotels and what kind of criteria you use before selecting them? Like for example, are there any conflict of interest guidelines that you adhere to?

Richelle Bourgoin: — So maybe I can speak to that in two parts. I can speak to the conflict of interest guidelines. Specifically as public servants, we would not be engaged in the vetting of vendors related to conflict of interest with members of the Legislative Assembly. That's done outside of the work that we do within the ministry.

But in terms of vetting hotels, we do have expectations with all of our vendors around standard practices like reporting transparency in the financial process. How we enter into the contracts would be consistent with our process, as well as that of

the SaskBuilds and Procurement team. And so we would treat those hotels as we do any other vendor that we work with at the ministry.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — I'm just going to try to look at that last recommendation. So something's not quite aligned in my thinking, and maybe you can help me understand. It's the one regarding the reporting policies. So it suggests that our neighbours — Alberta and Manitoba — report payees, but Saskatchewan doesn't because there's a reporting policy not to or . . . I just don't understand. Asking for the transparency on that and I'm confused.

Richelle Bourgoin: — So I will say that I'm not specifically familiar with Alberta and Manitoba, with their specific reporting requirements. But Erin can speak to the work that we do with our colleagues at the Ministry of Finance.

[15:45]

Erin Kiefer: — Hi, I'm Erin Kiefer. I'm the executive director of finance. So when the ministry makes a payment to a vendor on behalf of a client, it's considered a transfer payment. So the ministry makes many thousands of transfer payments on behalf of clients each year. So the financial administration manual communicates treasury board's policies and the Provincial Comptroller's directives to ministries and public agencies, and these financial policies and directives are made pursuant to *The Financial Administration Act*.

So section 2010.01 states that "For transfers, details are not provided for high-volume programs of a universal nature, or income security and other programs of a confidential and personal nature; or where governing program legislation requires payee information to be kept confidential."

So to support the client-facing services that we have at Social Services, we additionally have our own stand-alone financial systems that do both case management — so we can keep track of people and their needs — and to make payments to them. And so because transfer payments to individuals are excluded from public reporting and have been for a very long time, since at least the '80s when the first of the systems were completed, they were never designed to provide the rolled-up reports of the amounts that are being to paid to vendors on behalf of our clients. And so that's what makes it very difficult for us to be combing through to find the specific details to report.

So I could say that what we have done so far is that . . . Most vendors paid on behalf of clients are chosen by the client. They're not chosen by us, right. So sometimes we make payments that are invoice based. So, for example, the ministry might make a payment to a local pharmacy on behalf of a child and family caregiver. Or other payments that we make are requisition based. So that would be in a circumstance where someone comes into the office, and someone on the front line would write them a requisition for groceries, per se. And so then that person takes their requisition to a store of their choice. And as long as that store accepts our requisitions, they hand it in and then the business fills it in, sends it back to us, and we make the payment to them.

So recognizing the intent of the auditor's work was to ensure that we're looking for best value, we have done some work to ensure that in circumstances where the ministry is making the choice of where we're making purchases, that we've been reviewing instances where we do have some bulk purchasing and ensuring that we are using standing offers or looking at the opportunity for RFP [request for proposal].

So for example, we have a standing offer that we use to purchase car seats. So we buy a lot of car seats because when children come into care, you need to make sure you have a car seat, and they expire and so on and so forth. So we do things like that to make sure that we're finding the best public value on those bulk purchases that we do.

Joan Pratchler: — Thank you. I didn't realize it was that complex.

Chair Wotherspoon: — Just on this one here, so like the recommendation 2, you've committed, you've implemented, which is then the tracking of those costs to the hotels and monitoring the situation. And then you've provided, I believe, a commitment here to provide the information on the payees, if you will, the hotels, because no one's looking for the information of the clients, that that information is private.

So what's in question here is the summary annually of the costs paid to those vendors, to those hotels. From my understanding, no. 2, you've committed to implementing or have implemented it, which then compiles that information. And we've had an undertaking I believe here today to provide us the updated information for the previous years on the amount paid to those vendors.

So I guess just a question is, what's standing in the way? We can come to the committee and we can seek it here. We've received that undertaking. But why wouldn't that just be published? And of course the recommendation is to work with the Ministry of Finance to look at options on that front. So whether or not it's in volume 2, that could be one place that it fits by working with the Ministry of Finance. But nothing stops the ministry from publishing this in its annual report, for example.

Richelle Bourgoin: — And so what we have done is, taking the position that we are certainly meeting the expectations of our colleagues at the Ministry of Finance, looked at hotels as one service that we provide in a broader range of services related to that program. That is the income assistance program that's specifically identified in the FAM [financial administration manual] guidelines. And so hotels would be one service that we provide.

And again I think we're still working together with our colleagues at Finance to determine, but if that was to go into volume 2, it would be a much broader piece of work because hotels are just one component of the services that we procure on behalf of clients, or directly through clients in the income assistance programs and in the child and family programs.

Chair Wotherspoon: — Sure, but the focus is on hotels in this

case here, and you've committed to, I believe, collecting that information. You're providing that back to us here. So it's sort of secondary whether or not it's provided through volume 2 or whether it's provided publicly. I think the recommendation of the auditor calls for it to be publicly reported. What prevents the ministry? You could have something in the annual report for the Ministry of Social Services just stating those numbers without it even being — and I'm not suggesting this is the best way to go about it — without it being in the volume 2.

Richelle Bourgoin: — I think that's the work that we've committed to continue to do with the Ministry of Finance.

Chair Wotherspoon: — And so at this point is there a commitment to have . . . I guess we've received a commitment this year to receive the vendor information, the payments that were made to hotels in the previous fiscal year here. Is there a commitment then to make that available again next year? And at this point do you know . . . I think, I guess you're suggesting at this point you're not sure how you're going to provide that information, but do you commit to make sure that that's going to be public next year?

Richelle Bourgoin: — Not at this time.

Chair Wotherspoon: — I guess to the auditor, maybe with respect to 4 here, do I understand your recommendation properly? It's to have a public reporting of these amounts. You're not prescribing necessarily that it has to be in volume 2. It could be with some . . .

Tara Clemett: — I would say that we acknowledge there might be some challenges in perhaps the way this data is compiled for the ministry, and you've got to think through that. In terms of, I guess the FAM reporting requirements right now, I don't think they align with good practice. So I think the Ministry of Finance should look at them and look at what other jurisdictions are doing, and it should be updated accordingly.

I think that if this information was made publicly, you know, I think it would have helped the circumstances that arose around the hotel vendors and what should have been available to legislators and the public overall. So I do think that these are . . . While they're payments on behalf, they are payments that are made by the government to specific vendors with public money, and that information should be out there so the public and their legislators are aware of how much was paid to what vendors.

Chair Wotherspoon: — And I think the auditor's recommendations are clear on this front, and it would seem to me on this front. And this isn't towards the good lead civil servant that's before us here today or any of the folks at the back of the room. But this one, you know, to the minister: like we have the information. There's a duty to the public. Like let's get on with it.

We've had, you know, these pretty serious issues that we've gone through without having the level of transparency that the public deserves, and we have the ability here to provide that information. So you know, we can take that up, you know, with the minister if that's the barrier. But the recommendation's real clear, and you know, I certainly value all the progress we see on recommendations 1, 2, and 3 here. But you know, no. 4 should also be something that's able to have a clear commitment from the ministry and have that information provided to the public.

Any further questions from committee members at this time on these ones? Not seeing any. These are all new. Well we have the outstanding recommendation then we have four new recommendations, so I'd welcome a motion that we concur with and note compliance with recommendations 1, 2, and 3. Moved by Deputy Chair Wilson. All agreed? That's carried. And with respect to recommendation no. 4, I would seek a motion that we concur with the recommendation. Moved by MLA Chan. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay, that's carried.

Saskatchewan Housing Corporation

Chair Wotherspoon: — Okay, whipping right along here, we're shifting gears just a little bit here. And we'll turn our attention to the Saskatchewan housing authority and the pertinent chapter and the new recommendations. And I'll turn it over to the auditor while I think some officials adjust at the front. And if there's some officials that are departing that were involved in these last couple chapters, thanks very much for your time with us here today and your service.

Tara Clemett: — I'm going to turn it over to Jason to do a presentation. Just so you are aware, there is eight new recommendations within the presentation today that does require the committee's consideration and deliberation. With that, I'll turn it over to Jason.

Jason Wandy: — Thanks, Tara. Chapter 12 of our 2024 report volume 2 reports the results of our audit of the Saskatchewan Housing Corporation's processes for the 18-month period ended June 30th, 2024, to plan for social housing units to meet the needs of people in Regina.

We concluded the corporation had effective processes, other than the areas reflected in our eight recommendations. Having stable housing is important for individuals and families to succeed. Through its social housing program, the corporation strives to make safe, adequate housing available by providing social housing units and subsidizing rent based on financial need. The corporation owned about 3,000 social housing units in Regina as of June 2024, and the Regina Housing Authority managed these units.

Between 2019 and 2024 Regina had the highest level of vacancies in corporation-owned units, with a vacancy rate ranging from about 16 per cent to 25 per cent. At May 2024 the corporation had over 400 households waiting for social housing units in Regina. On page 102 we recommend the Saskatchewan Housing Corporation further analyze social housing applicant data to help determine social housing needs in Regina. We found the location and design of the social housing and portfolio in Regina does not align with current social housing need, demonstrated through persistent unit vacancies, yet long applicant wait-lists.

The corporation can produce a current approved applicant list

from its provincial housing IT system. While the corporation considered the approved applicant list in Regina in its capital budget requests, it does not analyze its approved applicant list to sufficiently determine and adapt to changes in social housing need, such as analyzing changing trends and types of applicants waiting, for example, families, singles, seniors, or people with disabilities.

At May 2024 the Regina Housing Authority approved 308 families or single persons and 96 seniors — so a total of 404 applicants — for the social housing program, but had not placed them in a social housing unit in Regina. Our analysis found the approved applicant list may be inaccurate or not up to date. Management indicated the corporation was reviewing the potential replacement of its provincial housing IT system, providing an opportunity to improve available data for decision making.

Our analysis of the monthly social housing vacancy reports for Regina found the demand for family or single social housing units significantly exceeded available units. Between February 2023 and May 2024 the number of approved family or single applicants increased to 308, but the number of vacant units available decreased to 56 in total, while more units were available for seniors than the number of approved applicants. Additionally our analysis of the approved applicant wait-list at April 2024 found almost 50 per cent of applicants seeking units with three bedrooms or more.

Without having accurate data and sufficient analysis, the corporation is unable to appropriately determine social housing needs. Periodically analyzing data on requested unit size and household compositions can provide insight into the demand for different types of housing units. This can also help the corporation plan future developments or adjust its housing portfolio to better meet applicant needs in a timely manner.

[16:00]

On page 105 we recommend the Saskatchewan Housing Corporation complete its forecast of long-term social housing needs in Regina. We found the corporation last forecasted core housing need in Regina in 2019 when it engaged a consultant to prepare a forecast to 2026. Our review of the corporation's forecast found it used data from the most recent census from 2016. Their forecast estimated Regina having about 15,500 households in core housing need by 2026 compared to 12,000 households from the 2016 census. Management acknowledged that lack of data, for example, tenant preferences, or requests for repairs from its provincial housing IT system impacted the breadth of information used in its forecast.

While the corporation engaged its consultant to update the core housing need forecast for Regina to 2038, management had yet to validate the forecast using the latest federal census released in 2021. They expected to complete this validation work in fall 2024. Without a long-term forecast of social housing needs in Regina, there is an increased risk of misalignment between social housing priorities and expected future demand.

On page 110 we recommend Saskatchewan Housing Corporation implement plans to help reduce vacant social housing units in Regina. While a social housing need exists, the corporation is facing challenges with accommodating clients' needs with its available social housing portfolio. At May 2024 Regina had 534 vacant social housing units, but only 170 were available for rent because 364 were out of service, that is, in need of repairs. This is in comparison to 404 households waiting for social housing units, 308 of which were families.

Beyond accumulating the vacancy data, we found the corporation does not further analyze its vacant units, for example, types of units under repair, which would allow it to focus repairs on units with higher demand, such as larger family units.

We also found the corporation does not track the time a unit available for rent stays empty. While it can determine chronically vacant units, those vacant for greater than six months, its reporting does not specify chronically vacant units available for rent versus those under repair. Due to data limitations within the provincial housing IT system, the corporation does not track how long vacant units are in disrepair.

Our comparison of vacancy reports from May 2024 found 334 chronically vacant units that mostly appeared to be under repair. Additionally we found these chronically vacant units reside in 32 social housing buildings in Regina, with 23 of these buildings noted as preferable locations by approved applicants. This indicates applicants want to live where these chronically vacant units are located in the city.

Our analysis of the corporation's ongoing cost to hold chronically vacant units found the estimated monthly costs, including things like property taxes or utilities, to be relatively consistent, about $300 per unit per month at December 2023. However when applying this estimate across all 334 chronically vacant social housing properties in Regina, the estimated annual cost is about $1.2 million for the corporation.

Without analyzing vacancies and tracking costs associated with holding chronically vacant social housing units, the corporation may not fully understand the financial impact of these vacancies. Further by planning to get chronically vacant units back into service, for example repairing more units with the right number of bedrooms in preferable locations, the corporation can help to address long applicant wait-lists and house more people in Regina.

On page 111 we recommend Saskatchewan Housing Corporation periodically analyze data to identify and respond to possibly over-housed social housing tenants in Regina. Household needs can change, for example fewer people living in a home, resulting in tenants possibly residing in units now too large for their household needs. This refers to tenants as being over-housed.

The corporation uses the federal government's National Occupancy Standard as a guideline when considering the maximum number of bedrooms a household needs. For example, for households with children or dependents, parents are entitled to their own bedroom, and there should be no more than two children to a bedroom. However while the corporation has specific requirements, we found it does not analyze the prevalence of over-housing within its social housing units in Regina.

At May 2024 our analysis identified 108 single individuals

residing in two-bedroom seniors' social housing units, indicating these individuals may be over-housed when there are applicants currently waiting for two-bedroom units. We also found the corporation had 105 vacant one-bedroom units available where single individuals could move.

Periodic analysis, such as annually, to identify possibly over-housed tenants can provide valuable information about whether the allocation of units address clients' needs effectively. Such information can provide the corporation an opportunity to consider changes to existing unit allocations to help meet the needs of more clients and reduce the applicant wait-list.

On page 115 we recommend the Saskatchewan Housing Corporation set performance benchmarks for its social housing operational reviews of the Regina Housing Authority. The corporation completes operational reviews every three years for its largest housing authorities, for example Regina and Saskatoon, and every five years for smaller ones. It last reported on an operational review of the Regina Housing Authority in 2023 and plans to do another in 2025-26.

Our review of the 2023 operational review report for the Regina Housing Authority found the corporation did not include benchmarks for measuring the housing authority's performance. For example, the corporation did not include benchmarks such as expected time frames for the Regina Housing Authority to place applicants in a rental unit.

We found the corporation also did not set benchmarks to measure tenant satisfaction with repairs in their units. The 2023 operational review report indicated 66 per cent tenant satisfaction with the quality of completed repairs and 53 per cent regarding the time taken to complete repairs. Both decreased from the 2017 operational review and were slightly worse than the other five large housing authorities.

Without setting and monitoring results against benchmarks in its operational review report, the corporation may be unable to effectively assess whether the Regina Housing Authority meets expectations and takes actions where necessary. This increases the risk of the housing authority not delivering appropriate services to social housing tenants.

On page 116 we recommend Saskatchewan Housing Corporation require the Regina Housing Authority to develop action plans addressing issues and recommendations identified in its social housing operational reviews. In its 2023 operational review of the Regina Housing Authority, the corporation noted three compliance issues and two recommendations.

The corporation expected to implement requirements in 2024-25 for the housing authority to document its action plans to address issues and recommendations from the operational review. Without having a formal process to follow up on compliance issues and recommendations, there's an increased risk of the Regina Housing Authority not taking timely action to improve its operations as expected by the corporation.

On page 116 we recommend Saskatchewan Housing Corporation enhance its monitoring and analysis of social housing tenant complaints in Regina. Both the Saskatchewan Housing Corporation and the Regina Housing Authority receive complaints, for example face to face, over the phone, or through email about social housing. However we found neither the corporation nor the housing authority track the complaints to analyze complaints received.

From January 2023 to April 2024, management compiled tenant complaints for our audit and indicated the corporation received 127 tenant complaints. It was unable to provide details on the tenant complaints. Without monitoring and analyzing complaints, there's an increased risk of unresolved social housing complaints.

On page 118 we recommend Saskatchewan Housing Corporation expand analysis and reporting on progress made against its building conditions target related to social housing in Regina. We found the corporation reports on progress made against some key goals and targets. For example, we found it annually reports against several goals relating to social housing as set out in its bilateral agreement with the federal government under the national housing strategy.

We found the corporation also provided periodic reporting about social housing vacancies to its responsible minister and to its board and housing management committee. However the corporation established a target to reduce the number of units with the facility condition index, or FCI, of critical or poor, but had not identified by how much. It had yet to start analyzing or reporting on this measure.

At the time of our audit, the housing portfolio in Regina was in poor condition with an average FCI of about 22 per cent. Having more information and analysis on its FCI improvement target can help the corporation identify issues and focus its efforts on buildings of highest need.

I'll now pause for the committee's consideration.

Chair Wotherspoon: — Thanks so much for the . . . this is a new chapter, and for the focus of this work. We've got new recommendations before us. So I invite Deputy Minister Bourgoin to provide some brief remarks, then we'll kick it open for questions.

Richelle Bourgoin: — Thank you very much. I'll be very brief. I'm going to turn it over to my colleague Brittany, who is the assistant deputy minister of housing and the CEO of the Saskatchewan Housing Corporation.

Brittany Csada: — Thank you. Good afternoon, everyone. I'll provide the updates for SHC [Saskatchewan Housing Corporation] this afternoon.

Related to the recommendation that the Saskatchewan Housing Corporation further analyze social housing applicant data to help determine social housing needs in Regina, the ministry considers this recommendation partially implemented. Saskatchewan Housing Corporation has already strengthened reporting to provide greater insights into social housing needs. We've added provincial approved applicant wait-list data into our dashboard report and our '25-26 quarterly corporate reporting, and a working group has been formed to lead vacancy response efforts and conduct a detailed analysis of vacancy data and the approved applicant wait-list.

More work is under way to be implemented by the end of December 2025. Monthly reports will be produced and shared with housing authorities to ensure accurate and reliable applicant data is used to assess social housing needs, and program and policy changes will follow from the vacancy response working group's analysis and recommendations.

Related to the recommendation that SHC complete its forecast of long-term social housing needs in Regina, the ministry considers this recommendation implemented. The core housing need forecast was updated to the year 2031 using the University of British Columbia's housing assessment resource tools model. The housing need forecast will be updated again following the 2026 census.

Related to the recommendation that SHC implement plans to help reduce vacant social housing units in Regina, the ministry considers this recommendation partially implemented. Capital investments of 10.8 million are budgeted in '25-26 to repair and renovate units in Regina to serve the growing demand for social housing in the community. This includes 4.3 million to begin a multi-year renovation and repair to 154 units at Prairie Place in Regina to bring vacant units back into service.

Along with this funding, the vacancy response working group that I mentioned earlier will analyze housing demand in communities — including Regina — review potential policy changes regarding vacant units, and implement actions as identified to reduce vacancies. Our timeline for full implementation is March 31st, 2026.

Related to the recommendation that SHC periodically analyze data to identify and respond to possibly over-housed social housing tenants in Regina, the ministry considers this recommendation not implemented. We are currently developing policy criteria and processes related to social housing tenants that may be living in units that provide more space than they currently need. An implementation plan will be prepared by the end of 2025.

To fully implement this recommendation by December 31st, 2026, we will gather and analyze data, including establishing a new periodic review schedule to identify instances in Regina where social housing tenants may be living in space larger than they need, and we'll prepare plans to accommodate those with greater demand on the wait-list.

Related to the recommendation that SHC set performance benchmarks for its social housing operational review of the Regina Housing Authority, the ministry considers this recommendation implemented. SHC has developed an action plan that includes benchmarks and goals to enhance communication with tenants and approved applicants, ensure more accurate and timely data entry, and improve the repair process. The plan has been reviewed with the Regina Housing Authority, and benchmarks will be reviewed as part of the '25-26 operational review.

Related to the recommendation that SHC require the Regina Housing Authority to develop action plans addressing issues and recommendations identified in its social housing operational review, the ministry considers this recommendation implemented. SHC has drafted an action plan and is working with the Regina Housing Authority on addressing compliance issues and recommendations from the 2022 operational review report. Meetings are occurring biweekly and additional follow-up will occur during the '25-26 operational review.

Related to the recommendation that SHC enhance its monitoring and analysis of social housing tenant complaints in Regina, the ministry considers this recommendation partially implemented. SHC currently maintains an internal database that is used to track tenant complaints received throughout the province. To address complaints in Regina, the Regina Housing Authority is working to develop an app to track and assign maintenance tasks in a clear and concise format.

As part of the '25-26 Regina operational review, tenants will be surveyed to provide a representative overview of tenant satisfaction with their unit, the service provided by the Regina Housing Authority, and other key indicators. Responses will help confirm whether the housing authority has compliance issues and will help in developing recommendations from the operational review. We anticipate fully implementing this recommendation by December 31st, 2026.

Related to the recommendation that SHC expands analysis and reporting on progress made against its building conditions target related to social housing in Regina, the ministry considers this recommendation partially implemented. In July 2025 SHC completed its annual facility condition index, or FCI, update. And SaskBuilds and Procurement is also conducting inspections on select SHC-owned buildings. The annual FCI update will be included in the Q3 dashboard report, and we are exploring opportunities to include additional details in the ongoing reporting, such as FCI breakdowns by community and building components. We anticipate fully implementing this recommendation by March 31st, 2026.

I'll turn it back to the Chair.

[16:15]

Chair Wotherspoon: — Thanks so much for the update and for all the actions that have been undertaken. I'll open it up to committee members that may have questions. MLA Gordon.

Hugh Gordon: — Hi there. You mentioned there was some progress made in terms of, you know, the approved applicant list for social housing. And you mentioned accuracy, also trying to improve the accuracy, I guess to reflect the actual needs of the clients that you're serving. When did you expect that to be fully implemented, that recommendation?

Brittany Csada: — December 31st, 2025.

Hugh Gordon: — Because what it seems to be is like we've got . . . According to the report, there's a bit of a disconnect between the demand, right, for seniors and for families, and that the supply is out of whack. So I'm just curious what efforts the ministry is taking in order to, you know, rebalance that need versus supply.

Brittany Csada: — So we know from the data that there's a growing demand for family housing, and in particular family housing with, you know, three bedrooms or more. That's a trend we're seeing. And so you know, we use that information. I'll give

you an example of something that we've done to rebalance the portfolio. One example is reflected in the investments made into the Regency Gardens property in Regina, and that's where we replaced units to accommodate larger families to meet that growing need.

Hugh Gordon: — Sorry. Is that going to be sufficient for the need? You think that once that's done at one facility that that's going to help rebalance the portfolio?

Brittany Csada: — No. That's an individual example. And so when we have the opportunity to sit down with the working group that is meeting on a biweekly basis and really trying to look at ways to maximize the capacity of the inventory, in particular in Regina, it's going to take a series of interventions to make sure that we can get there, including working with clients who are in larger units whose family composition may have changed over time — maybe they're empty nesters; maybe their children have moved into another unit because they're now living independently — and to be able to support those clients to effectively find the most appropriate housing.

So I think it's an all-hands-on-deck approach in addition to adding some larger family units — like the example that Brittany provided which would be where we see also a growing trend in the number of children that are in the family unit — to be able to have the diversity in the portfolio.

And we look at a property in North Battleford like Valleyview Towers. There's two of those towers. Traditionally they had been assigned for seniors' housing but we know that the demand for seniors' housing has shifted, in particular with the demographic of the province. And so we don't see individuals coming off the farm looking for support in a seniors' housing unit the way that we maybe did 30, 40 years ago.

How can we use that to provide an immediate response to a number of needs that are emerging — whether it be family housing, affordable housing, social housing — and try and meet the need of the community? By being flexible but very clear in how we support clients that are existing in those properties to be successful, either there or in an alternative location, but trying to be just I think really flexible in how we work with our housing authorities to ensure that we're maximizing all of the space that we have available.

Hugh Gordon: — Correct. And I would think, you know, also getting a handle of, a good understanding of who may be in an over-housed situation is going to assist, particularly in Regina, going forward. So that's very important work that you need to continue to do, I would imagine.

And on that point, if I heard correctly, you did say that the funds that have been allocated for renovating or repairing homes was going to be 154 units that were going to be renovated. Do I understand that correctly?

Brittany Csada: — That's at Prairie Place here in Regina. Correct.

Hugh Gordon: — In Regina. Of that amount — it sounds like a large amount though — how much do you think this is going to reduce the demand or help rebalance the demand for family units in Regina? Is that going to be a sufficient number? Does the ministry need to continue, let's say two, three . . . They have a five-year plan of having more units made available. And maybe you can comment on that first.

Roger Parenteau: — Good afternoon. Roger Parenteau, executive director of housing operations. With regard to your question on Prairie Place, that's just one example where more units will become available for seniors' housing in Regina. But there's also other initiatives and partnerships that are occurring throughout the portfolio in Regina.

Another example of that is Lovering Place, where through PATH [provincial approach to homelessness] we had supportive housing initiatives. And we had an RFP for groups to respond to an RFP to provide supportive housing services, and they required a building to operate out of. And Lovering Place is a building that is SHC owned, where we provided a group with a service provider to deliver supportive housing services out of that building, so taking that building out of its current role as seniors' housing and changing it to supportive housing, so just pivoting with using our portfolio for different purposes and trying to balance our portfolio based on the needs that we have.

Hugh Gordon: — Fair enough. But I guess my question really was, of 154 units that are going to be renovated, right, the government has said for this year it's going to be 283 units total across the province, if I'm not mistaken, of publicly owned homes, right, that are going to be refurbished or renovated and be made available — 283. Of that, 154 units appear to be allocated for renovation in Regina.

What I'm asking is, is that sufficient to meet the demand in Regina? And if not, what steps is the ministry prepared to take or going to ask to be taken in order to ensure more units come online and are available in the future?

Richelle Bourgoin: — So what I might do is just provide a bit of context. And I'm going to ask my colleague Kim to speak specifically about some of the real estate decisions that are being made more broadly in Regina. But you know, in the longer term, thinking about the forecasted demand in this city in particular, we are in the process of working with our colleagues at the Government of Canada. They have committed to renegotiating the national housing strategy, which is significant for us, which will allow us to make decisions on larger capital investments to be able to respond to the trends that we see and to the forecast that we have developed.

We also are starting to understand more about the potential for Build Canada Homes and what that might mean in Saskatchewan, although there's still work to do to fully understand how we can maximize the provincial investment to ensure that we are making those spaces available.

But I will ask Kim to speak about what we're doing right now just more broadly in Regina.

Kim Hornung: — Kim Hornung. I'm the executive director of housing infrastructure and business information. So in Regina what we're talking about, Prairie Place, that is only 154 units. The other investments we are looking at within Regina, we are looking at additional $4.6 million of operational capital

maintenance. So that investment would be across all the unit types. Whether it's to support individuals or families, that would go across that whole gamut of units.

We're also investing an additional 1.9 million for large component replacements. So that would also cover family initiatives like Prairie Place. Recently we've issued an RFP for a large family unit within Regina as well, Greer place, which is in the east end, towards the east end.

So again we are looking at larger investments, and we selected that location again based off of the demand. There's a school nearby. There's supports for families around. There's doctors. There's schools. There's bus routes, transportation. So we've really worked on using the information that we have to be able to select those locations to best invest in going forward.

Hugh Gordon: — So to be clear then, those 154 units are insufficient, is what you're saying, and that you've identified a need going forward for more units. Do I understand that correctly?

Richelle Bourgoin: — So the 154 units are major capital repair. What is important is that we maximize the capacity of each of the units that we have available, so ensuring that we're making capital investments, at the same time making sure that we're turning over units quickly when a family or an individual moves from one unit to another, that we're reducing the time frame between occupancy, trying to make sure that we're working with the housing authority to remove any barriers, to make sure that we are using every single available unit while at the same time understanding how we can shift the portfolio where necessary to meet the needs of today. Because some of them were built for needs that were previously existing, in particular seniors' housing in some of our rural communities.

And so what we know is that in order to make assessments on future capital investments, we need to make sure that we are fully using to the best of our ability all of the available space that we have. And then to continue to monitor, to the auditor's recommendation, on using the analysis as we successfully move quickly to be able to meet the demand to understand precisely what would come next. And that would be part of our larger capital plan.

Hugh Gordon: — So sorry. I'm going to continue to beat a dead horse a bit perhaps, and I apologize if I've been repetitive. I guess maybe to help clarify the problem, and perhaps the solution is, what is your current demand for family or senior housing right now for households who do not have a place? And how many vacant units are there awaiting a renovation or some other capital upgrades that need to be done to bring them online? Like that to me would help paint a better picture of what the demand and the supply, the need is, right.

Richelle Bourgoin: — Just for a point of clarification, speaking specifically to Regina in this instance, so we have a portfolio of 2,965 units in the city. 1,519 of those are for seniors. 1,446 of those units are designated for families.

The vacancy rate in June, which is the most recent data that we have, overall was 15 per cent, slightly higher rate for seniors' units and a lower rate for family units. But the availability rate — so that's the number of units that's available for tenants to actively move into — was 5.5 per cent, so about 165 units that are in turnaround, so to speak. So perhaps it's minor painting or cleaning a carpet. Somebody moves out on the 31st and we're not quite prepared with the housing authority to move them in on the 1st. So that breaks down to 91 seniors' units and 74 family units that would be available. At this point in time we have 350 families or single individuals on an approved wait-list with the Regina Housing Authority. We have 68 seniors.

Just a point of clarification to your question: because the clients are on a waiting list does not mean that they are unhoused. It just may mean that they are seeking the opportunity to move into a Regina Housing Authority building. So they may be in another community with an opportunity, for example, to come closer to some of the services that Regina has. They may be in independent housing. They may be renting from the market and this may just be a preferable and more favourable option for their family.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Will any of the findings on the social housing needs be made publicly available? And if so, how often will they be made available to track any changes or trends?

[16:30]

Richelle Bourgoin: — So it's excellent timing. I can speak to that because we've had those conversations very recently. We're in the process of evaluating how we best develop the dashboard that will provide reporting to ensure that there is transparency for housing authorities, but as well for individuals and families that may be looking for options. And so we do expect that that will be publicly available.

I don't have a timeline at this point. There's a bit of technical work that needs to be done in the background, but the intent is to have that publicly available.

Joan Pratchler: — And if we were to ballpark, are we talking one year, five years?

Richelle Bourgoin: — I think within the year.

Joan Pratchler: — Okay.

Richelle Bourgoin: — I should say within the fiscal.

Joan Pratchler: — Recommendation 4.4 reports that core housing need forecast was updated to 2031. Can you share what the core housing need is forecast to be in 2031?

Brittany Csada: — So I'll share the core housing need projections for Regina. So 10.3 per cent of total households, or 9,290 in total, are considered to be in core housing need. By 2031, the number is projected to increase to 10,500 total households in core housing need.

So what we know is that based on census data, 23.1 per cent of renters and 4.1 per cent of homeowners are considered to be in core housing need. We also know that, you know, 23.9 per cent

of families are in core housing need that were lone parents, and 21.3 per cent were Indigenous households.

Joan Pratchler: — How many housing units will need to be built or repaired to meet that 2031 core housing need forecast?

Brittany Csada: — So the SHC portfolio is not the only mechanism to meet core housing need. It supports, you know, other providers such as the market, other housing providers. But I would like to highlight that SHC continues to offer a number of housing programs that do address core housing need across the province, and I'll highlight a few of them.

The social housing program offers units at a rent geared to 30 per cent of an eligible household's income. The Saskatchewan housing benefit provides a monthly benefit that helps eligible Saskatchewan renters better afford their rent and utility costs. Home repair programs, including the emergency home repair program and the Adaptations for Independence program, offer financial assistance to help homeowners complete repairs to ensure the adequacy of their homes. And the rental development program provides one-time capital funding to help housing organizations develop affordable rental units for households with low incomes.

Chair Wotherspoon: — Pratchler has the floor maybe for another one here, then we'll come back your way, Gordon. MLA Pratchler and MLA Gordon. I should be proper here.

Joan Pratchler: — So I don't think I heard the answer I was looking for, so maybe I didn't ask the question properly. How many housing units will need to be built or repaired to meet the 2031 core housing need forecast?

Richelle Bourgoin: — And so perhaps I can provide a little bit of clarity, but we don't have an expectation that the Saskatchewan Housing Corporation inventory will meet the need for every single individual who's identified on the core housing list. So our approach is to ensure that we are fully utilizing every available door that we have in the inventory, and supplementing the inventory to ensure that we have immediate needs where they can't be filled by another solution.

And so the programs that Brittany was talking about — for example, the Saskatchewan housing benefit — allow individuals and families to afford market rent options where social housing may not be the solution for them. We also look at things like the rental development program to partner with other organizations, like municipalities as an example, to bring on innovative solutions that maybe haven't been contemplated before.

And so we see a number of, I think, really interesting community partnerships that are developing housing options that would be considered non-traditional. And I think about in Regina some of the work that RT/SIS [Regina Treaty/Status Indian Services Inc.] is doing, for example, or an organization like the Oxford House that provides a housing solution outside of the portfolio.

And so rather than thinking about the number of doors that would be required, we're trying to look at not only the best practices across Canada but tools that we have available to directly support the individual and unique need of the family or the applicant who is seeking our support.

So we do that by providing navigational services. We stack on programs like the Government of Canada's Reaching Home program to work with organizations like the Métis Nation of Saskatchewan. We work with Indigenous governing bodies to try and support the community regardless of what that looks like. And so we want to ensure that when we're working in communities, they understand that the Saskatchewan Housing Corporation is an important tool, but it is not the only mechanism that's available.

And so I know we're speaking generally of Regina, but when we look at some of the successes we've had outside of Regina, it's also been in ensuring that the inventory that we have is being used most appropriately for that community. If that means divesting some of the assets or looking to partner with an organization . . . One that comes to mind — just because I had the opportunity to speak with them earlier today — in Saskatoon is the partnership we have between the Saskatoon Housing Authority and Egadz, which is a children-serving organization that allows young people to live in the property to develop skills to build and maintain the property.

And so if you need a deck built, these guys know how to do it because they've done that maintenance on the building and they set the rules for their community. And they receive the support that they need to be successful to keep them from becoming at risk of homelessness as young people who are seeking independence.

And so I don't have the number that you might be looking for because we are looking at all of the solutions that we can bring to bear to meet core housing demand, of which the Saskatchewan Housing Corporation portfolio is one.

Joan Pratchler: — So if I'm to understand correctly, that could be every couple of years to even figure out what's needed there.

Richelle Bourgoin: — You know, I would suggest that that's an ongoing task. And to the auditor's recommendations, that importance of being on top of the analysis and making sure that we have the input data to be able to make good decisions and recommendations to government to provide us with direction to respond will be critical.

Joan Pratchler: — And do you feel you have that data or you have access to at least generating it?

Richelle Bourgoin: — Yes, yes. Absolutely. And what we've seen is, I think, across the country a real shift in expectations of communities and how they support individuals who are at risk of homelessness or individuals who are unsheltered.

And so we have the benefit of learning from our neighbouring provinces and territories, and as well our partners with the Government of Canada, who can work together with municipalities, with Indigenous governing bodies, with provincial and territorial governments to try and bring solutions to bear at a time where we can be innovative and take some risk because the payoff is so important.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I just was curious. I guess part of this data collection is an ongoing process, and hopefully you'll make, you know, some real progress in that regard. I'm just wondering how is the ministry currently prioritizing which units do get repaired or renovated?

Roger Parenteau: — So the main component to make our decisions on what we are doing on the units that we're repairing is our applicant data and the demand for the family unit. So paying a lot of attention, making investments in our family portfolio, and trying to get those units turned over and back in operation as quickly as possible, and also getting back to the Prairie Place and major capital investments that are required. So identifying buildings that are in need of major investments and asking government to make those investments, and getting those units back in operating service and making it ready to meet the demands of the wait-list.

Joan Pratchler: — Would you be able to talk a little bit more about the goals and the benchmarks created in the action plan from recommendation 4.9?

Brittany Csada: — So benchmarks and goals have been set for the Regina Housing Authority within the action plan developed following their last operational review that I mentioned. And these are really around enhanced communication with tenants and approved applicants. They consider the housing authority performance with regard to customer perspective, financial management, asset management, and business governance.

The benchmarks include targets related to overall tenant satisfaction, including repair time and repair quality satisfaction — and these are included — as well as targets related to support provided by the housing authority. Respect shown and fairness are also included as benchmarks.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Getting back to the over-housing, I guess, data collection. Can you just tell me what policy criteria processes are under development? What are the factors you're going to take into account when determining an individual is over-housed?

Brittany Csada: — The Regina Housing Authority regularly reviews tenant income and household composition to ensure that households are living in units that are most appropriate to meet their needs. As we've talked about, there's high demand for rental units for families here in Regina, and by matching tenants with the appropriate units for their household, more individuals and families in need can have access to housing.

[16:45]

We are working to centrally analyze data on tenants who have more bedrooms than they require. We're in the process of developing policy criteria and processes to respond to possibly over-housed social housing tenants, and this will include a plan for implementation by the end of 2025.

The scope of these policy changes and processes will be to address circumstances where a client is over-housed for reasons other than disability or medical need. So we know there are times when, you know, people might need more than one bedroom, and so we're going to make sure that we go through the data to sort through that. And the focus would be on those where, you know, medical or disability is not at play.

We'll also work to provide policy guidance to the housing authorities to address these situations where individuals may be over-housed. Once implemented, we'll review with the Regina Housing Authority the implementation of the policy criteria as part of their ongoing operational reviews — so we'll build them into there — to assess compliance, and that will be established on a regular schedule.

Richelle Bourgoin: — And if I could just add, we also understand that while it is necessary that we maximize the capacity of the inventory we have, it will not be easy for individuals who have been housed in an apartment or in an SHC unit for an extended period of time, and where they may have raised their children who have now moved independently. And so as part of the policy work that is being developed within the ministry, we are also looking at how we support individuals who will inevitably be required to move to be successful in their new community.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — How many inspections of select SHC-owned buildings have there been so far, and how many remain? What are the trends you're noticing?

Roger Parenteau: — So to answer the part of your question on the amount of inspections, our cycle is to have an inspection of the units, of all our units between three to five years, so our technical people going through the units every three to five years.

Joan Pratchler: — And have you noticed any trends over . . . Oh, sorry.

Brittany Csada: — You know, much of the social housing portfolio was created over 35 years ago, and so demographics and housing needs have changed over that time, and we've talked about some of that. I think in terms of our portfolio, that's where we're seeing some of the major component investments that we're having to do now, right — boilers, roofs, some of those pieces. Like I say, that's a trend, and that's the focus of some of our capital repairs this year.

Joan Pratchler: — So more larger . . . Okay.

Brittany Csada: — Yeah.

Chair Wotherspoon: — Any further questions from committee members? Not seeing any, we have eight new recommendations here. I'd welcome a motion to concur and note compliance with respect to recommendations 2, 5, and 6. Moved by MLA Crassweller. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. I'd welcome a motion that we concur and note progress with respect to 1, 3, 7, and 8. Moved by MLA Beaudry. All agreed? That's carried.

And I'd welcome a motion that we concur with recommendation no. 4. Do we have a mover? MLA Chan. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay, that's carried as well. So that concludes our considerations with the Ministry of Social Services and Sask Housing authority and for the day, in fact. But thank you very much to Deputy Minister Bourgoin for joining us here today, along with all the Social Services officials, as well as the officials with Sask Housing authority. Thanks for the work that you're involved in, day in, day out.

Deputy Minister Bourgoin, do you have any brief remark before we shut this meeting down?

Richelle Bourgoin: — Yes, I'll be very brief. Thank you very much, Mr. Chair. And to the members of the committee, we really do appreciate your time and taking this opportunity to update you on the progress we've made. And thank you, of course, to our colleagues at the Provincial Auditor's office for your work that supports the ministry to improve the essential services we provide to the people of Saskatchewan. Thank you.

Chair Wotherspoon: — Okay, well thank you for that. Committee members, unless folks have a bunch more business, is there a motion to adjourn? MLA Crassweller moves. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. This committee stands adjourned until Thursday, October 16th, 2025 at 10 a.m.

[The committee adjourned at 16:51.]